**PATIENT AGREEMENT**

The Good Samaritan Clinic (GSC) is a Christian ministry that respects and promotes the dignity and healing of all human life. Our mission is to provide primary health care and dental care to individuals who have low or no income and are uninsured. Good Samaritan Clinic provides referrals, when needed, to outside health services within a local network of pro-bono medical providers. To better serve you, we ask for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

**I UNDERSTAND AND AGREE TO THE FOLLOWING:**

\_\_\_\_\_\_1. I will inform Good Samaritan Clinic of any change if my address, telephone number(s), income or insurance changes within 30 days.

\_\_\_\_\_\_2. I will give Good Samaritan Clinic notice before my scheduled appointment if I will be unable to

keep my appointment. Phone (205) 343-2212 or email [goodsamclinic.appointment@gmail.com](mailto:goodsamclinic.appointment@gmail.com)

\_\_\_\_\_\_3. If I miss three appointments, I understand that I may no longer be able to receive services at the Clinic for six months or longer. This includes all appointments: eligibility, providers, lab work, and referral providers.

\_\_\_\_\_\_4. I do hereby authorize a health care professional associated with Good Samaritan Clinic to disclose any personal health information to other health care professionals, when medically necessary.

\_\_\_\_\_\_5. I do hereby authorize the administrative staff of Good Samaritan Clinic to disclose my registration and screening information for purposes of obtaining health care at another facility.

\_\_\_\_\_\_6. I understand that I must disclose all other health care providers, doctors, etc., I am currently under the care of or I may lose eligibility for services at the Good Samaritan Clinic.

\_\_\_\_\_\_7. I understand that if I choose to seek medical treatment outside GSC, I will be responsible for any bills that may incur. **If I go to the Emergency Room** it is my responsibility to inform them I am a GSC patient. I will contact Good Samaritan Clinic on the next business day to make them aware of my ER visit.

\_\_\_\_\_\_8. I agree to bring all medications to every visit, excluding those requiring refrigeration (bring box). Failure to do so may result in rescheduling of your appointment.

\_\_\_\_\_\_9. I am solely responsible for following through on testing and treatment ordered by providers at the clinic. I understand that if I fail to follow the physician’s orders, treatment may be unsuccessful.

\_\_\_\_\_\_10. I understand that if I am uncooperative, verbally or physically abusive, intoxicated or behaving in an inappropriate manner, I may not be eligible for services at Good Samaritan Clinic.

**I have received a full explanation of the Good Samaritan Clinic’s services. I understand and agree to all of the above. I understand that I can be terminated from the Good Samaritan Clinic if I have given wrong or misleading information or if I fail to follow the policies above.**

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

GSC’s Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Record of HIPPAA Notification**

I have received the Notice of Privacy Policy and Practices from Good Samaritan Clinic.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_