MISSION EAST DALLAS
FAMILY HEALTH CLINIC

OTHER ACKNOWLEDGEMENTS

1. PROVIDING RELIABLE INFORMATION: I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

2. INDEPENDENT CONTRACTORS: Mission East Dallas may defer to independent contractors for outpatient or inpatient treatment/procedures. These include, but are not limited to, specialists, physical therapists, consulting physicians or dentists. These independent contractors are not agents or employees of Mission East Dallas and are responsible for their own actions. I understand that Mission East Dallas shall not be liable for the acts or omissions of independent contractors.

3. NO GUARANTEE OF RESULTS: Mission East Dallas physicians, dentists, and other healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, or procedure. I release Mission East Dallas, its physicians, dentists, and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Mission East Dallas or its employees.

4. VALUABLES: Mission East Dallas assumes no responsibility for, and I hereby release Mission East Dallas from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

5. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release Mission East Dallas and its employees and agents to take non-identifying photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be appropriate for the purposes of evaluation and treatment planning. Such images may also be used for educational purposes.

These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Mission East Dallas may use cameras for security, and patient confidentiality will be maintained for all such images.

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Patient's Signature **Date**

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Patient's Name (please print)

Updated 9.12.2018 CP