Primary Care Medical Center, PLLC

15444 Dedeaux Road, Suite B
Gulfport, MS 39503
Phone: (228) 832-9038 Fax: (228) 832-9990
Email: info@primarycaregpt.com

MINOR MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

I_____, parent or legal guardian of

_____, born on _____,

do hereby grant consent to PRIMARY CARE MEDICAL CENTER OF GULFPORT, PLLC licensed physician or licensed nurse practitioner, for the **PATIENT'S RIGHTS, RESPONSIBILITES, & ORGANIZATIONAL ETHICS**

Primary Care Medical Center of Gulfport, PLLC herein referred to as PCMC.

Patient Rights:

This facility and medical staff have adopted the following list of patient rights. This list shall include, but not be limited to the patient's rights.

1. Exercise these rights without regard to sex or culture, economic, educational, or religious background, or the source of payment for his/her care.
2. Considerate and respectful care including the appropriate assessment and management of pain.
3. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care, and the names and professional relationships of other physicians and non-physicians who will see him/her.
4. Receive information from his/her physician about his/her illness, his/her course of treatment, and his/her prospects for recovery in terms he/she can understand.
5. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent, or to refuse this course of treatment. Except in emergencies, the information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment, or no-treatment, and the risks involved in each, and know the name of the person who will carry out the procedure/treatment.
6. Participate actively in decisions regarding his/her medical care. To the extent permitted by law; this includes the right to refuse treatment.
7. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communications and records pertaining to his/her care. His/Her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
9. Reasonable responses to any reasonable requests he/she make for service.
10. Have a family member, friend or any person of their choice accompany them in the exam room.
11. Leave the facility even against the advice of his/her physician.
12. Reasonable continuity of care and to know in advance the time and location of appointments, as well as the physician providing the care.
13. Be advised if his/her physician proposes to engage in, or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse participation in such research projects.
14. Examine and receive an explanation of his/her bill regardless of source of payment.
15. Know which facility rules and policies apply to his/her conduct while a patient.
16. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

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A list of these patient's rights shall be posted within the facility so that such rights may be read by the patients.

All personnel shall observe these patients' rights.

Patient Responsibilities:

The care a patient receives depends on the patient himself/herself. Therefore, in addition to these

rights, a patient has certain responsibilities as well. These responsibilities should be presented to

the patient in the spirit of mutual trust and respect.

1. The patient understands and accepts the responsibility of protecting his or her health care information.
2. The patient accepts the responsibility and authorizes the provider to discuss his or her health care information including those visits when the patient allows any additional person(s) in the examination room.
3. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health including existing level of pain.
4. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment, and what is expected of him/her.
5. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses, and other health professionals, as they carry out the physician's orders.
6. The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
7. The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
8. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
9. The patient will provide all information necessary to collect for services performed by PCMC.
10. The patient is responsible for following facility policies and procedures.
11. The patient is responsible for being considerate of the rights of other patients and facility personnel, which includes refraining from use of foul language and abusive, threatening, or disruptive behavior.
12. The patient will notify the clinic of prescription request at least 72 hours prior to being out of medications.
13. The patient will check with the pharmacy to verify the prescription refill at least 48-72 hours after the prescription request.

Organizational Ethics:

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PCMC operates under a Code of Conduct. The purpose of this Code of Conduct is to ensure that all members of PCMC are committed to conducting their activities in accordance with the highest levels of business ethics, and in compliance with all applicable state and federal laws and regulations.

MISSION STATEMENT

PRIMARY CARE MEDICAL CENTER IS DEDICATED TO EXCELLENCE IN PROVIDING HEALTH SERVICES AND EDUCATION THAT VALUES THE QUALITY OF LIFE AND FAMILY.

P-Prepare ourselves to exceed others exceptions.

A-Agree to work towards continuous improvement.

T-Train staff members to be energetic, friendly and willing to learn.

I-Incorporate internal communication and cooperation into our job activities.

E-Encourage the implementation of the Quality Process.

N-Never forget that the success of our clinic is largely impacted by our patient's opinions.

T-Treat others as you would like to be treated**.**

S-Strive to have a pleasant work environment.

purpose of administering medical treatment determined to be necessary for the welfare of my child (ren). Medical treatment includes but is not limited to Physicals, Injections, X-rays, Suturing of Wounds, Breathing Treatments, EKG, Lab Draws, Strep Test, Flu Test, and Pregnancy Test.

If you **REFUSE** any treatment to be completed on your child (ren), you **MUST** list the treatment below **OR** write NA (NA- None Applies).

_____

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In the event of an urgent medical emergency we authorize the following people to be contacted if we, the parents, are unable to be reached.

PERSON#1 NAME _____ PHONE NUMBER _____

PERSON #2 NAME _____ PHONE NUMBER _____

We assume full responsibility of the expenses incurred in the medical treatment of our child (ren), if required to do so.

This additional information will assist in treatment if it can be furnished with the consent but not required.

Allergies to drugs or foods_____

Special medications, blood type or pertinent information_____

This authorization is valid from the date of the signature until written notice is given indicating that you have revoked its intent.
Thank you,

PRINT NAME OF PARENT OR LEGAL GUARDIAN _____ SIGNATURE OF PARENT OR LEGAL GUARDIAN _____

PRINT NAME OF WITNESS _____ SIGNATURE OF WITNESS _____

DATE:_____