FORM 2

JACKSON-HINDS COMPREHENSIVE HEALTH CENTER
GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

I, the undersigned patient or responsible person, having registered at Jackson-Hinds Comprehensive Health Center (JHCHC) for the purpose of obtaining health services, do hereby voluntarily CONSENT TO SUCH DIAGNOSTIC AND TREATMENT SERVICES as might be provided by or at the direction of a physician, dentist or other qualified health care provider of the health center.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive services at the health center. I also recognize that I will be asked to sign a specific consent, as needed, for surgical and other special procedures including general and/or extensive local anesthesia.

I recognize that, according to the laws of the State of Mississippi, parental consent is not required in the case of a minor seeking treatment of a venereal disease or a female, regardless of age or marital status, seeking diagnostic or treatment services in connection with pregnancy or childbirth.

I am aware that health services are not based on exact science, but are provided according to the judgement of the physician, dentist or other qualified health care provider of the health center. I acknowledge that no guarantees have been made to me as to the results of any diagnostic or treatment services. Further, I authorize the health center to furnish requested patient information to requisite legal, health, social and government entities, as needed.

I acknowledge that I have received a copy of JHCHC'S NOTICE OF PRIVACY PRACTICES, which describes how medical information about me may be used and disclosed and how I can get access to this information.

For and in consideration of health services provided to the below named patient, the undersigned hereby agrees to pay the balance due after credit for all appropriate fee discounts and payments from third party payers. I further authorize JHCHC to use my social security number and date of birth for billing and clinic use only.

_____ _____

Print Name of Patient **Signature of Patient (or responsible person)**

- ☐ **Yes, I have an Advance Directive.**
- ☐ **No, I do not have an Advance Directive, but would like additional information.**
- ☐ **No, I am not interested in an Advance Directive.**

_____

Date

OFFICE USE ONLY

Reason acknowledgment of JHCHC Notice of Privacy Practice was not obtained:_____

_____

_____ **Account#**_____

Signature of JHCHC employee **Site:**_____

Revised 5-1-2017