

College Station Family Medicine Center General Consent and Disclosure

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: College Station Family Medicine Center (Hereinafter called "Clinic") encourages individuals to seek a personal physician for periodic health examinations and for the treatment of health problems. The Clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Clinic cannot assume the responsibility for payment of medical care received outside this Clinic, including the delivery of babies, unless previous authorization has been given.

DISCLAIMER: Among its services, the Clinic utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Clinic, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I give / I DO NOT give , permission to the Clinic, its designated staff and other medical personnel providing services under its sponsorship to perform the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, and HIV testing.

INFORMED UNDERTANDING: I understand that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical and Social Service Records may be released to representatives of the United States Department of Health and Human Services and to representatives of program or projects funded by this Department and other funding services sources for the purposes of determining contract compliance with Federal/State law and regulations.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name _____ Signature _____

Person Authorized to Consent (if not patient) _____ Relationship _____

Signature _____ Date _____

SECTION II: I CERTIFY THAT THE PERSON WHO HAS THE POWER TO CONSENT CANNOT BE CONTACTED AND HAS NOT PREVIOUSLY OBJECTED TO THE SERVICE BEING REQUESTED.

Patient's Name _____

Name of Person Giving Consent _____ Relationship to Patient _____

Signature _____ Date _____

Address _____ Phone # _____

SECTION III:

Counselor Signature _____ Date _____

* Translated into _____ /Read to me by _____

Signature of Person translating or reading consent to patient: _____

Date _____ Client # _____