KU WICHITA INTERNAL MEDICINE CLINIC POLICIES

EMERGENCIES: In case of emergency, call 9-1-1 or go to your nearest emergency room. For nonemergent calls, you may call the Midtown office at (316) 293-1840 or CHC at (316) 293-2622 and leave a message. Your call will be returned the next business day.

INCLEMENT WEATHER: In the event of severe weather, please call the clinic before you come. A recording will alert you if the clinic is closed and you may also receive a text message or call. We will call you the next open day to reschedule your appointment.

APPOINTMENT CANCELLATION POLICY: Please, call the clinic at least 24 hours before your appointment if you need to cancel or reschedule. Cancelling your appointment in advance gives us the opportunity to offer medical services to another patient. Three (3) missed appointments within 12 months, inclusive of cancelations less than 24 hours in advance, may prompt a discussion with our care team regarding your scheduling needs. If our clinic needs to reschedule your appointment, you will receive an automated call to reschedule.

VOICE REMINDERS AND TEXT MESSAGE: Are used to remind you about upcoming scheduled appointments and helpful clinic notifications. Standard texting rates apply. If you prefer to opt out of receiving important health reminders, please call the scheduling department at the Midtown office at (316) 293-1840 or CHC at (316) 293-2622 to update your account.

PATIENT PORTAL: Our electronic health record offers a secure Patient Portal and mobile phone application called HEALOW which allows you to access your health information and communicate with your physician and provider. Our staff can enable this access and assist you with setting up access.

UPDATED INFORMATION: Keeping the clinic informed of any changes in your personal information, including address, phone, insurance, or emergency contact information or clinical information such as hospitalizations, surgeries, changes in health status or medications is vital to receiving safe and effective health care.

RX HISTORY: I understand and give consent for the clinic to access my prescription medication history from other providers and/or pharmacies.

FORM COMPLETION: All forms requiring medical review and authorized signature will require a scheduled appointment. Forms will be completed during or after the visit and released accordingly. (This does not include new patient forms.)

ACTIVE STATUS: In order to provide you with the best care, it is recommended that most patients be seen in-person, once every 3-6 months. Your clinician will work with you to decide how often you need to be seen based on your health care needs. Patients that fail to maintain contact with the clinic may be placed in Inactive Status and we will not be able to provide care or prescription refills. If we have not seen you in three (3) years or more, your status will be considered inactive. Should you wish to return to the clinic after being placed in Inactive Status, you will need to repeat the intake process.

CONFIDENTIALITY: All communication between you and the clinic is held in strictest confidence and will not be released unless: (1) you authorize release of information with your signature; (2) you present with potential harm to yourself or others; (3) there is suspicion of abuse or neglect of a minor or elder; or (4) the clinic is required to do so by federal, state, or local law.

TRAINEES: You are receiving care at a teaching clinic; therefore, medical students, interns, advanced practice provider (APP) students, and resident or fellow physicians may be involved in your treatment, under the supervision of a faculty provider.

RESEARCH: This clinic works with physicians who are performing a variety of research projects. Your Physician, advanced practice provider (APP), or a member of the research team may discuss these projects as viable alternatives or additions to your regular care. You may be asked to participate in this research, but you are under no obligation to do so.

I have read, understand, and will adhere to the UKSM-W Medical Practice Association Clinic Policy.

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Patient Name ***(Print)*** **Date of Birth (MM/DD/YYYY)**

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Patient or Responsible Party Signature **Date**