**Notice of Inappropriate Behavior**

Patient Name: Date of Birth:

Physicians and staff must be treated respectfully to maintain therapeutic and productive relationships with our patients. The following behavior(s) have been identified and deemed inappropriate.

Date of Incident:

Description of behavior(s):

**I have read and understand this Notice of Inappropriate Behavior. I agree to take all steps necessary to correct the action(s) outlined herein and acknowledge that my failure to do so may result in my dismissal from this medical practice. I further agree to treat all team members with dignity and respect.**

Patient/Patient Guardian Signature Date

**A copy of this Behavior Agreement will be maintained in the Medical Record.**

8/11/2022