

I _____(resident name) have been given by _____(facility name) the option to see my own medical professionals. I am aware and by signing this I agree and choose the option to see the medical professionals that make house calls to the facility. I am aware that these medical professionals are not affiliated with the facility and I will be responsible for any cost that is associated as a result of the care provided by these health care professionals.

Resident Signature Date

Power of Attorney/Guardian Signature Date

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