I received a copy of “The Patient’s Bill of Rights” from the office of Dr. Suzanne Yee.

I understand the office of Dr. Suzanne Yee does not accept advance directives (specific instructions, prepared in advance, that are intended to direct a person’s medical care if he or she becomes unable to do so in the future).

I acknowledge I have received a copy of Dr. Yee’s biographical synopsis.

I hereby release Dr. Suzanne Yee of filing Medicare for any services she administers. I understand it is my responsibility to pay for any services rendered.

I agree to the following as a patient of Dr. Suzanne Yee:
a. To provide complete and accurate information to the best of my ability about my health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
b. To follow the treatment plan prescribed by Dr. Yee
c. To provide a responsible adult to transport me from the facility and remain with me for 24 hours, if Dr. Yee deems it necessary.
d. Inform Dr. Yee about any living will, medical power of attorney, or other directive that would affect my care.
e. Accept personal financial responsibility for any charges.
f. Be respectful of all the health care providers and staff, as well as other patients.

Signature:_____

Date:_____

Witness:_____