ER/ Hospital Fu

Date: _____/_____/_____

It is our responsibility as your Internal Medicine provider to provide you with the best care possible.

It is your responsibility to let us know when you are going to the Emergency room or Hospital. Our office would like to make sure that you are taken care of every step of your care.

Call the office to schedule a hospital follow up within 24 hours of being discharged. By signing this you are agreeing to call the office to schedule an appointment to be seen with in **7DAYS** of being discharged from the hospital.

Patient sign: _____ Date: ____/____/_____