STECK MEDICAL GROUP
Quality Medical Care Since 1927

1299 Bishop Road
Chehalis, WA 98532
Phone: (360) 748-0211

FAMILY PRACTICE: Monday-Thursday 8:00AM to 5:00PM
WOODLAND URGENT CARE CENTER: Monday-Friday 7:00AM to 7:00PM
WEEKENDS 9:00AM – 4:00PM and HOLIDAYS 12:00PM to 4:00PM

In order to serve you, we will need the following information. **(Please Print)** All information will be strictly confidential.

Patient's Name (Last, First, MI):	Sex: M F	Date of Birth: / / Age: _____	Patient SSN: - -
Previous Names Used:			Marital Status:
Residence Address:	City	State	Zip
Mailing Address (if different than physical address):	Home Phone: ( ) - Mobile Phone: ( ) -		Contact Preference: Home Ph ☐ Mobile Ph ☐ Work Ph ☐ Consent to leave a voice message? Yes☐No ☐
Patient email (encouraged for patient portal):	Work phone: ( ) -		Consent to text? Yes☐No ☐ Consent for automated reminder calls? Yes☐No ☐
Emergency Contact:	Home Phone: ( ) - Mobile Phone: ( ) -		Relationship to Patient:
Employer Name:	Employer Phone: ( ) -		Occupation:
Guarantor (person statements are sent to):	Guarantor Address:		Guarantor Date of Birth: / /
Race? ☐ American Indian ☐ Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Mexixcan American ☐Other: _____	Ethnicity? ☐ Non-Hispanic or Latino ☐ Mexican ☐ Hispanic or Latino ☐ Spaniard ☐ Latin American ☐ South American ☐ Puerto Rican ☐ Other: _____		What is your primary language?
Primary Insurance:			
Subscriber's Legal Name:	Relationship to Subscriber:		Subscriber Date of Birth:
Subscriber's Employer: Employer Phone Number: ( ) -	Policy #:		Group #:
Secondary Insurance:			
Subscriber's Legal Name:	Relationship to Subscriber:		Subscriber Date of Birth:
Subscriber's Employer: Employer Phone Number: ( ) -	Policy #:		Group #:

Clinic Policies

- 24-hour notice is required when cancelling an appointment. No-shows will result in a fee (not covered by insurance).
- We ask patients to arrive 15 minutes early in order to process any necessary paperwork. Patients arriving 10 or more minutes late for an appointment may be asked to reschedule or to wait for the next available opening on the provider's schedule.
- Please present current insurance cards when checking in and notify reception of changes to contact information or insurance company.
- Co-pays are due at the time of service. We accept Visa, Mastercard, Discover and checks.

Received_____ Completed_____

- I have been provided a copy of Steck Medical Group's office policies and payment procedures. I acknowledge and agree to these terms.

*Initial here*_____

- Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to STECK MEDICAL GROUP for any services provided to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

*Initial here*_____

- Private Insurance Authorization for Assignment of Benefits/Information Release: I authorize payment of medical benefits to STECK MEDICAL GROUP for any services provided to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

*Initial here*_____

- I agree to pay all charges for services provided for the following person:

Patient Name (PLEASE PRINT): _____ DOB: _____

I agree to pay all charges shown on Steck Medical Group statements in full, unless advance credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event collection efforts, including but not limited to legal action, should become necessary to collect any unpaid balance due for medical services rendered to me or the above named persons, I agree to pay the reasonable costs of collection, including but not limited to reasonable attorney's fees incurred in Lewis County. I agree that payments will not be delayed or withheld because of any insurance coverage or pendency of claims theron and all proceeds of insurance are assigned to STECK MEDICAL GROUP where applicable, but without STECK MEDICAL GROUP assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) I understand that it is my responsibility and not that of STECK MEDICAL GROUP to obtain proper insurance or other payor authorization for medical examination or other treatment, and that I am responsible for payment for all services rendered whether or not such services might have been covered by insurance or other source had proper authorization been obtained. I authorize STECK MEDICAL GROUP to bill my insurance carrier and payment will be sent directly to the provider. I give my specific authorization for these records to be released as necessary to complete billing to my insurance company or account holder. All accounts are due and payable in full within thrity (30) days from the statement date. In the event that the account is not paid in full within thirty (30) days of the statement date, a finance charge of one percent (1%) per month, which amounts to twelve (12%) per year, will be added on the outstanding balance(s) over sixty (60) days old.

I hereby consent to all medical treatment as ordered by the attending physician or health care staff of STECK MEDICAL GROUP.

_____ Date: _____
SIGNATURE OF RESPONSIBLE PARTY / GUARDIAN

_____
PRINT NAME OF RESPONSIBLE PARTY / GUARDIAN

☐ Self ☐ Parent ☐ Guardian ☐ Other (specify) _____

PAST, FAMILY AND SOCIAL HISTORY

STECK MEDICAL GROUP

Patient Name: _____ DOB: _____ Date: ____/____/____

MEDICINES TAKEN REGULARLY — Reason

PERSONAL PAST HISTORY

Have you ever had?			Year
Measles	yes	no	
Mumps	yes	no	
Whooping cough	yes	no	
Polio	yes	no	
Diphtheria	yes	no	
Meningitis	yes	no	
Valley fever	yes	no	
Malaria	yes	no	
Hives	yes	no	
Cancer	yes	no	
Venereal Disease	yes	no	
Arthritis	yes	no	
Rheum. Fever	yes	no	
Heart Failure	yes	no	
Blood transfusions	yes	no	
Hepatitis	yes	no	
Kidney disease	yes	no	
Hay fever	yes	no	
Glaucoma	yes	no	
Thyroid Disease	yes	no	
Other:			

Operations			Year
Tonsil	yes	no	
Appendix	yes	no	
Gallbladder	yes	no	
Stomach	yes	no	
Breast	yes	no	
Uterus, ovary	yes	no	
Prostate	yes	no	
Hernia	yes	no	
Thyroid	yes	no	
Varicose veins	yes	no	
Hemorrhoids	yes	no	
Hip	yes	no	
Knee	yes	no	
Other:			

INJURIES			Year
Head	yes	no	
Chest	yes	no	
Abdomen	yes	no	
Broken bones	yes	no	
Back	yes	no	
Other:			

ALLERGIES			Year
Tetanus	yes	no	
Penicillin	yes	no	
Sulfa	yes	no	
Other			

IMMUNIZATIONS			Year
Influenza	yes	no	
Pneumococcal	yes	no	
Tetanus	yes	no	
Hepatitis B	yes	no	

OB/GYN		Year
Pregnancies	# ___	
Miscarriages	# ___	
Abortions	# ___	
First Period:	Mo ___ Yr	
Last Period:	Mo ___ Yr	

SOCIAL HISTORY #1

Birth Place:

Religion: Marital Status:

Occupations:

Do you have a "**Living Will**?" yes no

PRACTITIONER'S NOTES

FAMILY HISTORY

Have **you** or any **blood** relative had any of the following:

			Relationship
Anemia	yes	no	
Bleeding tendency	yes	no	
Repeated infections	yes	no	
Heart Attack/Angina	yes	no	
Chronic lung disease	yes	no	
Tuberculosis	yes	no	
High Blood Pressure	yes	no	
Asthma	yes	no	
Severe allergies	yes	no	
Mental or emotional illness	yes	no	
Seizures	yes	no	
Migraine headaches	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Obesity	yes	no	
Ulcer	yes	no	
Chronic diarrhea	yes	no	
Cancer/Leukemia	yes	no	
Alcohol or Drug Problem	yes	no	
Family violence/abuse	yes	no	

	Present age or age at death	If living, health good, fair or poor. If deceased, cause of death.
Father		
Mother		
Brothers or Sisters		
Spouse		
Children		

SOCIAL HISTORY #2

In an average **week** I exercise or work vigorously: hrs.

My compliance with a healthy diet:

poor fair good excellent

My religious faith is:

none average important vital

My sexual orientation is:

heterosexual homosexual ("gay") other

AVERAGE PER DAY

Alcohol — type _____

Tobacco — type _____

Tea or coffee _____

*Please complete **both** sides*

CURRENTLY or in the last six months have you experienced:
(Circle 'yes' or 'no' — if in doubt, leave blank)

GENERAL:		
Fatigue, tiring easily	yes	no
Marked weight change	yes	no
Night sweats	yes	no
Persistent fever	yes	no
EYES:		
Trouble seeing	yes	no
Eye pain	yes	no
Inflamed eyes	yes	no
Wear glasses	yes	no
EARS, NOSE & THROAT:		
Loss of hearing	yes	no
Ringing in ears	yes	no
Discharge from an ear	yes	no
Loss of smell	yes	no
Nasal obstruction	yes	no
Excess nasal discharge	yes	no
Nose bleeds	yes	no
Sore gums or tongue	yes	no
Dental problems	yes	no
Post nasal drainage	yes	no
Hoarseness	yes	no
NECK:		
Stiffness, swelling, or pain	yes	no
CARDIAC SYSTEM:		
Chest pain	yes	no
Swelling of ankles	yes	no
Bluish fingers or lips	yes	no
High blood pressure	yes	no
Palpitations	yes	no
Vein trouble	yes	no
RESPIRATORY SYSTEM:		
Shortness of breath	yes	no
Cough, persisting	yes	no
Bloody sputum	yes	no
Wheezing	yes	no
DIGESTIVE SYSTEM:		
Change in appetite	yes	no
Difficulty swallowing	yes	no
Heartburn	yes	no
Abdominal pain	yes	no
Abdominal enlargement	yes	no
Belching or excess gas	yes	no
Nausea or vomiting	yes	no
Vomiting of blood	yes	no
Rectal bleeding	yes	no
Dark stools	yes	no
Constipation	yes	no
Diarrhea	yes	no
Hemorrhoids	yes	no
Any food intolerance	yes	no
Need for laxatives	yes	no

Which? _____

GENITOURINARY SYSTEM:		
Unable to hold urine	yes	no
Pain or burning in urination	yes	no
Nighttime urination	yes	no
Blood in urine	yes	no
Satisfied with sexual activity	yes	no
Vaginal discharge or malodor	yes	no
Pain with intercourse	yes	no
LOCOMOTOR:		
Muscle cramps	yes	no
Muscle weakness	yes	no
Joint pain, swelling, or stiffness	yes	no
SKIN:		
Rash	yes	no
Hives or itching	yes	no
Change in hair or nails	yes	no
Dry skin	yes	no
Easy bruising	yes	no
Change in a mole	yes	no
Non-healing sore	yes	no
BREASTS/CHEST:		
Lumps	yes	no
Pain	yes	no
Discharge	yes	no
NERVOUS/MENTAL SYSTEM:		
Headaches	yes	no
Dizziness/loss of balance	yes	no
Fainting	yes	no
Seizures or epilepsy	yes	no
Memory loss	yes	no
Change in sensation	yes	no
Poor coordination	yes	no
Weakness or paralysis	yes	no
Nervousness, anxiety	yes	no
Sleeplessness	yes	no
Depression, grief, or sadness	yes	no
Family problems	yes	no
Occupational concerns	yes	no
Hard to find pleasure	yes	no
ENDOCRINE:		
Excess thirst	yes	no
Menstrual problems	yes	no
Intolerance to heat or cold	yes	no
Hot flashes	yes	no
HEMATOLOGIC & IMMUNOLOGIC:		
Lymph node swelling or pain	yes	no
Allergy symptoms	yes	no
Risk of HIV (AIDS)	yes	no

Any other current concerns:

*Please complete **both** sides*

Authorization to Disclose

Health Care Information Release Form

PATIENT INFORMATION:

PRINT Patient name _____Patient DOB:_____

Adress_____

City, State, Zip_____

Daytime Telephone Number_____

INFORMATION TO BE RELEASED FROM:

Organization, Physician, or provider _____

Address_____

City, State, Zip_____

Phone_____Fax_____

INFORMATION TO BE RELEASED TO:

Organization, Physician, or provider _____**STECK MEDICAL GROUP**_____

Address_____**PO BOX 1267 / 1299 Bishop Road**_____

City, State, Zip_____**Chehalis, WA 98532**_____

Phone_____**(360) 748-0211**_____Fax_____**(360) 262-3679**_____

PURPOSE OF RELEASE:

☐ LEGAL ☐ INSURANCE ☐ DOCTOR ☐ MEDICAL LEAVE ☐ COPIES FOR PERSNAL USE ☐ OTHER (specify) _____

☐ TRANSFER CARE ☐

RECORDS TO BE RELEASED:

☐ Medical Records from date (YOU MUST INDICATE DATES): ___/___/_____ to date: ___/___/_____

☐ Specific Information (please specify):_____

☐ Billing Records (please specify):_____

☐ Diagnostic Images (please specify):_____

☐ Mental Health (please specify):_____

PATIENT AUTHORIZATION: I understand that:

- Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness and for patients age 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
- I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
- Once disclosed, health care information may be subject to re-disclosure by the recipient and may no longer be protected under health information privacy laws

SIGNATURE: _____Date____/____/_____

(Patient or Member, Guardian*, or Authorized Representative*). [*Documentation may be required to prove authority to sign on behalf of the patient.]

MINOR SIGNATURE: _____ Date___/____/_____

Signature of minor ages 13-17 is required for certain information.

This authorization expires 90 days from the date signed OR on the date or event indicated here: _____

DELIVERY PREFERENCE: _____Paper _____Disk *this option is only available to patients) **Mailed** _____ **picked up at Facility**_____.

Charge may apply-- Steck Medical patients and members can directly view and print some of their health information through their Electronic Health Record (EHR portal account. **NOTE**-The online record does not include certain scanned hospital records, behavioral health records, historical or care you have gotten from providers who do not work at a Steck Medial Group. There is **no charge** if you have the copies sent directly to a health care facility or provider for continuing or transfer of care. Copies requested by other parties may be **subject to a charge** in accordance with Washington state law (WAC 246-08-400). Contact the appropriate department listed below to request your copies of your medical record, for information about charges and/or questions related to copying health information from your Steck Medical Group medical record.

Steck Medical Group Medical records Department:
1299 Bishop Rd Chehalis, WA 98532. Phone (360)748-0211 - Fax (360) 262-3679

Standing Authorization to Verbally Disclose

Health Care Information Release Form

Health clinics are required by law to maintain the privacy of patient's PHI (Protected Health Information). PHI includes any identifiable information obtained from the patient or others that relates to the patient's physical or mental health, the healthcare the patient received, or payment for the patient's healthcare.

Patients have the right to restrict and limit the use and disclosure of their PHI to designated party(ies) of their choosing. Please review Steck Medical Group's NPP (Notice of Privacy Practices) for additional uses and disclosures of PHI without written consent.

Patient's name: _____ DOB_____/_____/_____ Patient #_____

My authorization

I authorize Steck Medical Group and its business associates to verbally disclose the following healthcare information:
(check all that apply)

☐ All healthcare information in my medical record

☐ Healthcare information in my medical record related to the following treatment or condition:
_____

☐ Healthcare information in my medical record for date(s): _____

☐ Financial healthcare information only

The following items must be ***checked*** and ***initialed*** to be included in this request for use and disclosure:
You may verbally disclose healthcare information regarding testing, diagnosis and treatment for:

☐ HIV/AIDS related information _____

☐ Mental health information _____

☐ Drug & alcohol treatment information _____

☐ Sexually transmitted disease information _____

Designated party(ies) _____ Relationship to patient_____ Phone # (_____) _____-_____

Designated party(ies) _____ Relationship to patient_____ Phone # (_____) _____-_____

Designated party(ies) _____ Relationship to patient_____ Phone # (_____) _____-_____

My rights:
The patient or the patient's representatives must read the following statements:

1. I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). I also understand this authorization only covers *verbal* disclosures. Washington State law (RCW 70.02) requires that a written authorization be signed for release of PHI other than verbal disclosures, and a written authorization of that type is only valid for 90 days.
2. I understand this authorization will (*must check one*)
   ☐ expire in one year from the date signed by the patient or the patient's representative; or
   ☐ be effective for the lifetime of the patient unless revoked (see #3 below)
3. I understand that I may revoke this authorization at any time by notifying Steck Medical Group; however, if I do revoke the authorization, it will not have any effect on any actions taken by Steck Medical Group prior to their receipt of the revocation.
4. I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____

Signature of patient or patient's representative — Date

(Form *must* be completed *before* signing or will not be valid)

_____ _____

Printed name of representative — Relationship to patient

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

STECK MEDICAL GROUP

MEDICAL RECORDS: Steck Medical Group maintains a patient record of all healthcare services provided. Patients may request a copy or correction of their record by contacting the Medical Records Department at 360-748-0211, option 8. Steck Medical Group will not disclose records unless the patient signs an "Authorization to Disclose" or unless the law requires it.

*For acknowledgment, Initial here*_____

MEDICATION RECONCILIATION: Medication reconciliation is performed at each visit. For the safety of the patient this information is shared within the healthcare community, which includes pharmacies, clinics and hospitals for the purpose of comparing patient's medications to ensure a continuum of care. This is performed any time a patient enters a health care organization, whether an emergency department, ambulatory clinic, an invasive procedure department or any other setting or service if medications could cause harm by the medications the patient is currently taking. This process avoids errors, omission, duplication of therapy, drug-drug-disease interactions, etc.

*For acknowledgment, Initial here*_____

PATIENT CHART SHARING: Each time a patient visits a health care provider, whether it's for a routine exam with a primary care physician, or a consultation with a specialist, information about the patients' health is recorded. Patients chart sharing helps ensure this information is accessible by all members of a patient's care team.

*For acknowledgment, Initial here*_____

The Patient Portal allows secure internet communication between Steck Medical Group and patients. Access to this secure web portal is an optional way to contact providers and to review patient healthcare by Steck Medical Group and staff. The Patient Portal is encrypted, secure and HIPAA-compliant and enables patient information to be added to their permanent medical record. A username and password are required to access secure messages and patient information. Users can and should change their password if their information has been compromised. You can access the patient portal at our website: www.Steckmedical.com.

By signing this consent, you understand, agree and will comply with Steck's policies and procedures for using the web Patient Portal and agree to not hold Steck Medical Group, or any of its staff, liable for any problems that may arise that is out of Steck Medical Group's control.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature I acknowledge that I have been given a copy of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Print Patient's Name | Patient's Date of Birth

_____ _____

Printed Name if signed on behalf of the patient (Parent, legal guardian, personal representative) | Relationship

OPTIONAL CONSENT

Patients have the option to designate third-party access to their Patient Portal and PHI by completing the information below. Patients have the right to revoke this authorization at any time in writing to Steck Medical Group.

Patient Designates:

Name _____E-mail _____Date____/_____/_____

Relation to Patient _____

Name _____E-mail _____Date____/_____/_____

Relation to Patient _____

This form will be retained in the patient's medical record.

OFFICE POLICIES AND PAYMENT PROCEDURES

STECK MEDICAL GROUP

Dear new patient,

Welcome! Thank you for choosing Steck Memorial Group to serve your needs! We are happy to offer primary care services and want you to know that our providers will deliver our best coordinated quality care. This may mean a change to your current regimen, as all providers practice differently. Because of this, you may receive alternative prescriptions and medical treatment than you've received from other providers. This is especially so with substances and pain management. If these are needed, you may be referred to a specialist that can best manage that portion of your care. Other conditions may also result in a referral, depending on the severity, such as diabetes, neurological disorders, depression, etc.

Thank you! And we look forward to meeting you in person.

Sincerely,

Dr. Harley Miller, MD & staff

INSURANCE CARDS: Insurance cards are required at every visit. If there are any changes to the patient's insurance, (new insurance member identification number and/or group number), please inform the office. If the patient has not provided our office with the correct insurance information, the patient will be responsible for any balance due. We are unable to re-submit insurance claims.

CO-PAYS: Co-pays are due at the time of service. Our office does not bill for co-pays. We accept check, Visa, MasterCard and Discover. All returned checks will be assessed a $31.00 returned check fee in addition to the original charge.

SELF-PAY PATIENTS: If the patient does not have insurance, the balance is due at the time of the office visit. Our office accepts check, Visa, MasterCard and Discover. Steck offers a 25% discount for services paid at time of service for self pay.

WORKMAN'S COMPENSATION (L&I): If the patient's visit will not be submitted under your insurance plan, our office must have all necessary claim information before or at the time of the visit. If the patient is unsure of what information to bring, call our office before the scheduled appointment. The appointment may need to be rescheduled until the clinic has all the necessary claim information. If the information provided is incorrect the patient will be personally responsible for outstanding account balances.

MONTHLY BILLING STATEMENTS: Every month, Steck Medical Group sends out a monthly billing statement to every patient. The balance due is the remainder owed after insurance has paid. It is the patient's responsibility to pay the balance each month, even if the patient and the insurance company are disputing coverage.

COLLECTIONS: If the patient's account balance is unpaid and overdue, after three monthly statements or more, and the patient has not responded to the clinic's contact attempts, the account will be referred to a collection agency. Once in collections, any further communication concerning the account must be between the patient and the collection agency. If the patient needs to be seen while the account is in collections the patient will be required to speak with patient services and any current balance and any charges due for the requested services will need to be paid before being seen. Again, please note that we will only resort to these measures if the patient does not respond to the clinic's attempts to communicate and set up a payment plan.

PAYMENT PLANS: If the patient has negotiated a payment plan with the clinic, the patient is responsible for making timely and consistent monthly payments. Steck offers payment plans as a courtesy to our patients in time of need. Failure to meet the scheduled due date, your account will be sent to collections for non-payment.

PAPERWORK TO BE FILLED OUT BY THE DOCTOR: An additional appointment *may* be required to have forms completed. Please check with the staff to determine if the form will require an extra office visit. If a scheduled appointment is required, a co-pay will be due at the time of visit.

LATE FOR APPOINTMENTS: Please try to make every effort to notify the clinic a late arrival. If delayed more than 10 minutes past the scheduled appointment time we may need to reschedule the appointment or ask that you wait for the next availability in the schedule so providers can continue to see patients who have arrived on time.

NOT SHOWING FOR YOUR SCHEDULED APPOINTMENT: 24-hour notice is required when cancelling an appointment. (Failure to cancel an appointment due to illness, adverse weather conditions or other unusual conditions will not be considered a failure to cancel appointments). A no-show will result in a fee, which is not covered by insurance. Steck Medical Group will notify patients by telephone or letter. Three no-shows or cancellations within a 12-month period may result in being discharged from the practice. If discharge occurs, Steck Medical Group will notify the patient in writing, and a 30-day grace period will be offered so patients can secure alternative services. The Woodland Urgent Care Center will see patients within the 30-day window and family practice providers will refill prescriptions in that timeframe, when medically appropriate.

EXCHANGE OF MEDICAL INFORMATION: All requests by patients must be signed and in writing by letter, fax or a medical release of information form. Verbal request are not accepted. A request is not necessary if the information is shared with a referred physician.

Only the patient or their personal representative has the right to access their medical records.

A health care provider or health plan may send copies of your records to another provider or health plan only as needed for treatment or payment or with your permission. (The Privacy Rule does not require the health care provider or health plan to share information with other providers or plans). HIPAA gives patient's important rights to access their medical record and to keep their information private.

COPYING FEES: Providers cannot deny the patient a copy of their records and cannot charge a fee for searching for or retrieving patient records. The clinic charges a fee for the copying of medical records and for mailing them. The fee is determined by the length of time to copy the record and for the cost of materials. Please give the office advance notice. Copying fee is due prior to pick up.

DIAGNOSIS CODES: Medical clinics cannot recode an office visit for the purpose of insurance coverage. This is illegal and considered fraudulent. It is the patient's responsibility to know what the insurance plan covers. Physicals, shots and psychiatric care are a few examples of what some insurance companies may not cover. Always call the insurance company to verify coverage. It is the patient's responsibility to pay any amount the insurance does not cover within 30 days.

RESULTS FROM TESTS: Our office will notify the patient with test results as soon as they become available and are reviewed by the patient's provider. If another physician ordered the test, and copies are sent to us, it is the responsibility of the ordering physician to contact the patient.

UNCOOPERATIVE PATIENTS: Physicians are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and / or presents difficulties in the doctor–patient relationship. Steck's goal is to try accommodate all patient needs. Demanding and abusive language does not help achieve that goal. Patients may be dismissed from the clinic for non-compliance.