FRASER STREET MEDICAL

PATIENT-PHYSICIAN AGREEMENT FOR HEALTH CARE MANAGEMENT

Patient Name: _____

Date of Birth: _____

Family Physician: _____

By signing this agreement, I confirm that the physician named above is my family physician and the Most Responsible Physician primarily responsible for coordinating my ongoing care.

I understand that I may see other physicians, nurse practitioners or members of the Fraser Street Medical team when my family physician is unavailable. My family physician will continue to oversee my overall health, chronic medical conditions and preventive care.

OBJECTIVE

The purpose of this agreement is to support a clear, collaborative relationship between you, your family physician and the Fraser Street Medical team.

WHAT YOU CAN EXPECT FROM YOUR FAMILY PHYSICIAN AND CARE TEAM

- Provide comprehensive and respectful medical care.
- Coordinate specialist referrals and other health services when clinically indicated.
- Maintain an ongoing medical record.
- Review and help manage your chronic medical conditions.
- Arrange follow-up visits as medically required.
- Monitor blood pressure and other vital signs as appropriate.
- Recommend laboratory testing and preventive screening based on your age, health conditions and individual risk factors.
- Provide reasonable access to urgent and routine primary care through Fraser Street Medical and its clinical team.

YOUR RESPONSIBILITIES

- Whenever possible, seek care from Fraser Street Medical, where your medical records are maintained and your care can be properly coordinated.
- Identify your Fraser Street Medical family physician as your family physician when attending a hospital, emergency department, walk-in clinic, specialist or other healthcare provider.
- Attend follow-up appointments as recommended by your physician.
- Bring an up-to-date medication list or have your medications available for review during appointments.
- Book an appointment when your health changes, you are discharged from hospital or you receive significant care from another healthcare provider.
- Complete recommended laboratory tests, investigations and screening.
- Inform the clinic promptly if your telephone number, email address, home address or other contact information changes.
- Inform Fraser Street Medical if you move, transfer to another primary care provider or no longer wish to remain attached to the clinic.
- Cancel or reschedule appointments at least 24 hours in advance whenever possible.

ACKNOWLEDGEMENT

By signing below, I confirm that:

- The physician named above is my family physician and Most Responsible Physician.
- I understand that other Fraser Street Medical clinicians may participate in my care.
- I understand the expectations and responsibilities described in this agreement.
- I authorize Fraser Street Medical and my family physician to coordinate my ongoing medical care.

Patient/Legal Representative Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient, if applicable: _____

Physician Signature: _____ Date: _____