Updated 2.2018

Welcome to The Wright Center for Primary Care

Quick Facts About Your Patient-Centered Medical Home

- We are an accredited Patient-Centered Medical Home and we will partner with you to make sure all your medical needs are met. Our goal is to be here for you, focus on your specific healthcare needs, and provide compassionate and culturally sensitive care.

- Our offices are located in Jermyn, Clarks Summit, Scranton and Wilkes-Barre and open Monday – Friday. You may choose to visit any of our offices for your primary care needs. Our Mid Valley (Jermyn) office is open to existing patients on Saturdays and Sundays and all holidays. Ask about weekend appointments at the Mid Valley office if those days are most convenient for you.

- We believe in preventative care of our patients. Collaborative partnerships enable us to provide our patients with services such as: dental care, nutrition counseling, behavioral health services including drug and alcohol, mobile x-ray, cardiology testing, smoking cessation and women's health issues. As a result, we assess all of our patients for alcohol dependence, depression, tobacco use and obesity. Ask your provider for more information during your visit.

- We are a teaching facility. During your appointment, you will first be seen by a resident physician. A resident physician holds a medical degree and works under the supervision of an attending physician. Your interaction with the resident will help develop them to become the best doctors possible. **You will have an impact on today's medical care and the future of medicine.**

- You will receive a Patient Agenda at every visit, so you can list any questions and concerns you would like to discuss at your appointment. It is important that you let us know about anything specific you would like to cover during your visit.

- You may be asked to participate in a patient satisfaction survey through The Wright Center or one of our partners. We always look to improve our services and better prepare our residents to become excellent doctors. **Please participate in surveys when asked to do so. Your opinion is very important.**

- Wright Center patients may receive calls from time to time to encourage preventative care recommendations set by national medical guidelines.

- We are committed to protecting your privacy and the security of the health information you entrust to us. Under both State and Federal law, you have a right to the privacy and security of your health information.

Scheduling an Appointment:
Our goal is to make access to medical care easy. Our phone numbers and convenient hours are listed below.

- **Asian Medical Home • (570) 941-0630 •** Wednesday 1pm–5pm
- **Clarks Summit • (570) 585-1300 •** Monday–Friday 7am–6pm
- **Mid Valley • (570) 230-0019:** Monday–Friday 7am–8pm; Saturday 8am–6pm; Sunday 8am–4pm;
  For your convenience, our Mid Valley clinic is open 365 days/year. **Holiday hours:** 8am–4pm
- **Ryan White Infectious Disease • (570) 961-5670 •** Monday–Friday 8:30am–5pm
- **Scranton Counseling Center • (570) 591-5250**
  Monday, Wednesday, Thursday and Friday 1pm–5pm; Tuesday 9am–5pm
- **Together in Health** (within West Scranton Intermediate School) **• (570) 591-5280**
  Monday and Wednesday 8am–6pm; Tuesday, Thursday and Friday 8am–4:30pm
- **Wilkes-Barre** (inside Children's Service Center's Outpatient Clinic Building) **• (570) 591-5283**
  Monday–Friday 8:30am–5pm
- **Old River Road** (next to Harrold's Pharmacy) **• (570) 826-5038**
  Monday, Wednesday and Friday 8:30am–5pm; Tuesday and Thursday 7:30am– 4pm

**** If you are experiencing a medical emergency,**
always dial 911 immediately and/or seek care at the nearest emergency room. **

Same day appointments are available when our patients are sick. If you call after clinic hours and are in need of clinical advice, the on-call provider can be reached.

Insurance and Co-Pay Information:
If you have insurance that requires you to choose a primary care physician, it is important to contact them prior to your appointment. This should allow your coverage to be in place at the time of your visit. **If your insurance has a co-pay, it is due at the time of your scheduled appointment. Please bring your insurance card** and a valid form of identification to every appointment.

Referrals and Testing:
For referrals and testing, please give a minimum of one week to process the arrangements. Typically, the service where you are being referred will contact you with their next available appointment. If you are in need of testing that requires scheduling, your doctor will send an order to our scheduling department. In some cases, a prior authorization or precertification will have to be approved. After approval, a person from our scheduling department will send the order to the facility. You will receive a phone call from the facility contact you with an appointment. If you do not receive a phone call in one week, please contact our central referral and scheduling department at (570) 230-0019 to check on the status of the referral.

Emergency Needs:
If you receive treatment from any other physician outside of The Wright Center, please be sure to inform us. It helps us to better care for you when we have these records prior to your visit.

Non-emergency Needs:
After-hours or weekends/holiday calls will be directed to our 24 hour answering service and your message will be relayed to the medical provider on call.

Online Access through our Secure Patient Portal:

For **non-urgent issues**, log in to our secure patient portal and your access medical records, request prescription refills, send a note to your provider, view lab results, make an appointment, check upcoming appointments, get statements and pay account balances by credit/debit card at your own convenience. All patients have access to this free service and any Wright Center employee can get you started. Visit www.thewrightcenter.org, click **"Patient Portal"** (near the top, right-hand corner of the website) and click **"Activate patient portal account."**

Please enter your name/date of birth exactly as NAME: _____ Date of birth: _____
(You will be able to make changes to your personal information once your portal account has been activated.)
Your **activation code** is case sensitive and will need to be entered exactly as it appears: _____

Please be as thorough as possible when filling out your personal information and medical history. It will save us time on the day of your appointment and will help us provide you the best medical care possible. If you have any questions, feel free to email support at: portalsupport@thewrightcenter.org.

Appointment Reminders:
See a team member at our front desk to sign up for reminders/notifications about your upcoming scheduled visits.

Medical Record Requests:
There is a charge for a copy of your medical records, as it takes time and materials to produce these for you. If you utilize our secure patient portal, you can access the information quickly on your computer, or call (570) 230-0019 to request a copy of your medical records.

Prescription Refills:
We encourage you to use the Patient Portal to request refills at your convenience. Prescription refills can also be requested during normal business hours or office visits. Some medications will not be prescribed without coming in for an appointment. It is your responsibility to plan ahead for any prescription refills. Refill requests for non-controlled medications are completed within 24 hours and **you can contact your pharmacy to request a refill electronically**. The Wright Center does not call back on refills sent.

Cancelling an Appointment:
Please give 24 hours' notice when cancelling an appointment. We realize this is not always possible and ask that you call immediately to reschedule if you cannot make it. We offer helpful appointment reminders/notifications. Ask a team member at our front desk about signing up for this free service.

Late Policy:
Please call and notify us if you are going to be late. This will allow our staff to make appropriate accommodations so you can be seen as quickly as possible when you arrive. If you do not notify the office of a late arrival, we cannot guarantee you will be seen by the provider with which you were scheduled. If you are more than 15 minutes late for your appointment, you will be given the option to wait for another appointment time that day or reschedule for a future appointment.

No Show Policy:
Please make every effort to keep your scheduled appointment; that time has been reserved for you. If you do not show up and do not call to cancel, it prevents us from seeing other patients. If a patient displays a pattern of "no shows", it will be discussed on an individual basis.

Check Out/Follow-up Appointments:
It's best to make follow-up appointments before you leave the office on our secure patient portal. For your best possible health outcome, see your physician regularly and remain an active participant to your care plan between visits. Do your part by managing diet and exercise, taking medications as instructed and participating in preventative health screens.

Photo/Filming Policy:
In order to protect the privacy and safety of our staff and patients, photographs, video recording or the use of any other technology capable of capturing an image, including but not limited to SnapChat, Skype or Facetime, are not permitted within the clinics. Informed consent must be given for any image to be obtained at any Wright Center clinic.

Lab Services:
For your convenience, lab service are available in or in close proximity to all our clinics. Patients can always select a lab of their choice.

Lab Results:
You will receive a phone call on all lab and diagnostic test results. Please call our office if you have not received communication after one week and always notify our office if your phone number or contact information has changed.

Health Information Exchanges:
We encourage you to bring copies of office visits with other providers or have the records faxed to our office to help us to better coordinate the care you receive from all of your providers and specialists.

The Wright Center participates in the **Keystone Health Information Exchange® (KeyHIE)** to coordinate between providers, health plans and patients in Pennsylvania. There is no cost to participate in this program and we encourage your participation.

The Wright Center is also a member of the **Keystone Accountable Care Organization (ACO)**, an organization geared towards our Medicare patients. The Keystone ACO is a group of doctors, hospitals and other healthcare providers who work together to make sure they have the most up-to-date information about your health care and services. In addition, the ACO can provide your doctor increased access to the expertise, staff, and technology needed to make sure your care is coordinated across all the places you get services. If you are eligible, we encourage your participation.

To Prepare for Your First Appointment:
Please bring your previous medical records, including immunizations, all medications/supplements; current insurance card; valid photo identification; Patient Agenda; co-pay (if applicable) and the completed Patient Registration form. An Authorization to Release Medical Records is included in this packet and can be shared with any previous/current providers.

IMPORTANT NOTE ABOUT YOUR PHONE LINE:
It is important you provide *at least one* working phone number. If we do not have a correct contact number on file, it will delay or prohibit a timely response from us. At registration, you can provide multiple phone lines if you wish.

We are committed to providing non-discriminatory safety net services for patients in the communities we serve.

Thank you for choosing The Wright Center for Primary Care.

Updated 2.2018

Patient Agenda

Please complete this form and discuss with your provider during your visit.
Please use one agenda for each patient.

Name: _____ Date of Birth: _____ Date:_____

1. The reason(s) for my visit today are:_____

_____

2. I would describe my overall health risk as: (please check one)
   - ☐ Low risk ☐ Mild risk ☐ Moderate risk ☐ High risk

3. I have had the following since my last appointment: (please check all that apply)
   - ☐ Hospitalization/ER visit
   - ☐ Specialist visit
   - ☐ X-Rays
   - ☐ Blood work
   - ☐ Medication changes
   - ☐ Significant health event
   - ☐ Significant change to my family or social history
   - ☐ Other: _____

4. Other issues I want to address during my visit today: (please check all that apply)
   - ☐ Prescription refills
   - ☐ Referrals
   - ☐ Vaccines
   - ☐ Mammogram
   - ☐ Colonoscopy
   - ☐ Review of recent lab tests
   - ☐ Physical Exam
   - ☐ Mental/behavioral health:
     - o Depression/anxiety
     - o Substance abuse
   - ☐ Forms
   - ☐ Note for work/school
   - ☐ Weight management
   - ☐ Nutrition
   - ☐ Diabetic education
   - ☐ Verbal and/or physical abuse
   - ☐ Stress related to:
     - o Caregiving: children, spouse, parents, friend
     - o Work
     - o Relationships
     - o Safety

Ask us for more information about our secure Patient Portal, where you can log in securely, request prescription refills, send a message to your provider, schedule appointments and more. As a reminder, and to protect your privacy, we will not communicate with patients electronically outside of our Patient Portal.

Notes from My Visit:

Medication Instructions:

To Do:

Mid Valley: 5 S. Washington Ave., Jermyn | (570) 230-0019
Clarks Summit: 1145 Northern Blvd., Clarks Summit | (570) 585-1300
Asian Medical Home: 326 Adams Ave., Scranton | (570) 941-0630
Scranton Counseling Center: 326 Adams Ave., Scranton | (570) 591-5250
Wilkes-Barre: 335 S. Franklin St., Wilkes-Barre | (570) 591-5283
Old River Road: 250 Old River Rd., Wilkes-Barre | (570) 826-5038
Together in Health (Scranton Intermediate Schools): Northeast: 721 Adams Ave. • **South:** 355 Maple St. • **West:** 1401 Fellows St. | (570) 591-5280
Ryan White Infectious Disease: 640 Madison Ave., Scranton | (570) 961-5670

THE WRIGHT CENTER MEDICAL GROUP, P.C.

Patient Authorization to Release/Obtain Protected Health Information

Patient Information:

Name	Date of Birth	Patient Account #
Address		Telephone

I authorize The Wright Center to release/obtain the information described in this form to:

Name of Provider, Person or Facility to whom information is to be released:	Telephone of Provider, Person or Facility
Address of Provider, Person or Facility	

for the purpose of: ☐ continuation of medical treatment ☐ payment of bill
☐ Worker's Compensation ☐ education ☐ legal purposes ☐ insurance purposes
☐ at the request of the patient or the patient's legal representative for personal access or
☐ other (specify):

_____
_____
_____

The information to be released will cover the time period from _____ to _____

SPECIFIC INFORMATION TO RELEASE/OBTAIN: ☐ **ALL RECORDS**

☐ Clinic Notes (NOT psychotherapy notes)

☐ Discharge Summary	☐ History & Physical	
☐ Medications	☐ X-Ray Reports	☐ Colonoscopy
☐ EEG, EKG, Stress Test	☐ Immunizations	☐ Operation Report(s)
☐ Consultation Report(s)	☐ Emergency Dept. Notes	☐ Itemized Bills
☐ Pathology Reports	☐ Disability/FMLA Form	☐ Endoscopy
☐ Laboratory Reports	☐ X-Ray Films	

☐ Other (specify):

_____
_____

☐ ***Psychotherapy Notes*** (Psychotherapy Notes are recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of your medical record. Psychotherapy Notes include: medication prescription and monitoring, modalities and frequencies of treatment furnished, and results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress and progress-to-date.) *Disclaimer: The Wright Center reserves the right to refuse to release psychotherapy notes if disclosure is deemed not to be in the best interests of the patient.*

SPECIAL AUTHORIZATION: If you are authorizing The Wright Center to release/obtain information related to the testing, diagnosis and/or treatment for any of the following conditions, please initial in front of the section which describes the type of information to be released:

☐ My evaluation, testing, diagnosis or treatment for *alcoholism and/or drug abuse or dependence* may be released to the recipient noted on the signed authorization.
☐ My evaluation, testing, diagnosis or treatment concerning my *mental health/rehabilitation information* may be released to the recipient noted on the signed authorization.
☐ My testing, diagnosis or treatment for *HIV/AIDS* may be released to the recipient noted on this signed authorization.

I understand that authorizing disclosure of health information is voluntary. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for each copy of my medical record, and that health records will be provided in electronic format unless I request hard copies (which will cost an additional fee). I understand The Wright Center will provide me with a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact The Wright Center's Privacy Officer.

By signing my name to this form, I understand and agree to the following:

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that if I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected pursuant to HIPAA regulations/federal law. A copy or fax of this authorization will be as valid as the original.

Cancelling This Authorization: I understand that I may change my mind and cancel this authorization at any time in writing provided to The Wright Center. After The Wright Center receives my written notice, it will cancel this release within five (5) business days. During these five days, The Wright Center may have shared some or all of my information. Neither The Wright Center nor any of its representatives are liable for any release of information during this time.

Right of Refusal: I have the right NOT to sign this authorization. My refusal to sign this form will not affect my/the patient's eligibility for treatment or benefits.

Revocation and Expiration: I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact The Wright Center immediately if I wish to revoke this authorization.

Unless I revoke this authorization in writing, this authorization will expire automatically:

☐ when the records requested on this authorization have been released, or
☐ one year from the date I sign it.

The Wright Center may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date/Time: _____

Patient/Parent or Legal Guardian Signature: _____

If Legal Guardian or Personal Representative, proof of guardianship or Power of Attorney must be attached.

Date/Time: _____

Witness Signature: _____

Verbal Authorization: If patient is unable to sign authorization form because of emergency, physical condition or age, describe the circumstances:

_____
_____
_____
_____

Date/Time: _____

Signature:_____ Relationship: _____

Witness:_____ Date/Time: _____

****

A COPY OFTHE COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT/GUARDIAN/REPRESENTATIVE

Name of Staff Providing Copy to Patient/Legal guardian or Personal Representative:

_____ Date: _____

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my Insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to The Wright Center Medical Group PC. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize The Wright Center Medical Group PC to:

1. Release my information necessary to the insurance carrier(s) regarding my illness and treatments.
2. Process insurance claims generated in the course of the examination or treatment.
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order is effective until revoked by me in writing.

I have requested medical services form The Wright Center Medical Group PC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible party: (please print):_____

Signature:_____ Date:_____

Witness:_____ Date:_____

Health Care Information Privacy Policy

Contact The Wright Center at (570) 591-5139 with any questions.

The U.S. Federal Government has established rules that healthcare providers, and specific others, must follow. The Wright Center for Primary Care is a health care provider and follows these rules to ensure the confidentiality of your health care information. Source: http://www.hhs.gov/ocr/privacy/

These rules, the Health Insurance Portability and Accountability Act (HIPAA), protect personally identifiable health-related information by restricting what can be done with it. Its restrictions apply to those who collect, retain or store your confidential health care information.

The Privacy rules provide federal protections for personal health information and give you, as a patient, protective rights over your information. The rules do allow, with your authorization, the disclosure of personal health information which is needed for your care, for reimbursement for your care and some other important, but specific, purposes.

With your authorization, health care providers can freely share information for treatment purposes.

A healthcare provider must obtain your written authorization for any specific use or disclosure of your personal health information that is not for treatment, payment or health care operations or as otherwise noted above.

A healthcare provider may always use or disclose for research purposes health information which has been de-identified.

I have read and understand the above information and have been given a copy of this signed document. The original will be kept with my health care information.

Date: _____ Patient's name: (Please print)_____

Patient/Guardian's signature: _____

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Financial Responsibility Agreement (1/2)

The Wright Center Medical Group, PC, 111 North Washington Avenue, Scranton, PA 18503

Patient name: _____ Date of birth: _____

The Wright Center Medical Group, PC appreciates the confidence you have shown in choosing us as your primary care provider. The services that have been/may be elected require a financial commitment on your part. Your signature below forms a binding agreement between **The Wright Center Medical Group** (the provider of health care services) and you, as the **Patient** or the **Responsible Party**. The Patient who is receiving health care services is financially responsible to pay all health care bills, co-pays, deductibles and balances for uncovered services. If the patient is a minor (those patients under 18 years old), the **Responsible Party** is the adult who is financially responsible for payment.

The **Patient** or **Responsible Party** must:

- Inform **The Wright Center Medical Group** of the current address and phone number of the Patient/Responsible Party.
- Present all current insurance cards upon check-in for each office visit.
- Verify at each visit that the information on file is current.
- Pay any required co-pay **at the time of the visit**.
- Pay any additional amount owing, including **deductible and coinsurance**, within 30 days of receiving a statement from our office.

We accept cash, personal checks and all major credit cards as methods of payment.

Medical Insurance:
We have contracts with several insurance companies, including Medicare, and we will bill them as a service to you. It is your responsibility to know the limits and coverage of your particular health insurance policy and to provide us with your **current** insurance card(s) upon check-in at each visit. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Depending on your plan, you may be responsible for paying any balance due. Your insurance company may also need you to supply certain information before acting on your claim, and it is your responsibility to comply with that request. If you do not, and the insurance company does not pay the claim, you will be responsible for the entire amount due.

If your insurance company pays you directly, you are responsible to pay **The Wright Center** in accordance with your plan.

Ability to Pay:
If you believe you are unable to pay for health care services, you may meet with our Financial Counselor and provide information regarding your ability to pay. He/she will work with you to determine if you are eligible for a payment plan, discounted services, or a sliding scale discount (which is based on Federal Guidelines for family size and income).

Self-Pay:
If you do not have insurance, and you are otherwise ineligible for discounted services based on ability to pay, you will be entitled to a "prompt payment" discount if you pay any balance due in full within ten days from the date of service. We also offer a payment plan for those patients who qualify.

Financial Responsibility Agreement (2/2)

Returned Checks:
A returned check will result in a minimum $25 service charge in addition to any fees that your financial institution may charge you. In the case of a returned check, **The Wright Center Medical Group** may require all future payments to be made by cash or credit card.

Failure to Pay:
Any balance due and owing after 120 days (unless a payment plan has been arranged in advance) is subject to collection proceedings. Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient/Responsible Party understands that **The Wright Center Medical Group** has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving health care services or as the Responsible Party for a minor patient. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

I acknowledge that I have read and understand the above statement regarding my financial responsibility to The Wright Center Medical Group and agree to pay The Wright Center Medical Group the full amount of bills received.

I will immediately notify The Wright Center Medical Group of any changes in insurance coverage relevant to patient services. If I do not notify The Wright Center Medical Group of changes or termination of insurance coverage, I may be responsible for charges accrued.

Name of patient/Responsible party	Relationship to patient
Signature	Date

Release of Medical Records:
I authorize **The Wright Center Medical Group** to release pertinent records to my insurance carrier for the purpose of securing payment for services provided.

Signature: _____ Date: _____

Assignment of Benefits:
I hereby authorize my insurer to pay any and all benefits for services provided to the Patient directly to **The Wright Center Medical Group.**

Signature: _____ Date: _____