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.

STECK
MEDICAL GROUP
Quality Medical Care Since 1927

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 Phone ☐ Mobile Phone ☐
Patient email (encouraged for patient portal):	Work phone: ( ) -		Consent to text? Yes☐No ☐ Consent to leave a voice message? 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 ☐ Mexican 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 Name & Type:			
Subscriber's Legal Name:	Relationship to Subscriber:		Subscriber Date of Birth:
Subscriber's Employer: Employer Phone Number: ( ) -	Policy #:		Group #:
Secondary Insurance Name & Type:			
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.

- 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 & Social History

Steck Medical Group

Patient Name: _____ Date of Birth: _____ Date: _____

PERSONAL PAST HISTORY

Have you ever had any of the following: Year

Measles	Yes No _____	Tonsil	Yes No _____
Mumps	Yes No _____	Appendix	Yes No _____
Whooping Cough	Yes No _____	Gallbladder	Yes No _____
Polio	Yes No _____	Stomach	Yes No _____
Diphtheria	Yes No _____	Breast	Yes No _____
Meningitis	Yes No _____	Uterus/Ovary	Yes No _____
Thyroid Disease	Yes No _____	Prostate	Yes No _____
Malaria	Yes No _____	Hernia	Yes No _____
Hives	Yes No _____	Thyroid	Yes No _____
Cancer	Yes No _____	Varicose Vein	Yes No _____
Venereal Disease	Yes No _____	Hemorrhoids	Yes No _____
Arthritis	Yes No _____	Other: _____	
Rheum. Fever	Yes No _____	_____	
Heart Failure	Yes No _____	_____	
Blood Transfusion	Yes No _____	_____	
Hepatitis	Yes No _____		
Kidney Disease	Yes No _____		
Hay Fever	Yes No _____		
Glaucoma	Yes No _____		
Other: _____			

Operations:

AVERAGE PER DAY

Alcohol- type _____

Tobacco-type _____

Tea or Coffee _____

ALLERGIES

Seasonal	Yes No
Penicillin	Yes No
Sulfa	Yes No
Other: _____	
_____	

IMMUNIZATIONS

Influenza	Yes No
Pneumococcal	Yes No
Tetanus	Yes No
Covid	Yes No
Hepatitis B	Yes No

OB/GYN

Pregnancies _____

Miscarriages _____

Abortions _____

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/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/Drug Problems	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: _____

_____

Sisters: _____

_____

Spouse: _____

Children: _____

_____

_____

My compliance with a healthy diet:
Poor _____ Fair _____ Good _____ Excellent _____

Do you have a Living Will? Yes No

(CIRCLE "YES" OR "NO" – IF IN DOUBT, LEAVE BLANK)

Currently or in the last 6 months, have you experienced any of the following:

GENERAL

Fatigue, Tiring easily	Yes No
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

EARS, NOSE & THROAT

Loss of hearing	Yes No
Ringing in the ears	Yes No
Discharge from ear	Yes No
Loss of smell	Yes No
Nasal obstruction	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 ankles	Yes No
Blue 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	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
Belching or excessive 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
Food intolerance	Yes No
Need for laxative	Yes No

GENITOURINARY SYSTEM

Unable to hold urine	Yes No
Pain or burning while urinating	Yes No
Frequent Urination	Yes No
Blood in urine	Yes No
Vaginal discharge or malodor	Yes No
Pain with intercourse	Yes No

MUSCULOSKELETAL

Muscle cramps or pain	Yes No
Joint pain, swelling or stiffness	Yes No

SKIN

Rash 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

BREAST/CHEST

Lumps	Yes No
Pain	Yes No
Discharge	Yes No

NERVOUS/MENTAL SYSTEM

Headache	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
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

HEMATOLOGY & IMMUNOLOGIC

Lymph node swelling or pain	Yes No
Allergy symptoms	Yes No

MEDICATION RECORD

Steck Medical Group * (360) 748-0211

PATIENT NAME: _____ DOB: _____

PREFERRED PHARMACY: _____

ALLERGIES/SENSITIVTIES AND REACTIONS: _____

_____

_____

DATE PRE-SCRIBED	RX #	MEDICATION NAME	DOSAGE	HOW MANY TIMES A DAY
	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			
	12			
	13			
	14			
	15			

Property of Steck Medical Group

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

_____ _____

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.