Samaritan Health Ministries

Consent for Treatment and Agreement to Privacy Practices

Patient Name:_____ Birthdate:_____

1. I understand that medical, dental, and other health-related services at Samaritan Health Ministries (SHM) are provided by licensed and certified health professionals, including: physicians, resident physicians, and dentists, as well as alternative health providers, including nurse practitioners, nurses, physician assistants, midwives, social workers, and psychologists. I understand that I have the right to request to see a physician rather than an alternative health provider.

2. I understand that services I receive at SHM may be provided by a volunteer who is providing medical care that is not administered for or in expectation of compensation. I further understand that Texas law imposes on the recovery of damages from such volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if: the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization; the volunteer commits the act or omission in the course of providing health care services to the patient; the services provided are within the scope of the license of the volunteer; and before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges that the volunteer is providing care that is not administered for or in expectation of compensation; and the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

3. As an SHM patient, I understand that I need to go to a hospital emergency room if I have a medical emergency.
4. If necessary in the course of my care, I consent for my SHM Provider to access my medication history, if available, from retail pharmacies.
5. I understand that SHM services are provided regardless of race, residence, religion, income, sex, age, national origin, color, sexual preference, or contraceptive preference.
6. I understand my records are confidential. **I have read and agreed to Samaritan Healthcare Ministries' Patient Privacy Practices which explain how my records will be handled.**

I understand the information above and I voluntarily request and consent to the services of this clinic (tests, treatments, procedures and other services as indicated) for myself or the minor I am accompanying. I understand that this consent is valid until revoked in writing.

Signature of patient or authorized adult:_____ Date: _____

Signature of interpreter, if any: _____

Printed name of authorized adult accompanying minor: _____