NEWPORT CARDIAC & THORACIC SURGERY

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments:
Follow-up examinations are required at periodic intervals to monitor your health status. Additional testing may also be necessary. Your doctor will provide you with the appropriate time frame for the follow-up appointment and/or testing.

I understand that my doctor will explain to me when follow-up visits are appropriate and what additional testing may be necessary. **These follow-up visits/tests can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for the follow-up visits/testing, I put myself at risk of letting serious health problems go undetected. I will schedule the necessary follow-up visits and testing with my doctor.

IT IS YOUR RESPONSIBILITY TO CALL THE OFFICE TO SCHEDULE THE FOLLOW-UP APPOINTMENT/TESTING DISCUSSED BETWEEN YOU AND OUR STAFF (949) 650-3350.

Call the Office When I Do Not Hear the Results of Labs and Other Tests:
I understand that my physician's goal is to report my test results to me as soon as possible. However, if I do not hear from my Physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow Recommended Treatment Plan:
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

____________________________ __________ ____________________________
Patient Signature Date Physician Signature

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Printed Name