



PRIMARY CARE ASSOCIATES

QUALITY AND COMPASSIONATE CARE

To our Appreciated & Honorable VA Patients:

Due to the complexities of having multiple physicians taking care of you, we are requesting that you appropriately choose one of the following options for your physician management choice for your chronic conditions.

_____ 1. The VA will manage all of my chronic conditions, and I, the patient, release Dr. _____ from any responsibility with regard to chronic conditions. I will see Dr. _____ only to satisfy my insurance obligation, and/or for any acute conditions that may arise.

_____ 2. I want Dr. _____ to manage all my chronic conditions and acute conditions. I will provide all test results done by the VA, but understand that Dr. _____ may need to repeat some tests or do additional testing as the need arises. I will not allow the VA to make any changes to my medications without first notifying and checking the medication with Dr. _____.

_____ 3. While I have chosen an option (#1 or #2) above, I would like the following exceptions (*fill in the condition or disorder*):

Dr. _____ to do: _____

VA to do: _____

If you have any of the following done at the VA, please make sure to bring a copy to us so we can add to your record.

• Eye Exam

• Colonoscopy

• Lab Work

Note: None of the above options will in any way affect where you get your medications/supplies.

Signature of Patient

Date (MONTH/DAY/YEAR)

PRINTED Name of Patient