MEMPHIS MUSLIM MEDICAL CLINIC
a project of
Memphis Muslim Medical Services, Inc.
1055 Stratford Road, Memphis, TN 38122 • Phone: (901) 685-3901 • Fax: (901) 685-3903
www.muslimclinic.org

GENERAL CONSENT FORM

Last Name:_____ **First Name**:_____ **MRN**:_____

CONSENT FOR TREATMENT

I desire to be seen and treated at Memphis Muslim Medical Clinic and hereby give my consent for the clinic, its physician(s), non-physician healthcare providers, employees, and contractors to see and treat me, as they deem necessary and appropriate for diagnosis and treatment. I authorize and consent to examinations, x-rays or other radiologic or diagnostic studies, blood test(s) including blood test(s) for communicable disease such as hepatitis and AIDS (and including testing where health care personnel have been exposed to my blood and/or body fluids), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, radiation therapy and other services, treatments and procedure rendered or performed at the clinic or ordered or performed by its physician(s), non-physician healthcare providers, employees, or contractors. I understand that state law requires the Clinic to report certain positive test results, such as, but not limited to, hepatitis and the antibody for the AIDS virus, to the Health Department.

I understand that I have the right to ask questions and to receive information regarding my care and treatment, to receive respectful and compassionate care, and the right to withdraw, in writing, my consent to treatment or tests.

Signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for payment for all services rendered to my family or me. Although the Clinic may bill or arrange for billing to my insurance carrier (if applicable), I understand and agree that I am responsible for payment of all charges for services provided regardless of the availability of any insurance coverage(s). I agree to pay any and all fees, token charges, co-payments, co-insurance, and deductibles. In the event that I fail to pay any charges and the account is turned over to a collection agency or an attorney, I agree to pay all collection costs incurred, including, but not limited to, reasonable attorney's fees and court costs.

Signature: _____ Date: _____

RELEASE FROM LIABILITY FOR REFUSING MEDICAL CARE & LEAVING AGAINST MEDICAL ADVICE

I agree that if I refuse treatment recommended by the clinic, its physician(s), non-physician healthcare providers, or Clinic personnel, then the Clinic, the physician(s), non-physician healthcare providers, employees and all other persons are released from any responsibility or liability for any injuries, conditions, or damages that may result from my refusal of treatment or my acting against such advice.

Signature: _____ Date: _____

STATEMENT OF UNDERSTANDING OF LIMITED SERVICES

I understand that this is a Charity Clinic with limited hours on the weekends, as posted on notice boards and brochures. I also understand that the Clinic does not provide any medical services during weekdays and after-hours and if I need medical care during such hours, depending upon the urgency, I will have to go to another medical facility, emergency room, urgent care facility, etc. The Clinic, its physician(s), non-physician healthcare providers, employees and all other related persons are released from any responsibility or liability for any injuries, conditions, or damages that may result from my acting against such advice.

Signature: _____ Date: _____