FREE CLINIC OF CULPEPER
PATIENT REFERRAL AGREEMENT

CONSENT FOR REFFERAL:

I, the undersigned, authorize the health care providers and staff of the Free Clinic of Culpeper to make referrals to other health care providers and/or specialists on my behalf.

______________________________________ ____________________
Patient Signature Date

PATIENT EXPECTATIONS AND RESPONSIBILITIES:

I understand the following:

- Health care providers are providing time to accommodate the needs of Free Clinic patients;
- Receiving a referral appointment is a privilege that must be respected and appreciated;
- Many other patients are waiting for referral appointments.

I agree to the following:

- I will be on time for all appointments;
- I will call at least 24 hours before my appointment time if I have an emergency and I am unable to make the appointment;
- I will not reschedule a missed appointment more than two times (you may be charged a rescheduling fee);
- I will be polite and respectful at all times; and
- I will follow the recommendations/directions of the health care provider or specialist.

My signature below indicates that I agree to follow the patient expectations and responsibilities. I understand that failure to meet these requirements may result in losing the privilege of receiving referrals from the Free Clinic of Culpeper.

______________________________________ ____________________
Patient Signature Date

______________________________________ ____________________
Clinic Representative Date