GynoFitMD
Women's Health & Medical Weight Loss Expert

Patient Office Policy Agreement

Patient's Name: _____ DOB: _____ Date: _____

We, at GynoFitMD strive for excellent patient care in a positive and caring environment. We want to maintain a healthy atmosphere for both staff and patients that is safe, clean and enjoyable. ***Please read the following office policies and initial each indicated line, acknowledging your compliance.***

(initial) _____

Cell Phones

Please be courteous of other patients and staff. Please turn off all cell phones and/or pagers during your visit with the doctor. Individual uninterrupted attention is very important when it comes to your health.

(initial) _____

Treatment of Staff

Any inappropriate treatment of staff will be a cause for discharge from our practice, this includes but is not limited to aggressive or threatening behavior towards the staff, use of foul/bad language towards staff and/or any other behavioral, verbal, or written communication, which is deemed inappropriate towards staff.

(initial) _____

Good Communication/Appointment Reminder

Good communication is crucial between patient and doctor. We have an automated courtesy reminder system that will send a text, email or call via the method you selected on your demographics. ***Do not depend on the automated reminder system; you are still responsible for keeping your appointments when scheduled.***

(initial) _____

Constructive Criticism

Constructive criticism of our practice is welcome. We do reserve the right to discharge anyone from the practice in the event of patient non-compliance of care, the breakdown in communication and/or willful slander/putting derogatory comments about our practice in person or on social media.

(initial) _____

Office Appearance

Please be courteous when in the lobby, using the restrooms or while in an exam room to be sure all trash is thrown away in a receptacle. Please don't leave a mess, leave it as tidy as it was before.

By signing this form, you acknowledge that you are aware of this policy and understand your responsibilities.

Patient Name *(print)*: _____

Signature of Patient/Authorized representative: _____ Date: _____