

Clinic Policies Acknowledgement

FORM 129 - R260205

Please review the following list of Salem Pediatric Clinic policies and initial that you understand each.

- 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 without authorizations.
- I understand I am responsible to pay in full for services that my health insurer will not cover, that all copays may be required at the time of service, and that 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.
- 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 also 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 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 I have the right to inspect and copy health information such as medical and billing records.
- I understand that Salem Pediatric Clinic will comply with all state and federal laws regarding disclosure of information for legal proceedings.
- I understand that Salem Pediatric Clinic has a policy not to write or provide letters or documentation of opinion for the purpose of legal or custody proceedings.
- I understand that individuals should be prepared to show a valid photo identification and sign for health information disclosures when arriving at the clinic.
- I consent to an AI-powered scribe to be used during the visit to assist in documenting the clinical encounter. I acknowledge that personal health information will be processed through the system in a secure and confidential manner. I acknowledge that I may opt-out of using the AI scribe at any time.
- I authorize Salem Pediatric Clinic to send me text (SMS) messages to the primary mobile number I have provided. I understand these messages may include appointment reminders, appointment requests, test results, and other information related to my care. I understand that text message charges from my mobile provider may apply. I understand there is a risk of unauthorized access or interception of information and that I am communicating with the practice via a text message at my own risk. I understand I may opt out of texting at any time.

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

Signed by _____

Date _____

Print Name _____

Relationship to patient _____

Patient Name _____

Patient date of birth _____



Salem Pediatric Clinic

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