SEVENTH-DAY ADVENTIST® CHURCH
Lake Union Conference

Patient Consent for Health Care

_____ _____
Patient's Name Birth Date

PATIENT CONSENT FOR GENERAL PRIMARY CARE

I hereby authorize the Physicians, Nurses, Dentists and/or health care providers of Adventist Community Health Initiative (ACHI), some of whom might be closely supervised advanced students, to examine and/or treat me and/or my dependent as named above. I understand that it is my responsibility to notify ACHI (269-473-8290) of any changes in contact information, such as change of address or new telephone number when follow-up may be necessary.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

As a health care provider, we are making available to you the following notice:

- If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. By checking "Yes" below, you are deemed to have consented to the release of the test results to the person exposed.
- If you should be directly exposed to blood or body fluids of one of our health care professional, workers or employees in a way that may transmit the disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the results of the test.

This deemed notice for HIV, Hepatitis B and C exposure has been explained to me and I understand it. ____ **Yes** ____ **No**

IMPORTANT NOTICE

We are a volunteer organization with no paid volunteers, and are **NOT** part of a government program. ACHI may not be able to provide you with all the services you need, but if you would like to consult with our volunteer team and receive the type of treatment being offered today, **PLEASE READ THE PATIENT WAIVERS BELOW VERY CAREFULLY.**

DENTAL PATIENT WAIVER

Dental Patients Note: While the volunteer dentists, oral surgeons and hygienists offer high quality procedures with good equipment, I understand that because of the number of people needing to be see, I might not receive multiple extractions or multiple fillings. I understand that I might have certain medical conditions which would keep me from having the type of treatment I am requesting. I also understand that the dental care providers are volunteers, some from out-of-town, and are not available for follow-up care in the event of complications. I agree to seek any follow-up care I might need from my local dentist, health department, family physician or a hospital emergency room. **Please initial** _____

WAIVER FOR ALL HEALTH CARE TREATMENT

In consideration of the free health care services received on the date below, I, for myself and anyone entitled to claim through me, do hereby waive and release ACHI, and any persons or organizations acting on their behalf or sponsoring or volunteering at this clinic, from all claims of liability arising out of my acceptance of such free care including, but not limited to medical, eye-care, dental and /or other health care or medical advice.

I grant to ACHI and their agents the right to use my picture, voice and other reproductions of my physical likeness in connection with advertising or publicizing ACHI and their activities in all forms of media and perpetuity.

I, the undersigned patient, consent to the release of my patient records to other licensed health care professionals as necessary. I have read, or had read to me, and understand and agree to all of the above.

_____ _____
Patient Signature Date
(Parent or Guardian if Patient is Under 18 Years of Age)