AGREEMENT FOR SHARED RESPONSIBILITY FOR CONTINUING CARE AND FOLLOW-UP

Patient's Name Date

I have been told that my condition will require continuing follow-up, sometimes for years, in order to assure that there is proper healing and/or no recurrence of the disorder.

I acknowledge that **Dr. Tyler L. Clark** has advised me of the importance of returning for long-term follow-up which, if not done, may cause infection or other complications to go undetected, and which could lead to a recurrence, relapse or serious complication in treatment of my disorder. I understand that if I do not return for proper continuing care, my condition may progress and require more advanced treatment or further surgery, or in rare cases may be life threatening.

I agree to comply with regularly scheduled exams when notified by this office, understanding that I may choose a convenient appointment, but not postpone care beyond a reasonable time. When notified of my appointment, I will call to confirm as soon as possible.

I also understand that if I feel there are adverse changes in my symptoms or condition between scheduled visits, I should notify this office immediately.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date

Print Witness' Name and Address

A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original. 09/2009