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## The Patient-Provider Partnership Agreement

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, *your doctor*, and you, *my patient*, work together. This concept is called the Patient Centered Medical Home.

### As our patient, your responsibilities are:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your healthcare team about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor’s advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call us *first* with all problems, unless it is a medical emergency
- End every visit with a clear understanding of your doctor’s expectations, treatment goals, and future plans

### As your provider office, our responsibilities are:

- Explain diseases, treatments, and results in an easy-to-understand way
- Take time to listen to your feelings and questions and help you make decisions for your care
- Keep your treatments, discussions and records secure
- Provide 24 hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Provide you with clear directions about medicines and other treatments
- When necessary, direct and coordinate your care through referrals to specialists and community resources
- End every visit with clear instructions about expectations, treatment goals, and future plans

Thank you,

Dr. Pamela A. Georgeson, Dr. Mark L. Decco, Vanessa Kondziolka C-NP, Joan O’Lear C-NP  
Kenwood Allergy and Asthma Center, PC

I, \_\_\_\_\_ (patient/patient representative), have read and agree to the above information.

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Date Patient/Patient