HILLCREST FAMILY HEALTH CENTER (HFHC)

PATIENT AGREEMENT

I understand that in order to benefit from healthcare provided to me as a patient, I am responsible for participating in the determination of my medical care plans, and following recommended treatment plans.

PATIENT RESPONSIBLITIES

1. **Attending Appointments As Scheduled:**
   a. I will attend my appointments as scheduled with my HFHC physician(s). I will attend my other appointments with other physician specialists, consultants, or other tests and procedures as recommended by my HFHC physician(s). If you are late for a scheduled appointment, you will become a work in and could be rescheduled depending upon visit reason.
   b. If I am unable to keep my HFHC appointment, I will provide HFHC physician's office with at least 2 hours notice prior to my appointment. If I am unable to keep a specialty appointment, test, or procedure I will notify my HFHC physician's office. If I cancel my appointment with less than 2 hours notice, or do not show up for an appointment and do not call to cancel, I will be considered a, "no-show." Any patient that has 2 or more no-shows per year will be reviewed for discharge from the practice.

2. **Taking Medications:**
   a. I will take medications as prescribed by HFHC physician(s), or notify physician's office if unable to comply.
   b. I will not contact non-HFHC physician(s), for medication prescriptions or refills, unless it is for emergency purposes, or mutually agreed upon.
   c. I will follow the instructions/recommendations given by HFHC physician(s).

3. **Payment:**
   a. I am responsible for payment of all services, either through my 3rd party payers (insurance company), or by personally making payment for any services not covered by my insurance policy(s). Payment plans may be arranged under any circumstances when mutually agreed upon.
   b. If a balance is owed on my account, I understand that I will not be able to schedule an appointment for any non-urgent visit until at least partial payment is made on the account.
4. **Behavior:**
   a. I will be considerate to providers, staff and patients, through honesty, cooperation and respect.

I understand my signature indicates that I am in agreement with the previously outlined patient responsibilities.

I understand that if I violate this agreement, I may be subject to termination of my primary physician/patient relationship, as well as, physicians of other Hillcrest Family Health Center facilities.

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Patient Name – Please Print **Date**

_____ _____

Patient Signature **Witness Signature**

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