Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

INFORMED REFUSAL

My provider, _____ has recommended the following:_____

_____

_____

He/she explained to me that the potential benefits of the test, procedure, treatment or consultation and the risks. Despite my provider's recommendation, I am declining to consent to his/her recommendations. The provider has explained to me the risks associated with not following through with this recommendation:

_____

_____

By signing this document, I acknowledged that 1.) my medical or/dental condition has been evaluated and explained to me by my provider who has recommend treatment as stated above, 2.) my provider has explained to me the potential benefits of such treatment or referral and risks associated with it, 3.) my provider has explained to me the possible risks of not following through with the recommendation for treatment or evaluation, which I fully understand, and 4.) I have had an opportunity to discuss any and all questions related to the recommendation for treatment. In spite of this understanding, I refuse or decline to consent to medical treatment.

I have refused this recommendation due to:

- ☐ Lack of transportation
- ☐ Lack of money/insurance to cover the cost of services
- ☐ Personal choice not to have the procedure or evaluation
- ☐ Waiting for insurance coverage
- ☐ Religious reasons
- ☐ I will make my own appointment
- ☐ Other *(please explain)*_____

I understand that my refusal for this appointment or procedure may result in late detection of disease; the inability of my health care provider to assess my health concern and provide treatment; and possibly may lead to a decline in health status and death.

I understand that if I change my mind, I can contact Carolina Family Health Centers, Inc. staff at any time to help me arrange this appointment or evaluation.

I agree that Carolina Family Health Centers, Inc.'s Referral Specialist has adequately informed me of other medical providers in the area that may provide the same services, but I am still unable to make the appointment for the above listed reasons.

_____	_____	_____
Patient's Name (Printed)	*MR #*	*DOB*
_____		_____
Patient's Signature		*Date*
_____		_____
Witness' Signature		*Date*