Expectations of Treatment Agreement

This document will serve as an agreement between (patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and the staff at (facility) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The purpose of this agreement is to provide in writing, reasonable expectations of behavior in order to maintain the patient-provider relationship between (patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and staff at (facility) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Our goal is to provide every patient with safe, quality care. We need everyone’s help to accomplish this. The staff will work with you and your family to meet your healthcare needs. It is also important for us to partner with you to help you set and continue your healthcare goals.

In order to determine your goals and our expectations of you to be a patient at (facility) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, we would like to schedule a meeting with you on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at (time) \_\_\_\_\_\_\_\_\_\_\_\_. We encourage you to bring a family member, caregiver or friend with you to the meeting.

Based on our discussion at the meeting on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_, we have agreed on the following expectations:

Patient Actions:

1.

2.

3.

4.

Staff Actions:

1.

2.

3.

4.

The care team will meet with you monthly to review progress towards the identified goals and change the agreement as needed. This agreement will be in effect for 90-days or 3-months, at which time we will meet for a final review of the agreement and make a determination of whether or not to admit you to (facility) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a permanent patient.

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Administrator Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Facility Manager Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Social Worker Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Patient Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_