

**Consent for Care at the Hope Medical Clinic**   **Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Hope is a free clinic staffed with volunteer physicians, nurse practitioners, physician assistants, nurses, and staff. I consent to receiving services at the Hope Medical Clinic. I acknowledge that no guarantee will be provided regarding diagnosis or outcome of treatment. I understand, as stated by Federal and State law that these volunteers are not liable for civil damages as a result of acts or omission while providing care.

Services provided at the Hope Medical Clinic may include physical exams, routine procedures, and assistance applying for free prescriptive medications provided by the drug manufacturers for expensive medications. Eligibility for Medication Assistance Programs is determined by the drug manufacturers.

Services NOT provided within the walls of the Hope Medical Clinic may incur a charge. We will do our best to inform you prior to seeing a specialist or having a test or procedure done elsewhere if there will be a charge. Although Hope Medical Clinic offers free visits to primary care and specialists; **we cannot guarantee free testing services** such as labs & x-rays, through healthcare systems in the area. Specialty care such as seeing a surgeon or advanced radiology procedures such as an MRI, may require approval from the hospital financial counselor prior to scheduling.

**I agree to cancel all clinic visits and specialty care appointments a least 24 hours in advance. I also understand that if I fail to cancel an appointment and do not show up as scheduled, another appointment may or may not be rescheduled depending on availability. Repeated “no shows” may result in a “walk-in only” status. “Walk-in only” patients will not be able to schedule future appointments but will be asked to wait at the clinic for available openings in order to be seen by a clinician.**

Hope Medical Clinic does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

I authorize the Hope Medical Clinic to transfer clinical information about me to other health care providers/agencies if needed to carry out my treatment/plan of care.

I understand that I am responsible for my own valuables while at the clinic and the clinic is not responsible for loss or damage to any valuables.

**I agree to allow Hope Clinic to send email, automated voice and/or text messages for appointment reminders to the email and/or cell phone number listed below:**   **YES**  or  **NO**

My signature below constitutes my acknowledgement that I have reviewed a copy of this request for consent of care and that I agree to its contents.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TheHopeClinic.org

Ypsilanti: 518 Harriet St / Ypsilanti, MI 48197 / 734-481-0111 + Wayne: 33608 Palmer Rd / Westland, MI 48185 / 734-710-6688