

**HARRINGTON MEMORIAL HOSPITAL
HARRINGTON FAMILY HEALTH CENTER**

**ACCEPTANCE FOR TREATMENT AND PATIENT RIGHTS AND
RESPONSIBILITIES**

This notice is to inform me of my acceptance of treatment by the Harrington Family Health Center.

I, _____, have engaged the Harrington Family Health Center to evaluate my health needs and to order services as he/she sees fit to assess these needs. I understand that sometimes problems develop in the course of treatment. I want the physician to go ahead with whatever his/her best medical judgment leads him/her to believe should be done in case any complications should occur that cannot now reasonably be foreseen.

I have read the patients rights. I have told the Harrington Family Health Center that I understand this matter and have read the above. I have told him/her to go ahead with the medical treatment proposed.

Patient signature

Date

Sponsor if minor or unable to sign

Date

Witness

Date

clinicacceptance