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 Physicians and staff of Irvine Family Care

By signing this form, I declare my understanding of the importance of follow-up as directed by the medical provider at Irvine Family Care. This includes the need for office visits and scheduling annual physical examinations as well as visits to recommended specialists and completing ordered labs/test. I further understand that it is my responsibility to retrieve test results from NextMD (e-mail) (if instructed from>Lab Talk, or calling the office for test results if they are not in my email NextMD, after 14 days of the test being performed. I understand that if I do not follow-up as directed, I could be worsening a problem beyond the point of cure.
As a result of my failure to follow-up, I understand that I may be discharged as a patient of Irvine Family Care.

Please Print Name _____ D.O.B_____

Patient Signature_____ Date_____