Dear Patient,

We would like to personally welcome you to our clinic. We are pleased that you have chosen us to be your primary care provider. It is our responsibility to deliver the best healthcare possible with an emphasis on quality, access and compassion. Our primary care provider team specializes in the care of patients of all ages.

Patients are seen by scheduled appointment only, though we offer many same day appointments as allowed by cancelations or for acute needs. You may also find our Urgent Care Clinic, which is open seven days a week, beneficial. After hours, care is provided through our Urgent Care Clinic and Emergency Department.

If you need to be hospitalized, we work directly with the hospitalists to assure a smooth transition with your health care. We also offer inpatient services here in Elma if you need to spend time recovering in a facility and want to stay close to home. If you need to be referred to a specialist, we will be happy to arrange that for you.

Summit Pacific Medical Center, and its affiliated clinics, offer financial assistance and referral programs. If you do not have insurance at this time, we also have an Insurance Enrollment Specialist on staff, who may be able to assist you with signing up for health insurance. In addition, we offer a variety of financial assistance options, which you may qualify for, which includes charity care (see the enclosed documents). If you need help with paying your bill, whether or not you have insurance, please contact our billing office at 1-888-292-8810, as they would be happy to help you.

Enclosed you will find our *Policy Statement and Office Procedures*. We hope that it will be informative to you and may answer some questions you may have regarding your first appointment with us. **We ask that you fill out and bring with you the following forms:**

1. Friends and Family: Consent to Discuss Authorization Form
2. Release of Records
3. Medical History Form

When you arrive for your first appointment, please bring the following with you:

1. Current Insurance Cards
2. A list of all medications, vitamins and over the counter medications you are taking.
3. Photo identification
4. Copayment

Thank you for choosing Summit Pacific Medical Center and affiliated Healthcare Clinics to help with your healthcare needs. We look forward to seeing you!

Sincerely,

Summit Pacific Medical Center Clinic Staff

Policy Statement and Office Procedures

Please take a moment to review the following office policies and procedures. We believe that these policies enable us to create a successful atmosphere for our patients and staff at Summit Pacific Medical Clinics. Should you have any questions or concerns, please do not hesitate to speak with any clinic staff member.

Insurance Information

Each patient is responsible for knowing and understanding his or her insurance information. You will need to present your current insurance card each time you visit one of our clinics. ***Please understand we may need to reschedule your appointment if you do not have your current insurance card, or if you are not assigned to one of our providers and/or to one of our clinics.*** In order to determine if you are assigned to one our providers and/or clinics is to contact your insurance sponsor directly. Many insurance cards have a phone number on the backside of your insurance card. In addition, co-pays are due at the time of service. Summit Pacific Medical Center accepts various payment options for your convenience, which include:

- Check
- MasterCard
- Visa
- Discover

Refills

There is a three business day policy for all medication refills. **Please allow three working days' notice by contacting your pharmacy for any refills.** Narcotic medication refills requiring a signed prescription will not be filled on weekends or major holidays.

Referrals

If you are referred to a specialist, we will make every effort to assist in this process by contacting your insurance, selecting a provider, scheduling the initial appointment, and sending your records. Nevertheless, if you are scheduled with a specialist and find the appointment is not convenient, you will be responsible for rescheduling that appointment.

"No Shows"

Please know that SPMC clinics have a "No Show" policy. If you miss 3 or more appointments within a calendar year you become ineligible for scheduled appointments for one calendar year. During that year you can visit the Emergency Department, Same Day Clinic and Urgent Care Clinic for your healthcare needs. Continuity of care is imperative for healthy outcomes; one of the best ways to obtain this is to show for all scheduled appointments. If you must cancel an appointment for any reason, please provide a minimum 24-hour notice of cancellation. You may leave a message on our voicemail after hours. Any cancellation with less than 24 hours prior notice will be considered a "no show." If you arrive for your appointment five or more minutes late to a scheduled appointment time you may be asked to reschedule.

Summit Pacific provides the following discounts available to patients:

- **Property tax credit:** Patients living within the district may receive a credit in the amount of the public hospital district portion of their property taxes paid over the previous 12 months from their related date of service, up to a maximum annual credit of $500. Patients **are required to supply** their property tax statement **and** complete the Property Tax Application.

- **Community Care:** Patients, including employees, that have a family income below 200% of the federal poverty level can apply for a full write off of their balance. Those that earn between 201% and 300% can apply for a partial write off. All Community Care applicants are **required to complete** the Determination of Eligibility for Community Care Application, **as well** as provide proof of income.

- **Prompt pay discount:** Patients are eligible to receive a 25% discount if the balance is paid within 30 days. The discount amount is to be calculated and deducted from the billing statement by the patient, as noted on the invoice. Statements will only print the “Prompt Pay Discount” message on the first statement.

- **Payment Plan:** As of July 1st, all new payment plans will need to be set up with the billing office by calling 1-888-292-8810.

- **Billing Questions:** Any patient billing questions can be asked of CBO, our billing office, who can be reached at 1-888-292-8810. In addition, CBO can collect and apply all of these stated discounts to a patient’s billing statement.

- **Return of Applications:** All applications, **and** their related support, can be returned to the District or to CBO directly at:

The CBO Solutions
P.O. Box 2726
Spokane, WA 99220

Patient Rights and Responsibilities

As a Grays Harbor County Public Hospital District patient, you have the following rights and responsibilities:

- The right to receive quality care and safe treatment, given in a respectful and considerate manner regardless of race, color, creed, national origin, religion, sex, sexual orientation, age, or disability. Reasonable accommodation will be given in cases of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
- The right to privacy regarding your medical care in case discussion, consultation, examination, and treatment.
- The right to be protected from invasion of privacy, although staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
- The right to be protected from any type of abuse by staff at all times or from other patients who are on the clinic's premises.
- The responsibility to be considerate of other patients and staff and to respect their rights to privacy and property.
- The right to receive all information necessary from your physician to give informed consent prior to the start of any procedure and/or treatment and the responsibility to ask questions if you do not understand any aspect of your care and treatment.
- The right to participate with your physician in making decisions involving your health care and the right to choose a surrogate decision maker in the event one is needed.
- The right to know the names, professional status, and experience of the personnel providing care and the responsibility to be considerate and respectful of those who are caring for you.
- The right to know whether the facility is involved in any teaching, research, or experimental programs.
- The right to refuse any drugs, tests, procedures, or treatments and to be informed of the medical consequences of your decision.
- The right to be informed of the clinic's policy and procedures as they pertain to your care.
- The right to receive an estimate of the charges for services and an estimate of any co-payments or other charges that may not be covered by your insurance plan based on the insurance information you have provided.
- The right to view your medical record with an administrator or designee within the guidelines established by law. Your medical records may be disclosed to individual entity only if involved in your care. Any other request must have your written consent.
- The right to 30 days notice in the event of a clinic closure or treatment service cancellation, assistance with the relocation, refunds if entitled, and advisement on how to access your medical records.
- The responsibility to provide accurate, honest, and complete information about your medical history that will help us care for you, including information about medications and drugs you have used, previous illnesses, injuries, or medical care you have received, and information about your current health status.
- The responsibility to follow your health care provider's instructions, take medications as prescribed and ask questions concerning your health care.
- The responsibility to understand SPMC Clinic policy regarding "No Show".
- The right to have a copy of the patients' rights given to the patient at the time of service or during disciplinary discharge.
- The right to express complaints and concerns about your care without fear of recrimination. Formal grievances can be filed by contacting the Clinic Manager at (360) 346-2222 ext 2234.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-305, filed 9/23/03, effective 10/25103. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-305, filed 11121/00, effective 1/1/011

Family and Friends Consent to Discuss Authorization Form

I understand that my healthcare information at Summit Pacific Medical Center is protected and I have received the copy of their Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Information Form.

In addition, Summit Pacific Medical Center may use or disclose information regarding the following conditions for the purposes of Case Management Services as appropriate

(Check all that apply).

☐ *Mental Health/Psychiatric Disorders (including depression)*

☐ *Chemical Dependency (drug and/or alcohol abuse/treatment)*

☐ *HIV/AIDS Virus*

☐ *Sexually Transmitted Diseases*

***A minor patient's signature is required in order to release information concerning care for:
1) Conditions relating to minor's sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above)
2) Alcohol and/or drug abuse (age 13 and above)
3) Mental Health conditions (age 13 and above)

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date as I recognize that relationships and friendships may change over time.

	Name	Relationship
1.	______________________________	______________
2.	______________________________	______________
3.	______________________________	______________

Emergency Contact Information

Name: ______________________________ Relationship: ______________

Phone Number(s): ______________________ ☐ Home ☐ Work ☐ Mobile

Phone Number(s): ______________________ ☐ Home ☐ Work ☐ Mobile

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Patient Name: ______________________________ **Date of Birth:** ____/____/____

Patient Signature: ___________________________ **Date:** ____/____/____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY; IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU REQUIRE MORE INFORMATION, PLEASE CONTACT OUR HIPAA COMPLIANCE OFFICER AT THE CONTACT INFORMATION AT THE END OF THIS NOTICE.

At Summit Pacific Medical Center and our associated clinics, we are committed to treating and using personal health information about you responsibly. We are required by federal and state laws to maintain the privacy of your Protected Health Information (PHI) and to give you this notice explaining our privacy practices with regard to that information. This notice explains your rights and our legal obligations regarding the privacy of your **PHI**.

Protected Health Information is information that individually identifies you. It may be used and disclosed by your provider, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

<u>How We May Use and Disclose Your Protected Health Information:</u>

For your Treatment: Your **PHI** may be provided to a physician or healthcare provider to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide you a service.

For Payment: Your **PHI** may be used and disclosed to enable us to bill and either collect payment from you, a health plan or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree to pay for that treatment.

For Health Care Operations: We may need to use and disclose your **PHI** in order to support the business activities of this organization. These activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to provider, nurses, medical technicians, medical students and other authorized personnel for educational and learning purposes.

As Required by Law: We will disclose your **PHI** about you when required to do so by federal, state, or local law.

Marketing & any purpose which required sale of your information: These disclosures require your written authorization.

Fundraising: We may contact you as part of a fundraising effort, but you have the right to opt-out of these communications.

Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your **PHI**, except to the extent that your provider or the organization has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

The Right to Inspect and Copy: Under federal law you have the right to inspect and copy your **PHI** (we have up to 30 days to make your **PHI** available to you, fees may apply). You have a right to a Summary of your **PHI** instead of the entire record, or an explanation of the **PHI** which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

The Right to an Electronic Copy of Electronic Medical Records: You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your medical records, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request, however, if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fees may apply).

The Right to Request Restrictions: You have the right to request a restriction or limitation on the **PHI** we use or disclose for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your **PHI** and by law we must comply when the **PHI** pertains solely with a health care service for which Summit Pacific Medical Center or one of its associated clinics has been paid out of pocket in full. You also have the right to request a limit on the **PHI** we disclose about you to someone involved in your care or payment of your care. Your request must be made in writing to our HIPAA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of that restriction for emergency treatment purposes. By law, you may not request that we restrict the disclosure of your **PHI** for treatment purposes in an emergency situation.

The Right to Get Notice of a Breach: You have the right to be notified upon breach of any of your unsecured **PHI.**

The Right to Request Amendments: If you feel that the **PHI** we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer. In certain cases we may deny your request. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

Authorization to Use, Disclose, and Release Protected Health Information

600 East Main Street, Elma, WA 98541

Fax Authorization Form to 360-346-2216

Medical Records are Faxed to the Clinic or Hospital (Receiving Party)

Wellness Clinic: 360-346-2191

McCleary Clinic: 360-346-2193

SPMC HIM: 360-861-2521

Patient Information

Name: ______________________________ **DOB:** ____________

Address: ______________________________ **City:** ____________

State:________ **Zip:** ____________ **Home Phone:** ____________ and/or **Cell Phone:** ____________

Name of Clinic, Hospital, or Healthcare Provider—*Who has the information the patient wants released?*

Name: ______________________________

Address: ______________________________ **City:** ____________

State: ________ **Zip:** ____________ **Phone:** ____________ **Fax:** ____________

Receiving Party— *Where do you want the information sent? Who may have the information?*

Name: ______________________________

Address: ______________________________ **City:** ____________

State: ________ **Zip:** ____________ **Phone:** ____________ **Fax:** ____________

SPMC medical records will be faxed unless an alternative method of delivery is requested.

Information to be Released—*What do you want sent or released?*

I understand that the protected health information (PHI) I am requesting may include disclosure of information regarding HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or mental illness. I authorize the release or disclosure of this information unless I check the box below. Please note that this form **will not** be used to disclose psychotherapy PHI.**I do NOT want any information relating to**:

☐ HIV/AIDS, ☐ sexually transmitted disease, ☐ drug and/or alcohol or ☐ mental illness disclosed.

Please release the following (check all that apply):

☐ Clinic Records* ☐ Labs ☐ Radiology Reports/Films ☐ Consult Reports ☐ All Medical Records (<50 pages)

☐ Billing Records ☐ All Vaccinations/Immunizations ☐ EKG's ☐ Special Tests

☐ Recent 2 years of physician reports (no more than 50 pages)

☐ Other (Specify):______________________________

***** SPMC wants to receive only the last two years of records for Transfer of Care not to exceed 50 pages.

Indicate date(s) of service or event ______________________________

This authorization expires in one year unless specified.

Purpose of Release – *Why is this information needed?*

☐ Transfer of Care ☐ Personal ☐ Legal ☐ Continuity of Care ☐ Other* ______________________________

Consent—*Approval for Release of Records*

By signing this this Request of Information, I give my authorization for the records designated to be released as directed above.

If patient has reached his/her thirteenth (13th) birthday, and has consented to treatment, **ONLY** the patient can authorize disclosure relating to HIV/AIDS, Sexually Transmitted Diseases, Drug and/or Alcohol Abuse, Mental Illness.

I understand the following: See CFR §164.502(c)(2)(i-iii) I have a right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization. I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Information disclosed under this authorization might be re-disclosed by the recipient and the re-disclosure may no longer be protected by federal, state or privacy laws. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay (RCW70.02.080). I understand that I have a right to receive a copy of this authorization.

Signature: ______________________________ **Relation(If not self)** ____________ **Date:** ________

☐ **ID Checked** *(Driver's License, Military ID, Photo ID, SS Card)* **SPMC Clinic Staff Initials:**__________ **SPMC HIM Staff Initials:**________

The Right to an Accounting of Disclosures: You have a right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, health care operations; required by law, that occurred six years prior to the date of request. Your request must be in writing and you must indicate in what form you want the list, for example, on paper or electronically. The first accounting of disclosure in any 12 month period will be free. Any additional requests within that same time period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you at a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for the request.

Complaints:

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. To file a complaint with us, you must make it writing to our *HIPAA Compliance Officer* at 600 E. Main Street, Elma WA, 98541. Complaints must be submitted within 180 days of when you knew of or suspected the violation. **There will be no retaliation against you for filing a complaint.**

To file a complaint with the Secretary, mail to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W. Washington, D.C. 20201. Call (202)619-0257 or toll free (877) 696-6775; or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hippa/, for more information. **There will be no retaliation against you for filing a complaint.**

If you have any questions in reference to this form, please as to speak with our HIPAA Compliance Officer in person or by phone. You have a right to request a paper copy of this Notice of Privacy Practices at any time even if you have agreed to receive this notice electronically. A copy of this Notice may also be found on our website. Please sign or initial below to acknowledge you have received or have been given an opportunity to receive a copy of our Notice of Privacy Practices.

ADULT MEDICAL HISTORY FORM

Summit Pacific Healthcare Clinic | Elma Family Medicine | McCleary Healthcare Clinic

This questionnaire will be a private and confidential part of your medical record as provided by the law.

Name: ________________________________ DOB:____________ Gender:__________ Date:___________

Preferred Pharmacy: ____

Allergies	**Reaction**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Medications

____

____

____

____

Medical Conditions and Problems (Circle or add in lines below)

Hypertension	Diabetes	High Cholesterol	Cancer	Stroke
Heart Attack	Depression	Thyroid Problems	Anxiety	Chronic Pain
COPD	Asthma	Heart Failure	Sleep Apnea	Heart Disease

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Surgical History

Appendix	Gall Bladder	Hysterectomy	Tonsils	Carpal Tunnel
Back/Neck	Knee/Hip Replacement	Tubal Ligation	Hernia	Heart Surgery

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Family Medical History

☐ Family history unknown ☐ Adopted

Family Member	Condition
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Social History

Do you have a caregiver, support person? ☐ Yes ☐ No

Do you have a power of attorney or guardian? If yes, name: ______________________________

Do you have a POLST or Advance Directives? ☐ Yes ☐ No

Household Members – Who lives with you? ______________________________

Do you have a place to live? ☐ Yes ☐ No

Please Describe: ______________________________

☐ Single ☐ Married ☐ Life partner ☐ Widowed ☐

Tobacco

What is your nicotine use status?

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Electronic cigarette ☐ Chewing tobacco ☐ Second hand smoke

If you currently smoke, what do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarette

If you currently use nicotine, would you like to quit?

☐ I am considering quitting ☐ *I am not considering quitting* ☐ I have a quit date ☐ I have quit before

When did you start smoking? ______________________________

If you are a former smoker, when did you quit? ______________________________

Alcohol

Do you drink alcohol? ☐ Current ☐ Never ☐ Former (quite date: ______________________________)

How often do you consume alcohol?

☐ 0-2 drinks per day ☐ 3 or more drinks per day ☐ A few times per week ☐ A few times a month

☐ Holidays/special occasions only ☐ Other:______________________________

For women

Have you had a hysterectomy? ☐ Yes ☐ No Why? ______________________________

How old were you when you had your first period? ____

How long does your period last? ☐ Less than 3 days ☐ 3-5 days ☐ 6-7 days ☐ 8-10 days ☐ Over 10 days

☐ Other: ____

When was your last menstrual period? ____

What kind of birth control do you use? ____

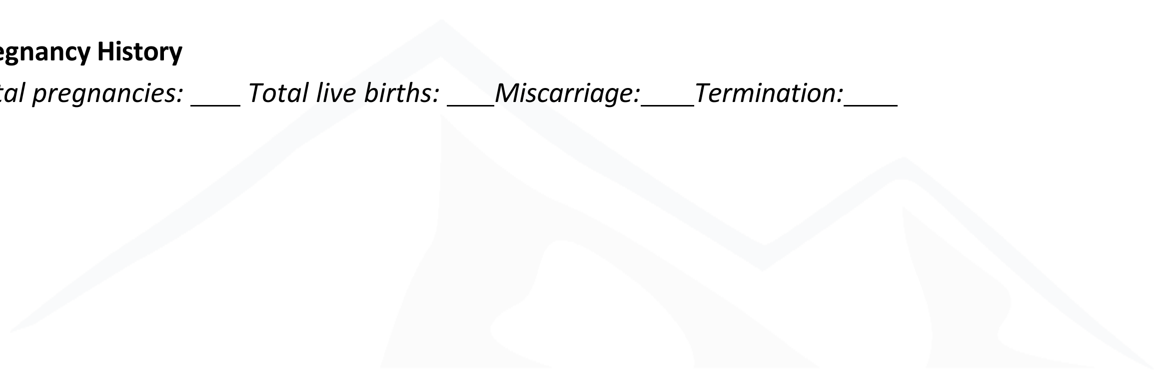
Have you ever had an abnormal pap smear? ☐ Yes ☐ No

When was your last pap smear? ______________________*Was your last pap smear normal?* ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes – When: _____________________________ ☐ No ☐ Current

Pregnancy History

Total pregnancies: ____ *Total live births:* ____*Miscarriage:*____*Termination:*____



PATIENT HEALTH QUESTIONNAIRE – 9

(PHQ-9)

Name: ________________________________DOB: ___________________Date: ______________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	*Not at all*	*Several Days*	*More than half the days*	*Nearly every day*
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowing that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	PHQ9 Total Score:			
How difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult	Somewhat difficult	Very difficult	Extremely difficult