Florida Digestive Health Specialists

COMMUNICATION AGREEMENT FORM

Dear Valued Patient,

Thank you for choosing Florida Digestive Health Specialists as your digestive health provider.

As a participant in your own care, it is your responsibility to ensure that there is a clear and open method of communication from our office to you. It is also your responsibility to make sure that this office always has a way to contact you to communicate test results and other important matters related to your medical care.

We may recommend/perform diagnostic studies that we feel are important to your well-being. These studies are to diagnose your ailment(s), define treatment strategies and to maintain your health. As with all diagnostic studies, at times we find results that, if undiagnosed or diagnosis is delayed, can result in death or a serious disability. Some of these studies will be at the time of an active issue, and other times it will be recommended for the future.

We attempt to contact every patient with results of diagnostic studies and reminders for follow-up issues. Ultimately, if you do not hear from us within 14 days about your test results, it is your responsibility to contact us.

By initialing below and signing this letter you agree to the following:
(Please initial each line)

1. Call our office two weeks after any diagnostic study, if we have not notified your with results. _____
2. Call our office again, for any issue, if we do not return your call. _____
3. Immediately notify our office of a change of address and/or contact telephone numbers. _____
4. Keep a written record of when your diagnostic studies are scheduled and notify our office
5. if you cannot comply. _____
6. Keep a written record of your future follow-up needs, even if it is ten years in the future. _____

By signing this letter you are agreeing that the responsibilities and obligations outlined in lines 1 through 5 are important to your future health and that you will comply with these obligations.

Thank you for trusting us with your care.

_____
Patient Name Printed

_____
Witness Name Printed

_____
Patient Signature

_____
Witness Signature

_____
Date