

**McLaren Print System Order**

**Order No: 84717 Reprint Previous Order No: 5259**  
**Order Date: 2024-04-19**  
**User: Nicole Felton**  
**Phone: 810-667-4149**

**Ship Location: McLaren Lapeer Medical Office Building Attn: Nicole Felton**  
**1200 Barry Dr**  
**Lapeer, MI 48446**

**Forms**

**Quantity: 1000**  
**Paragon Dept No: 50523**  
**Dept Name: McLaren Lapeer Medical Office Building**  
**Company Number: 810**

**Order Total Price: 31.00**

**Item Number: MM-31**  
**Item Description: PCMH Patient and Physician Agreement**  
**Revision Date: 2/2019**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish: None**  
**Drill: None**  
**Misc Info:**



**PATIENT CENTERED MEDICAL HOME (PCMH)  
 Patient/Provider Agreement**

A Medical Home is a trusting partnership between a doctor led health care team and an informed patient. Good communication between patients and providers is the key to better outcomes. We are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your responsibilities as a patient in our practice.

**OUR RESPONSIBILITIES TO YOU**

- ▶ **RESPECT YOU AS AN INDIVIDUAL** - we will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation or genetic information.
- ▶ **RESPECT YOUR PRIVACY** - your medical information will not be shared with anyone else unless you give permission or as required by law.
- ▶ **PROVIDE THE BEST POSSIBLE CARE** - based on evidence based medicine and best practice recommendations.
- ▶ **MANAGE YOUR HEALTH STATUS** - including well person/preventive care as well as treatment for acute and chronic diseases.
- ▶ **LISTEN TO YOU AND EXPLAIN** - discuss treatment and results in a way you can understand.
- ▶ **PROVIDE 24 HOUR ACCESS TO MEDICAL CARE** - 7 days a week, 365 days a year.
- ▶ **NOTIFY YOU OF TEST RESULTS** - we begin contact within 2 business days of the ordering provider receiving the test results. Contact will be made via phone, portal or US mail.

**WHAT WE ASK OF YOU**

- ▶ Ask questions, share your feelings and be part of your care.
- ▶ Be honest about your history, symptoms and other important information about your health.
- ▶ Tell your doctor about any changes in your health and well-being.
- ▶ Take your medicine as ordered and follow your doctor's advice, if unwilling or unable to do so, let us know.
- ▶ Make healthy decisions about your daily habits and lifestyle.
- ▶ Prepare for and keep scheduled visits or reschedule visits in advance.
- ▶ Call your doctor first with all problems, unless you have a medical emergency.
- ▶ End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans.

**PLEASE NOTE:** When the office is closed, call us to reach a provider on call to address medical issues which cannot wait until regular office hours. It is important that you keep all scheduled appointments. Please notify us in advance if you need to cancel or reschedule appointments.

**URGENT OR EMERGENCY CARE:** Please call us before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention.

By signing below, you indicate that you have read this document, have had your questions answered, and that it is your wish to have our health care team care for you based on the statements described above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

|  |                        |   |                      |
|--|------------------------|---|----------------------|
| _____<br>Patient Name (Print)                          | _____<br>Date of Birth | _____<br>Patient/Guardian Signature                 | _____<br>Date & Time |
| _____<br>Provider/Clinical Representative Name (Print) |                        | _____<br>Provider/Clinical Representative Signature | _____<br>Date & Time |