Silverado Medical Clinic
#806, 19369 Sheriff King Street SW Calgary, AB T2X 0T9
Tel: (403) 873-7300 Fax: (403) 873-8880

PATIENT AGREEMENT FORM

Silverado Medical Clinic is committed to provide you with quality health care. To be able to provide this care, we need you to agree and adhere to our clinic policies and guidelines.

- Your first visit to the clinic will be to meet the physician and discuss your medical history. This allows you and the physician a chance to get to know each other. No medical concerns will be addressed at this visit.
- Patients must provide a valid Health Care Number. Patients without valid Health Care wil be charged for the services at the time of their visit.
- Please inform the clinic of any changes to your contact information as soon as possible.
- Some services are not covered by Alberta Health and a fee will be charged to the patient at the time of the appointment. Please
- Patients who missed an appointment or cancel less than 24 hours' notice will be charged $50 for regular appointment and $120 for Complete Physical Exam.
- We understand that sometimes emergency situation happens and you won't be able to attend your appointment. If this happens, please call us as soon as possible.
- Abuse of staff is not tolerated. Any abuse will result in a patient being dismissed from the clinic.
- Please limit each visit to 1 issue. If you have a complex issue or multiple problems that you would like to discuss, please inform the receptionist so that additional time can be booked as appropriate.
- Test results will not be given over the phone. Our office will call to set-up an appointment to discuss abnormal results.
- We do not do prescription refills via phone or fax. Patients are expected to give themselves adequate time to see their family doctor to get their prescription.
- We try our best to keep appointments at a timely manner. However, sometimes patients have complex problems that require more time than was scheduled. We appreciate your understanding.

By signing below, you confirm that you have read and understand the items outlined in this agreement.

Signature of patient or parent/guardian: _____

Print Name: _____ Date (dd/mm/yy) : _____