SUMMIT VIEW CLINIC PATIENT POLICIES

ID:

_____**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:** We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Department.

_____I have received a copy of the Notice of Privacy Practices describing in more detail how my health information may be used and disclosed, and how I can access my information.

_____**COMMUNICATION POLICY:** When it is necessary to contact patients outside of a normal office visit, Summit View Clinic may communicate by phone, through the mail using the United States Postal Service (USPS), or through a secure internet portal called Webview. You may choose your preference for receiving written information (USPS or Webview). The following information is typically sent as written information: Routine (non-critical) lab and diagnostic test results; Patient surveys, reminders, medication alerts, disaster information, announcements, patient newsletters, seminar/event notifications, and new services.

In addition, Webview allows 24/7 access to appointment information, medication and allergy lists, and communication from your provider. It also offers patients the ability to securely request referrals, access forms to release or transfer medical records and request billing information.

Summit View Clinic Inc., P.S., will use all reasonable means to protect the security and confidentiality of electronic information sent and received. However, Summit View Clinic cannot guarantee the security and confidentiality of internet based communication, and will not be held liable for improper disclosure of confidential information that is not caused by Summit View Clinic's misconduct. Patients are required to read the Patient Portal Agreement and Privacy Policy before accessing the portal.

I have read Summit View Clinic's communication policy and choose the following as my preferred method of receiving written communication:

_____**Letter via U.S. Mail:** I prefer to receive my lab/diagnostic results as well as any other routine communication from my provider via standard U.S. Mail to the address in my file. I understand that results may take up to 14 business days to receive.

_____**Webview Portal:** I prefer to receive my lab/diagnostic results as well as any other routine communication from my provider via the secure patient portal known as Webview. I agree to monitor my Webview portal for communications from my provider and understand that it is my responsibility to check my Webview portal for results.

I understand this agreement applies to **ROUTINE** communications only. Any communication qualifying as urgent or critical will be addressed by phone or in person.

WEBVIEW PARTICIPANTS ONLY: Please choose a security prompt from the list below and write your answer in the field provided.

_____Mother's maiden name _____City of birth _____Father's middle name

_____First pet's name _____High School mascot

Answer:_____

_____**APPOINTMENT REMINDER CALLS:** As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

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_____ **APPOINTMENT TIMES:** Check in is **15 minutes prior to your scheduled appointment** time. This is to allow us to collect information from you and assemble your clinical information prior to your appointment. This allows us to optimize the time spent with your provider. We realize your time is valuable and strive, whenever possible, for you to see your provider on time. If you have an unexpected delay, call us as soon as possible and we will try to work with you. However, you may be asked to reschedule your appointment for another day and time.

_____ **NO SHOW POLICY/LATE CANCELLATION POLICY:** Failure to keep or cancel your appointment more than 24 hours prior to your appointment time will result in a $25 fee. This fee is due and payable prior to scheduling future appointments. If you have three no show/late cancellations within a 12 month period, you may be discharged from our office. We want to be reasonable and we understand issues beyond your control may prevent you from keeping your appointment time. Please contact your receptionist if that is the case.

_____ **COPAYS, COINSURANCE AND DEDUCTIBLES:** Copays, coinsurance and deductibles are patient responsibilities and will be collected at time of service. **KNOW YOUR COVERAGE AND COME PREPARED TO PAY YOUR PORTION.** If your coverage cannot be verified, the minimum due will be $75.00. If you are not prepared to pay, we may be required to reschedule your visit with the doctor.

_____ **NO INSURANCE: PAY AT TIME OF SERVICE:** Patients with **no insurance** or who **have an insurance we are not contracted with** will be required to pay in full at time of service.

_____ **INSURANCE BILLING: READ AND UNDERSTAND YOUR INSURANCE POLICY. DO NOT ASSUME YOUR POLICY AUTOMATICALLY COVERS EVERYTHING.** Your policy is a **CONTRACT** between you and the insurance carrier. Read it, understand it, and ask questions. Even different policies from the same insurance company can have different requirements. It is YOUR responsibility to know what your policy covers and what it does not. Always carry your insurance card with you. You will need it for all office visits and may need it in case of an emergency. Some insurance carriers require we verify your coverage for each office visit. Without this information, we may have to reschedule your appointment or you may have to pay at time of service.

_____ **MOTOR VEHICLE ACCIDENTS:** We are not contracted with any auto insurance plans, but as a courtesy, we will submit the bill to your plan. Motor vehicle claims are the patient's responsibility and payment is expected within 30 days, either from the insurance company or from the patient. We do not follow up with the insurance company. If you arrive at the appointment without the necessary information you will be required to pay at the time of service.

_____ **NSF CHECKS:** A $40.00 NSF charge applied in addition to the amount of the check.

_____ **DELINQUENT ACCOUNTS:** If your account is delinquent you will receive a letter from the Patient Accounts Manager notifying you that you need to make a payment to clear your account. If payment is not made, your account will be turned over to a professional collection agency. At that time, you and your family will be discharged from Summit View Clinic.

_____ I give my consent to Summit View Clinic and any of its agents acting on behalf to communicate with me regarding my accounts through means such as 1) any cell, landline, or text number that I provider, 2) any email address I provide, 3) auto dialer, 4) voicemail messages, and other forms of communications.

PATIENT/PARENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE

DATE AND TIME

PRINTED NAME

RELATIONSHIP