TRINITY COMMUNITY CARE

Patient Consent Contract

Authorization for Medical Treatment
And
Acknowledgement of Written Discloser Regarding MCL 333.16277 of
NO Civil Liability for Nonemergent Medical Services

READ CAREFULLY—THIS IS A CONTRACT

I acknowledge that Trinity Community Care is a not for profit health clinic. The services provided are for nonemergent care only and all services are free of charge. I further acknowledge that services provide by Beaumont Health System are provided for the convenience of the patient and all costs associated with said services will be charged to Trinity Community care, not myself.

I FURTHER ACKNOWLEDGE THAT THE VOLUNTEERS, WHETHER PROFESSIONAL OR NOT, INCLUDING BUT NOT LIMITED TO PHYSICIANS, DENTISTS, NURSES, DENTAL ASSISTANTS, SOCIAL WORKERS, OR OFFICE STAFF, SHALL NOT BE HELD LIABLE FOR ANY ACTS OF NEGLIGENCE, POOR OUTCOMES, OR THE FAILURE TO PROPERLY DIAGNOSE OR TREAT ANY OF MY MEDICAL CONDITIONS. MCL 333.16277 PROVIDES PROTECTION FROM CIVIL LIABILITY FOR ALL SERVICES PROVIDED BY TRINITY COMMUNITY CARE. BY SIGNING THIS ACKNOWLEDGEMENT I AGREE TO BE BOUND BY THE LANGUAGE OF MCL 333.16277 AND ITS INTERRPRETATION BY A COURT OF COMPETENT JURISDICTION.

I consent to receiving services at Trinity Community Care. These services may include assessment, routine diagnostic procedures, medications, and other medical treatment as the attending Physician/Nurse Practitioner/Physician's Assistant/Dentist/Dental Hygienist/Oral Surgeon considers necessary and within the scope of care provided by Trinity Community Care. I understand that the practice of medicine is 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 Trinity Community Care, or as a result of a referral from Trinity Community Care, are being provided by health care practitioners and lay volunteers who are not receiving compensation and compensation will not be requested from any source.

As per Center for Disease Control recommendation, I agree to be tested for blood borne pathogens in the case of a volunteer's inadvertent exposure to my blood and/or body fluid(s).

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I agree that I have been given this information before seeing a medical or dental professional, and that I have been given an opportunity to ask any questions I may have before signing this form. I agree that I have not been coerced or otherwise compelled to execute this agreement and acknowledgement and that the presence of my signature indicates that I have voluntarily and with full understanding agreed to the terms of this agreement and all other documents executed by me in connection with my request to obtain treatment from Trinity Community Care.

My signature below constitutes my acknowledgement that I have understood this request for consent and that I agree to its contents.

_____	_____
Date	Print Patient's Name
_____	_____
Signature of Patient (or Responsible Consenting Party)	Relationship to Patient
_____	
Signature of Witness	