



FOUNTAIN CLINIC

CONSENT FORM

I consent to receive services at the Fountain Clinic, which may include assessments, routine diagnostic procedures, medications and such medical treatment as the attending Physician/Nurse Practitioner/Physician's Assistant/Dentist consider to be necessary for my care. I understand that the practices of medicine and dentistry are not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment at this clinic.

I understand that the services I receive at the Fountain Clinic, or as a result of a referral from the Fountain Clinic, are being provided by health care practitioners and lay volunteers. I understand, as provided by Federal and State law, that these volunteers are not liable for civic damages as restful of acts or omissions which may occur in providing services to me, except acts or omissions amounting to gross negligence or willful and wanton misconduct.

I consent and understand that should I receive health insurance of any kind, including Medicaid/Healthy Michigan Plan that **I have six months from the active date of coverage to find a new primary care physician before I can no longer be an active patient of The Fountain Clinic.** Should I lose insurance coverage at anytime I am welcome to come back to The Fountain Clinic for my healthcare needs.

I authorize the Fountain Clinic to transfer clinical information about me to other healthcare providers/agencies if needed to carry out my treatment/plan of care. I understand that I am responsible for loss or damage to any valuables. My signature below constitutes my acknowledgment that I have understood this request for consent, and I understand its contents.

I authorize disclosure of my protected health information only in the specific manner for the named reason and to the specific person:

- Can leave on answering machine/voicemail
- Can leave with specified family member(s):
Name(s): _____

Specified description of information to be disclosed: _____

Patient Signature or Consenting Party

Date

Fountain Clinic Staff/Volunteer

Date