Notification of Healthcare Services Provided without Compensation and Limitation of Physician/Physician Assistant/Nurse Practitioner Liability

Patient Name (Print) _____

Physician/Physician Assistant/Nurse Practitioner Name (Print)

_____

Check one:

☐ I am the patient

-OR-

☐ I am a person who has legal authority to make healthcare decisions for the patient.

My physician/physician assistant (PA)/nurse practitioner (NP) is providing me with healthcare services free of charge. However, I may be required to pay my physician/PA/NP for laboratory fees, testing services, or other out-of-pocket expenses. In cases where my physician/PA/NP is providing the services at a health clinic, I may also be required to pay the clinic fee for my physician/PA/NP's services. However, my physician/PA/NP will not be paid for providing these services.

By signing this notification form, I understand and agree that my physician/PA/NP is not liable for any injury, death, or other loss arising out of these healthcare services unless the injury, death, or other loss is caused by my physician/PA/NP's gross negligence.

I received and am signing this notification before receiving any healthcare services. Additionally, I have given my informed consent to receiving these healthcare services from my physician/PA/NP.

_____ _____

Patient's Signature *Date*

-OR-

_____ _____

Signature of Patient's Authorized Representative *Date*

Form Oct. 2012