MIRROR IMAGE | MEDICAL CLINIC

PATIENT INTAKE FORM

FIRST NAME:

SECOND NAME:

THIRD NAME:

PREFERRED NAME:

LACE ADDRESS:

STATION ADDRESS:

GENDER IDENTITY:

PRONOUNS:

MARITAL STATUS:

PHYSICAL AGE:

SUBJECTIVE AGE:

FACTION:

EMERGENCY CONTACT:

EMERGENCY CONTACT LACE ADDRESS:

EMERGENCY CONTACT RELATIONSHIP:

INSURANCE?

YES NO

IF YES:

PATIENT SIGNATURE:

WRITTEN SIGNATURE:

DATE:

LACE HEURISTIC SURVEY CONSENT FORM

By signing this form, the patient consents to allowing Mirror Image Medical Center temporary access to their Lace implant for the purposes of collecting relevant medical history.

The survey lasts as long as the patient connects to the survey module.

The survey process allows the practitioner to view Lace data while connected. The practitioner **cannot** edit the patient's Lace implant under **any** circumstances (due to ethical and technological reasons).

MIMC stores all collected data digitally offline. Airgaps and encryption protect patient confidentiality.

Data gained via survey is wholly confidential. Authorities cannot access patient data unless patient actively plans to or is threatening the Mauran Concern.

PATIENT SIGNATURE

WRITTEN SIGNATURE

DATE

SURVEY RESULTS

Please use this form to give us as much personal medical info as you'd like; allergies, recurring complaints, patient history, prescriptions, drug use, alcohol use, guilt confessions, etc. If the survey would pick it up but anyone in the scene forgot about it, bring it up OOC at any time.

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CONSENT TO TREATMENT/DIAGNOSIS

I, the undersigned patient, do hereby agree and give my consent to the doctors and medical practitioners of the Mirror Image Medical Clinic to furnish treatment considered necessary and/or proper in diagnosing or treating me. This may include withholding of treatment or diagnosis due to ethical or logistical concerns.

In matters of life and death, my, the undersigned patient's, survival is first priority over cost of treatment. Treatment is not applied with future debt exploitation in mind; my health and survival is paramount.

I, the undersigned patient, agree to use of proxies, reactive digital tools, and exploratory/experimental techniques and tools in my treatment.

PATIENT SIGNATURE

WRITTEN SIGNATURE

DATE

PURPOSE OF CONSULTATION

In five hundred words or less, please explain the nature of your request. Important details to consider: is the work medically necessary, cosmetic, self-affirming, possible under current health and science developments? What is your budget? What is inflexible about your request (an absolute "must have")? What are you willing to, or able to, compromise on in the face of reality or other limitations? Keep answering questions like these in mind while writing your response.

I, the undersigned patient, understand that my request is confidential and kept between me and Mirror Image Medical Center. Mirror Image Medical Center must gain my consent before broaching details of my request with other parties who may be able to help. I understand these consultation sessions are billable and, while medically informed, are not explicit medical advice or instructions unless prescribed as treatment by a practicing medical official of Mirror Image Medical Center.

PATIENT SIGNATURE

WRITTEN SIGNATURE

DATE

WAIVER OF LIABILITY

In consideration of risks of complication and injury in treatment (herein defined as direct medical intervention constituting, but not limited to: consultation, prescription, medical procedures, operations and surgery) and the right to participate in treatment:

I, the undersigned patient, hereby knowingly and voluntarily enter this waiver and release of liability and hereby waive and all rights, claims or causes of any kind whatsoever arising out of my participation in treatment. I hereby release and forever discharge the practitioners and staff of Mirror Image Medical Center responsibility for any physiological or psychological injury, included but not limited to illness, paralysis, death, damages, economic or emotional loss, that I may suffer as a direct result of my participation in treatment, including traveling to and from treatment.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Mirror Image Medical Center, its agents and its employees.

If any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

I agree to indemnify and hold harmless Mirror Image Medical Clinic against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. I agree to reimburse Mirror Image Medical Clinic for any of these types of expenses if incurred.

PATIENT SIGNATURE

WRITTEN SIGNATURE

DATE