

# Pulmonary Hypertension Program Patient Agreement

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The Pulmonary Hypertension Program team has physicians, nurses, research and administrative support staff with extensive experience in diagnosing and treating this disease.

- I understand the team provides support and knowledge and will guide me through the complex steps of diagnosis and treatment. The team will ask me to have blood draws and other tests; these are crucial in decisions that affect my health.
- As a patient in this program, I must be accessible by phone and able to travel to my appointments. **If my address or phone number changes, I will notify the program as soon as possible.**
- If I am left a message to return a call to the Pulmonary Hypertension Program, I will call within 24-48 business hours.
- To obtain the maximal benefits of treatment, I understand I must carefully follow (comply with) the prescribed medications, diet restrictions, recommended life style changes, and other suggestions from the nurses and doctors.
- I am willing to **comply** - to follow instructions about taking medication regularly, eating a proper diet, and notifying the clinic about all drugs I am taking (including over-the-counter drugs and supplements).
- I understand that **noncompliance** with recommended care - medication, testing, and appointments can result in serious complications, deterioration, and increase the need for emergent hospitalization.
- I may be contacted at the following numbers:

Home: \_\_\_\_\_

Alternate: \_\_\_\_\_

- My correct address is:

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*Street*

*Town*

*State*

*Zip code*

\_\_\_\_\_

*Patient Signature*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Witness Signature*

\_\_\_\_\_

*Date*

Disclaimer: This document is for informational purposes only and is not intended to take the place of the care and attention of your personal physician or other professional medical services. Talk with your doctor if you have Questions about individual health concerns or specific treatment options.

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