Hillcrest Baylor Scott and White

Hillcrest Family Health Center

PATIENT AGREEMENT

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

Patient Responsibilities:

1. **Attending Appointments as scheduled**:
    a. I will attend my appointments as scheduled with HFHC physician(s). I will attend my appointments with other physician specialists, consultants, or other tests and procedures as recommended by HFHC physician(s). If you are late for a scheduled appointment, you will become a work in and could be rescheduled depending on visit reason.

    b. If I am unable to keep an HFHC appointment, I will provide HFHS physician's office with at least 4 hours notice prior to the 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 for an appointment and do not call to cancel, I will 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 or office if unable to comply.
    b. I will not contact non- HFHC physician 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 third party payers (insurance company), or by personally making payment for any service not covered by my insurance policy(s). Payment plans may be arranged under certain 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 a well child check 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 that 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.

_____

Patient Signature

_____

Witness Signature

_____

Date/ Time