Bush MD
Family Medicine

Dear Patient,

We are concerned about you and want to provide the best possible quality of care for you. We have found by experience that we cannot do this without your active participation and cooperation. We ask that you read and sign the following statement to attest to your willingness to do so. Thank you.

The Physician(s) at Bush MD Family Medicine.

By signing this form, I declare my understanding of the importance of follow-up as directed by the medical provider at Bush MD Family Medicine. This includes the need for office visits and scheduling annual physical examinations as well as visits to recommended specialist(s), and completing order labs/ tests. I further understand that it is my responsibility to retrieve test results from Athena Portal or calling the office for test results if they are not sent to me via secure email through the practice. I understand that if I do not follow-up as directed, this could cause a problem to worsen to the point of permanent disability or death, and/or delay the treatment of a potential problem beyond the point of cure. I understand that I may be discharged as a patient of Bush MD Family Medicine as a result of my failure to follow-up.

Further it is my responsibility to arrive a few minutes before my scheduled appointment time to allow for registration.

Please note: As providers we make every effort to care for our patients in a timely manner. Unfortunately the realities of working with people and their medical issues lead to unpredictability in scheduling as well as time delays. Thanks for your consideration we know your time is important as well.

Please print:

Patient name ____ D.O.B _________________

Patient signature ____________________________________

Date ____________________________