HOPE CLINIC OF ROSS COUNTY

Patient # _____ I-3

Place printed label here

Consent for Treatment
Rights and Responsibilities

Patient Name (please print legibly) _____
Gender: ☐ Female ☐ Male

I hereby consent to the provision of care, diagnosis and/or treatment by the Hope Clinic, a free medical and dental ministry of Ross County, Ohio, and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence. As an eligibility requirement for medical care provided at Hope Clinic, I acknowledge that I am medically uninsured and meet income requirements for the services provided.

I hereby acknowledge that under 2305.234 of the Ohio Revised Code, subject to certain exceptions, the Hope Clinic and its health care professionals and health care workers who are volunteers are not liable for damages related to injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteers, unless the action or omission constitutes willful or wanton misconduct. I understand and hereby acknowledge that the Hope Clinic will provide me with a copy of 2305.234 of the Ohio Revised Code if I so request.

I have been provided the opportunity to read the patient rights and responsibilities for Hope Clinic. I have had the opportunity to ask questions or request explanations or clarification personally from a Hope Clinic volunteer staff member and I fully understand my rights and responsibilities as a patient.

<u>If patient is a minor</u>, please complete following information (please print legibly):
Mother's name: _____
Address: _____Telephone:_____
Father's name: _____
Address: _____Telephone:_____

X_____ _____
Signature of Patient or Person Authorized to Consent* Date

_____
Relationship if not patient

*If this consent is signed by someone other than the patient, it must be signed in the patient's presence.