Physician HealthCare Network & Children's Health Care
Asthma Group Medical Appointment

*Appointment Confirmation**

Patient Name:	
Appointment Date:	Appointment Time:
Location:	
*Bring this confirmation ticket with you to the Group Medical Appointment to receive your free gift.	

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[redacted]	[redacted]	[redacted]
Name: PCP: Insurance:	Name: PCP: Insurance:	Name: PCP: Insurance:
Name: PCP: Insurance:	Name: PCP: Insurance:	Name: PCP: Insurance:
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Physician HealthCare Network & Children's Health Care
Asthma Group Visit Appointment

Group Visit Note

Patient Name: DOB:	Parent /Guardian Name:
Date of Last Office Visit:	Provider Name:
Location of Group Visit: Date of Visit:	Group Visit Focus:
Group Visit Duration: Start time: End time:	Self Management Goal:
Visit Summary:	
Plan:	

Meeting Sign-In Sheet

Project: _____ Date: _____

Facilitator: _____ Time: _____

Place/Room: _____

PRINT NAME	PARENT SIGN		PHONE	EMAIL
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2.				
3.				
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22.				

Physician HealthCare Network & Children's Health Care Confidentiality Commitment

During Group Visit Appointments personal/health information may be shared not only by you but your fellow Group Visit Appointment participants. As a matter of trust, it is your duty to keep everything you hear confidential.

Nothing that identifies a participant in any way (including job, ethnicity, religion, etc.) can be shared outside of this group setting.

Like any health appointment, appropriate information about you becomes a part of your clinic medical record.

The Group Visit Patient's Confidentiality Commitment

- I accept that the health care team will discuss my medical issues in front of others.
- I will keep the confidentiality of group members' personal/health information heard during a Group Visit Appointment.
- I am committed to maintaining this confidentiality even if I am no longer participating in Group Visit Appointments.

	Name (Printed)	Signature	Date
Patient			
Witness			