Chart #_____

HEALTHCHECK
Check on your health.

ADHS HealthCheck Program
Refusal of Diagnostic or Treatment Services

☐ WWHP
☐ FFHP

Last Name: _____ First Name:_____ Middle Name:_____

Address: _____

Date of Birth: _____/ _____/_____(MM/DD/YYYY)

Contractor/Location:_____ Provider:_____

PLEASE COMPLETE THE SECTIONS BELOW THAT APPLY TO THE CLIENT:

☐ The results of your _____test(s) are abnormal.

☐ Your healthcare provider would like to see you to evaluate this condition more thoroughly and to give you a better diagnosis. Your healthcare provider recommends the following tests to determine what is happening in your body: _____

☐ Your healthcare provider has diagnosed your condition and you need to be referred to: _____ _____for treatment.

PLEASE READ AND SIGN THE STATEMENT OF REFUSAL OF PROCEDURE/TREATMENT BELOW:

I understand that I may have a potentially serious condition and my health care provider recommends this procedure/treatment. I understand that there may be a severe risk to my health if I do not have the recommended procedure/treatment. The reasons that this procedure/treatment has been recommended for me have been explained. I understand why I need this procedure/treatment and how it is performed. I understand the potential harm to my health that I may undergo by not having or by delaying this procedure/treatment. I understand that signing this form does not stop me from having this procedure/treatment at a later date.

I assume the risks and consequences involved by not having or by delaying this procedure/treatment and release those offering this procedure/treatment to me, including the ADHS HealthCheck Program and its staff, medical providers and employees, from any responsibility whatsoever and from any and all liability caused by my refusal.

My signature below certifies my refusal of this procedure/treatment. I forever waive all actions and claims by me or on my behalf resulting from my refusal.

Client's Name:_____

Client's Signature:_____ Date: _____/ _____/_____

Case Manager's Name: _____

Case Manager's Signature:_____ Date: _____/ _____/_____