Texas Department of State Health Services

Hansen's Disease Program

Patient Agreement for Receiving Services in DSHS Supported Hansen's Disease Clinic

To: (Name)_____

(Address)_____

(Phone #)_____

I _____ understand and voluntarily agree to receive clinical examinations, biopsies or skin care, tests and medications as part of my treatment for Hansen's disease and or follow up care after being treated for Hansen's disease.

I also understand and voluntarily agree that:

(Initial each statement after reviewing)

_____ I may receive services at this clinic for outpatient care only, for the treatment and care of Hansen's disease and or complications from Hansen's disease, as determined by the Hansen's disease clinic physician.

_____ I will schedule my clinic appointments.

_____ I will keep (and be on time) for all my scheduled appointments with clinical staff as instructed.

_____ I will follow all medical instructions from my physician or clinic staff regarding treatment for Hansen's disease and or reactions or medical issues that have occurred due to my current diagnosis or history of Hansen's disease.

_____ I will arrange my own transportation to the clinic. I understand that if I cannot make travel arrangements to the clinic, I will notify the clinic staff to see what options, if any, I may qualify for.

_____ I will follow all instructions regarding transportation arrangements and other services as instructed.

_____ I will keep my medicine safe, secure and out of the reach of children. If my medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other members of the treatment team.

_____ I will not call at night or on weekends looking for medication refills. I understand that prescriptions will be filled during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for medication refills. If I am having trouble making an appointment, I will tell a member of the clinic staff immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients, my services from DSHS may be terminated

and I will be responsible for my medical care.

_____ I will sign a release form to let the doctor speak to all other doctors or providers, as deemed necessary by the Hansen's disease physician or clinic nurse.

_____ I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____ **I understand that I may lose my right to treatment in this office if I break any part of this agreement, as determined by the Hansen's disease clinical staff.**

This agreement shall be effective as long as treatment is requested, and until a physician determination is issued indicating that I no longer need treatment or follow up care for Hansen's Disease.

Signed this_____day of_____20____.

Nurse case manager NAME _____

Nurse case manager SIGNATURE_____

Physician NAME _____

Physician SIGNATURE_____

Please sign in the space provided below.

I hereby acknowledge that I have received a copy of this agreement and understand and agree to the content.

Signed _____ Date _____
(client's signature)

Witness _____ Date _____