MEDICAL GROUP

Patient Centered Medical Home Neighborhood (PCMH-N)

Patient and Physician Agreement

I have received the Patient Centered Medical Home-Neighborhood handout describing this model of care, what I can expect from my physicians, and what is expected of me.

My physician has discussed the details of PCMH-N with me and has answered all of my questions.

Patient Signature ______________________ Date __________

Printed Patient Name ______________________ Birth Date __________

Parent/ Guardian ______________________ Date __________

Physician Signature ______________________ Date __________

Printed Physician Name ______________________

MM-31-N (8/15)