Notification of Health Care Services Provided without Compensation and Limitation of Liability

Patient Name (Print) _____

Physician/Physician Assistant Name (Print) _____

Check one:

☐ I am the patient

-OR-

☐ I am a person who has legal authority to make health care decisions for the patient

Authorized Representative Name (Print) _____

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

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

I received and am signing this notification before receiving any health care services.

Additionally, I have given my informed consent to receiving these health care services from my physician/PA.

_____ _____

Patient Signature Date

-OR-

_____ _____

Authorized Representative Signature Date