Our Shared Commitment
AGREEMENT FORM

As your personal physician, my responsibilities are to:

• Explain diseases, treatments and results in an easy-to-understand way.
• Listen to your feelings and questions, which will help us to make decisions about your care.
• Keep your treatments, discussions and records confidential.
• Provide same-day appointments whenever possible.
• Provide instructions on how to meet your healthcare needs when our office is not open.
• Give you clear directions about medicine and other treatments.
• Send you to a trusted specialist, if needed.
• End every visit making sure you have clear instructions about expectations, treatment goals and future plans.
• Provide Telehealth appointments wherever possible.

As our patient, your responsibilities are to:

• Ask questions, share your feelings and take an active part in your care.
• Be honest about your history, symptoms and other important information, including any changes in your health and well-being.
• Take all your medications as directed. Inform us whenever there is a problem with the medication you are taking.
• Make healthy decisions about your daily habits and lifestyle.
• Keep your scheduled appointments or reschedule in advance whenever possible.
• Call our office with your health concerns, unless it is an emergency.
• Be sure you leave our office with a clear understanding of our expectations, treatment goals and future plans.

I have read and understand my responsibilities as a patient of this practice. I understand it is imperative that I meet these responsibilities so my physician can provide optimum care for me.

__________________________________________  __________________________  __________
Patient Name                          Patient Signature       Date

As your personal physician, I understand my responsibilities to you as a patient of this practice. I will do my utmost to provide you with the highest quality of care possible.

__________________________________________  __________________________  __________
Physician Name                        Physician Signature       Date