HARBOR PHYSICIANS
Primary Care & Internal Medicine

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PATIENT CONDUCT & DISCHARGE ACKNOWLEDGMENT

Patient Name: _____
Date of Birth: _____

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1. Acknowledgment of Standards of Care

I understand that this medical practice is committed to providing safe, professional, and medically appropriate care in accordance with applicable clinical standards and policies. I acknowledge that respectful communication and cooperation are necessary for the delivery of effective medical care.

2. Required Patient Conduct

I agree to:

- Communicate respectfully with all providers, staff, and other patients.
- Follow agreed-upon treatment plans or actively discuss concerns before refusing care.
- Comply with clinic policies, instructions, and scheduled appointments.
- Refrain from behavior that disrupts clinic operations or the delivery of care.

3. Behavior That May Result in Discharge

I understand that the following behaviors are considered incompatible with ongoing care in this practice and may result in discharge from the practice, either immediately or after notice at the provider's discretion:

a. Noncompliance

Repeated refusal to follow medical advice, failure to adhere to treatment plans, or repeated missed appointments that compromise care continuity.

b. Disruptive or Inappropriate Behavior

Verbal abuse, harassment, intimidation, profanity, or disruptive behavior toward staff, providers, or other patients.

c. Threatening or Unsafe Behavior

Any threats of violence, aggressive conduct, or actions that create a perceived or actual risk to safety.

d. Interference with Care Delivery

Any action that interferes with clinical workflow, staff duties, or the safe and effective provision of medical services.

4. Termination of Care Relationship

I understand that the provider reserves the right to terminate the patient-provider relationship when clinically or administratively appropriate. This includes situations involving repeated noncompliance, disruptive behavior, safety concerns, or breakdown of trust necessary for care.

If terminated, I understand I may be provided with written notice and reasonable assistance or resources to transition care to another provider, consistent with applicable regulations and continuity of care standards.

5. Acknowledgment of Understanding

By signing below, I acknowledge that I have read, understood, and agree to comply with the terms outlined in this Patient Conduct and Discharge Policy.

Patient Signature: _____ Date: _____

Staff Witness: _____

Date: _____
