Chronic Disease Patient Contract

You are enrolled as a patient in the Chronic Disease Program at Free Clinic of Rockingham County, Inc. (FCRC) As a patient you must understand and agree to the following:

- FCRC is my health care provider/medical home. FCRC will work with me to coordinate my health care. I understand that I am a partner in my health care.
- This also means that I will not see any other physician for medical services without prior notification to the FCRC. I WILL NOT go to the EMERGENCY DEPARTMENT for routine care or sick visits unless advised to do so. During clinic hours, I agree to call FCRC so that I can be scheduled for the first available appointment to see a provider.

- Only in the case of a true emergency such as
    - Chest pain
    - Possible heart attack or stroke
    - Accident or serious injury
    - Rapid onset of a serious illness (High fever, severe N&V, dehydration, bleeding)

  should I go to the local ER.

- If I go to the emergency room or am hospitalized I will notify FCRC at once and sign a records release.
- I agree to keep my scheduled appointments. Rescheduling an appointment should be done 24 hours prior to the scheduled appointment. Failure to keep 3 scheduled appointments (called a "no show") within a year may result in dismissal from FCRC. No show policy is as follows:
    - 1st no show=warning letter;
    - 2nd no show=30 day suspension from all services including prescriptions;
    - 3rd no show=dismissal for 1 year.
- I agree to attend education classes as advised.
- I agree to follow instructions and guidelines given by my providers.
- I will bring all medications to FCRC for each scheduled appointment. This includes all medicines prescribed by any and all doctors/providers, any over the counter medicines, and any vitamins or herbals that I might take.
- I understand that patients are not guaranteed or entitled to any specific services.
- I understand that at times FCRC will be unable to provide a service that is recommended, and it will be my responsibility to make payment arrangements for the needed service(s). I understand that any and all charges for service provided outside FCRC are my responsibility.

- All services are subject to maintaining a current, active eligibility status. If for any reason I am not eligible for services at FCRC I understand it will be my responsibility to arrange medical care elsewhere.

- I am expected to pay my administrative fee to FCRC prior to each scheduled appointment.

- **I understand that if I**
    - **do not agree to these terms,**
    - **fail to follow through with the requirements and expectations of the staff and volunteer providers, and/or**
    - **do not keep my eligibility current,**

  I will no longer be able to be served at FCRC.

☐ I agree to the terms and expectations set forth above and understand the consequences.
☐ I do not agree with the terms and expectations set forth above and will seek health care elsewhere.

Signature of patient: _____
Print name here: _____
Date: _____

Witness: _____

☐ Copy of agreement given to patient, copy scanned to chart