Healing Hands Resource Center

Safe Place Clinics

Integrated Health Services

Insurance ID No:

HEALING HANDS RESOURCE CENTER MEDICAL CONSENT FORM

Patient Name: _____Birthdate:_____

Social Security # _____ Grade: _____ Marital Status: _____

Address:_____

City: _____State: _____Zip: _____

Is Patient a DCFS Ward? _____ Yes _____ No

Name of Insurance _____ ID No _____Group No. _____

Patient or Legal Guardian Information:

Name (if different from above): _____ Relationship to Patient _____

Home Phone: _____Work Phone:_____

Cell Phone: _____ Email: _____

Other Emergency Contact Name_____ Emergency phone no: _____

Patient Consent:

I, _____(printed name), do hereby give written and oral consent to participating in medical exam/ psychiatric evaluation/ treatment conducted by _Healing Hands Resource Center .

Authorization of Consent to Treatment of Minor /Ward:

(I) (We), the undersigned, parent(s) / guardian of _____, a minor/ward, do hereby authorize Healing Hands Resource Center for and on behalf of the undersigned to consent, oral and written, to any x-ray examination, anesthetic, medical, psychiatric, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital, during all times that the Minor is in the presence of said Agent. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable and release Agent from all damages of same.

Signature of Parent/ Legal Guardian (if applicable)_____Date: ___

Printed Name: _____

Signature of Patient(if applicable): _____ Date _____

From: The Healing Hands Resource Center Administration Family
To: Patients, Families, Friends and External Agencies.

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Many of those we serve request the completion of medical and legal documentation. However, without adequate patient information and knowledge, an honest, accurate and sound evaluation is not likely. Though we use information from many sources including family accounts and hospital and other agencies' reports, we form our own diagnostic impressions. In an effort to best represent those we serve, we require time and experience with our patients prior to writing any type of report for patients, their families or other agencies. From experience with our patients, we feel that six continuous months and six visits are necessary to gather the essential information required to best represent our patients.

All admissions to HHRC will require completion of six (6) continuous months of enrollment at HHRC and six (6) visits with a HHRC provider prior to completion of any external documentation, including SSI or FLA . For the sake of fairness, there will be no exceptions. All known documentation must be presented at the time of admission to the clinic; this includes any legal actions or psychiatric recommendations or referrals. Other wise the six months and six visits will begin at the point of presentation.

Concerning Missed Appointments:

If a patient needs to cancel or reschedule an appointment, we ask that he/she give 24hours advance notice. Otherwise, the appointment will be considered a missed appointment and a $25 fee will be charged.

Concerning Insurance Co-pays:

Depending on the type of insurance, a co-pay will be charged for each visit.

Patient or Guardian Signature: _____

Printed Name: _____

Date: _____