HEALTH FIRST™ BLUEGRASS

PATIENT LABEL HERE

PATIENT AGREEMENT FORM

I,_____, understand and agree to:

Appointment Times

- Arrive 20 minutes prior to your appointment time.
- Your medical provider may cancel your appointment if you are late. We do our best to remain on time, but please be patient as some delays may be beyond our control.

Patient Initials: _____

Cancelations

- Canceling or missing your appointment makes it hard for us to help you get better.
- If you cannot attend your appointment, please give 4 hours notice by calling (859)288-2425.
- If you have 3 no shows in a 3-month period this will result in only being able to schedule same day appointments except for emergencies
- If you continue to cancel or miss appointments, your provider reserves the right to discontinue your care.

Patient Initials: _____

Patient and Care Team Partnership

We are committed to providing patient and family centered care to promote healing, inclusion and mutual respect.

- Patient will inform care team if they are receiving care from another health professional and will disclose their health history and current medications.
- Patient and care team will work together to provide the best possible care, remaining courteous and respectful at all times.
- Patients will refrain from intimidating, aggressive or disrespectful behavior: including abusive language, derogatory remarks, shouting, verbal/physical threats, and/or damaging/stealing property.

Patient Initials: _____

Refill/Medication/Forms Request

- Please give our office 72 hours' notice for any prescription refills or completion of forms. (Sports Physicals etc)

Patient Initials: _____

Medical Records Requests

- Please give our office at least 2 weeks notice when requesting copies of medical records.
- By state law, each person is entitled to one free copy of their records. Additional copies can be obtained for a cost of $1 per page.
- Picture ID is required to obtain any records.

Patient Initials: _____

Expectation of Payment

- No patient will be denied care for the *inability* to pay. Patients that verify their income could qualify for reduced cost. Flexible payment agreements are available upon request. If you are *unwilling* to pay for services, we reserve the right to discontinue your care.

Patient Initials: _____

I have read, understand, and agree to comply with this agreement. I have also received and accept the terms of my Patient's Rights and Responsibilities which further details my responsibilities as a patient.

Patient/Guardian Signature _____ Date: _____

Please contact us at 859-288-2425 to schedule your appointment and/or to talk to your care team

COMMUNITY HEALTH CENTER FQHC QUALITY SM

NCQA RECOGNIZED PRACTICE