Patient Partnership Plan

To Our Patients:

We would like to welcome you to **Coast Neurosurgical Associates**. Our intent is to provide you with the service quality that you expect and deserve. However, in order to facilitate achieving the best medical care and service possible, we ask you to join us in our "Patient Partnership Plan". As our "partner in health" we ask that you assist our office in the following ways.

1. **Take responsibility for scheduling and attending your follow-up tests and appointments.** Depending on your individual medical condition, failure to comply with a follow up may cause your condition to deteriorate and progress.

2. **Assist our office in obtaining and communicating the results of your diagnostic studies and consults.** We will do our best to obtain and communicate those results to you in the timeliest manner. We also ask that you assist us in ensuring that these results are released to our office. In the event that your results are not obtainable (either for patient privacy reasons, or other reasons, etc.), we ask that you participate in obtaining these results directly from the facility/entity which has provided the diagnostic service.

3. **Assist our office in obtaining the appropriate authorization for medical services.** Depending on your individual insurance coverage, certain services may require re-certification and/or authorization. Please be patient with our office while we obtain pre-certification and/or authorization. We may ask that you contact your insurance company or primary healthcare provider to help expedite the pre-certification and /or authorization process.

4. **Keep Communication lines open.** Based on your individual medical condition, recommendations will be made regarding which treatment course is best for you. This may include prescribing medication, ordering further diagnostic evaluations, conservative observation versus surgery, therapy, or referring you to another physician/specialist. If you do not agree with the recommended treatment plan, or if you change your decision, please share your plans with us. If you fail to do so, our Doctors will not be able to advise you of any risks or untoward consequences which may result from your decision to delay and or refuse treatment.

5. **Become informed.** Lastly, we want you to know that as our patient, you have the right to be fully informed of your medical condition and the recommended plan of care. We encourage you to report symptoms, ask questions, and discuss any concerns you may have regarding your care. We look forward to providing you with the best care we can, and expect that you would be extremely satisfied with the care you receive at our office, Once again, welcome to our office and thank you for your participation.

6. **Electronic recording/videotaping**. This office strictly prohibits electronic recording or videotaping of any kind in consideration of the privacy and confidentiality of the physician-patient relationship. We sincerely appreciate your compliance with our request.

_____ _____

Print Name Patient Signature Date

2017