Clinic Policies Acknowledgement

FORM 129 - R190412

Please review the following list of Salem Pediatric Clinic policies and initial that you understand each. We encourage you to read the full details regarding each policy which are available on our website at salempediatricclinic.com.

- ☐ I understand that protected medical information including allergies, medications, clinic diagnoses may be disclosed to covered entities including other clinics and physicians for treatment, coordination of care, payment, and health care operations.
- ☐ I understand that protected medical information including mental health information, HIV status, drug/alcohol use, and sexually transmitted information requires a separate authorization and will not be disclosed electronically without authorizations.
- ☐ I understand I am responsible to pay in full for services that my health insurer will not cover.
- ☐ I understand that all copays may be required at the time of service.
- ☐ I understand there will be a $25.00 minimum charge for any check returned for insufficient funds.
- ☐ I understand all outstanding accounts are due and payable at the time of a visit unless satisfactory arrangements have been made with our business office.
- ☐ I understand Salem Pediatric Clinic reserves the right to terminate care at any time or for any reason including but not limited to bankruptcy, insolvency, delinquency, or at the sole discretion of a physician.
- ☐ I understand I may be asked to arrive 15 minutes prior to my appointment time to allow for check in, verification of insurance, and photo identification when necessary.
- ☐ I understand that arriving more than 5 minutes past my scheduled appointment time may affect my ability to be seen by a provider. I understand that I may be given the option to wait for another appointment time on the same day if one is available or I may be asked to reschedule.
- ☐ I understand that an appointment is deemed a “no show’ if arrival is more than 15 minutes past scheduled time.
- ☐ I understand that whenever possible I must give 24 hours notice if I am unable to keep an appointment.
- ☐ I understand that if/when I am referred to care outside our clinic, I have the right to request that a test or service be completed at a facility other than the one recommended by my health care provider.
- ☐ I understand that the State of Oregon conducts genetic research on health information or biological samples which may include blood, urine, or other materials collected from a person’s body, and that I have the right to allow or decline participation in this research. I also understand my decision will NOT affect the care I receive from my health care provider. Please select one:
  - ☐ I ACCEPT having my health information and biological samples available for anonymous or coded genetic research.
  - ☐ I DECLINE having my health information and biological samples available for anonymous or coded genetic research.
- ☐ I understand I have the right to inspect and copy health information such as medical and billing records.
- ☐ I understand that Salem Pediatric Clinic has an immunization policy that requires children to be immunized. Children not up to date on recommended immunizations will require provider review. I understand that I may be asked to seek medical care elsewhere if I am not willing to comply with this policy.

BY SIGNING BELOW, I AGREE THAT I HAVE REVIEWED AND UNDERSTAND THE POLICY INFORMATION ABOVE.

Signed by _____ **Date** _____

Print Name _____ **Relationship to patient** _____

Patient Name _____ **Patient date of birth** _____

Salem Pediatric Clinic

2478 13th Street SE
Salem, Oregon 97302
503-362-2481 · Phone
503-371-7803 · Fax
SalemPediatricClinic.com