Jackson Purchase Medical Associates

General Consent and Acknowledgement Form

_____ _____

Consumer Name Social Security # /ID #

Permission For Treatment

I herby authorize staff at Jackson Purchase Medical Associates to render treatment and/or services to:

_____ Consumer Initials: _____

Whose relationship to me is (check one) ___self ___child ___ward (I am a guardian) Other (specify)_____

(Copies of Guardianship or custody court documents must be provided to Jackson Purchase Medical Associates)

_____

Consumer Rights, Responsibilities, and Grievance Procedure

I herby acknowledge that my Rights, Responsibilities, and Grievance procedure as a Consumer of Jackson Purchase Medical Associates have been explained to me and that I have been given a written explanation of these.

Consumer Initials: _____

_____

Privacy Notice: I herby acknowledge that I have received a copy of the Jackson Purchase Medical Associates Privacy Notice. Consumer Initials: _____

_____

HIV, Hepatitis and TB Information: HIV/AIDS, Hepatitis A, B, and C, as well as, Tuberculosis (r11) are significant health concerns for the citizens of the Unite States. As part of your treatment with this agency, we encourage you to obtain testing for these. Early detection can be very beneficial. Tests are given at the local Health Department. Attached is information for your review concerning these health issues. I herby acknowledge that I have received information sheets on HIV/Aids, Hepatitis A, B, C and TB. Consumer Initials: _____

_____

Advance Directives: Kentucky allows its citizens to prepare directives for family and friends to know what to do for if you become unable to make healthcare decisions for yourself. Advance Directives give your doctor(s) information about what you want done for your physical and mental health care.

Do you have an Advance Directive? ___Yes ___No

If no, I herby acknowledge that I have been provided information regarding Advance Directives.

Consumer Initials: _____

_____

Primary Care: KY Medicaid Managed Care Companies request Jackson Purchase Medical Associates provide information to your primary care doctor. Will you sign a release of information for this request? ___Yes ___No

____I or consumer does not have KY Medicaid.

_____

Voter Registration Information: *(Consumer is a child-not applicable)* Consumer Initials: _____

As a result of the National Voter Registration Act, we are required to determine if you are a registered voter.

I am a registered voter: ___Yes ___No

If NO

_____I herby acknowledge that I have been given a voter registration form.

_____I do not desire to register to vote. Consumer Initials: _____

_____

Notification of Follow-UP

Representatives of this agency may contact you during the course of treatment and/or following termination from treatment to determine your satisfaction with the services at this agency. Consumer Initials: _____

_____

Method of Contact

1. May we mail information that identifies the agency to your home address? ___Yes ___No
2. May we call your home phone number at all times of the day? ___Yes ___No
3. May we leave a message, which identifies the agency at your home phone number? ___Yes ___No

**List any restrictions or preferred alternative methods of contact: _____

Accepted by Jackson Purchase Medical Associates Staff: _____

I have read and understand the above information:

_____ _____

Signature of Consumer or Custodian or Legal Guardian Date

_____ _____

Witness Date