



# TRIFECTA

MEDICAL GROUP

## PATIENT RESPONSIBILITIES

*You are an important and active member of your care plan. You have certain responsibilities to yourself and to your care team.*

In the spirit of shared trust and respect, we ask you to:

- Give true and complete information about your:
  - Health status
  - Medical history
  - Hospitalizations
  - Medicines
  - Other matters about your health
  - Contact information, family members and caregivers and other needed information
- Let us know:
  - Any risks about your care
  - Changes in your care, illness, or injury
  - Safety concerns
  - Violation of your patient rights
  - If you understand your care plan and what we expect from you
  - If you don't understand your care plan or its information
  - If you have or need to ask questions
- Please:
  - Follow your care plan and instructions created by your provider, nurses or other health care team members
  - Keep appointments and, if you cannot make your appointments, let us know at a minimum of 24 hours before your appointment
  - Be responsible for your actions if you refuse care or don't follow provider's orders
  - Pay your health care bills in a timely manner
  - Follow practice procedures, rules and regulations
  - Be thoughtful of the rights of other patients and our staff
  - Be respectful of yourself, our staff, all patients, and visitors
  - Help staff to assess your pain, to assist you to discuss and get prompt relief, communicate your concerns about pain medicines and develop a pain management plan
  - Treat the providers and our health care staff with respect and consideration
  - Treat all patients, family members, and visitors with respect and consideration

- o Accept that we will be respectful of your time and try our best to keep your wait times to a minimum but understand exceptions and urgent events requiring our attention can and will occur.
- o Accept that bad/offensive and/or threatening language or behavior is not tolerated and will be grounds for dismissal
- o Accept we may end our relationship if you do not follow your provider's orders or care plan, including the vaccination policy

I, [ResponsiblePartyName], have read, understand, and accept the patient responsibilities of Trifecta Medical Group.

[RequiredSignature]

Signature of Patient or Legal Guardian

Patient Name: [PatientName]

[CurrentDate]