Updated 12.2018

**Welcome to the Wright Center for Community Health (TWCCH)**
Quick Facts About Your Patient-Centered Medical Home

We are an accredited Patient-Centered Medical Home and we will collaborate 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.

We believe in preventative care for 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, tobacco 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. Patients may receive calls from time to time to encourage preventative care recommendations set by national medical guidelines.

**Scheduling an Appointment or Contacting a Provider After Hours:**
Our goal is to make access to medical care easy. Same day appointments are available when our patients are sick**.** We use a **Call Center** to ensure you are always able to reach us during peak hours and after hours. **If you call after hours and are in need of clinical advice, the on-call provider can be reached at the number used to contact the office you visit**. We are able to offer language assistance for anyone who is hearing impaired or does not speak English as their primary language and/or who have a limited ability to read, write, speak, or understand English. Our phone numbers and convenient hours are listed below:

- **5 South Washington Avenue, Jermyn • (570) 230-0019** Monday - Friday 7am–8pm; Saturday 8am–6pm; Sunday 8am–4pm. For your convenience, **our Jermyn clinic is open 365 days/year**. **Holiday hours:** 8am–4pm
- **1145 Northern Boulevard, South Abington Township • (570) 585-1300** Monday - Friday 7am–6pm
- **640 Madison Avenue, Scranton** (Ryan White Infectious Disease) **• (570) 961-5670** Monday - Friday 8:30am–5pm
- **326 Adams Avenue, Scranton** (lower level of Scranton Counseling Center) **• (570) 591-5250** Monday - Friday 1pm–5pm
- **1401 Fellows Street, Scranton** (connected to West Scranton Intermediate School) **• (570) 591-5280** Monday and Wednesday 8am - 6pm; Tuesday, Thursday and Friday 8am - 4:30pm. **Open to students and community members.** We also provide care to students at Northeast Scranton Intermediate and South Intermediate Schools. Please call (570) 591-5280 for more information on how to receive services.
- **335 South Franklin Street, Wilkes-Barre** (inside Children's Service Center's Outpatient Clinic Building) **• (570) 591-5283** Monday–Friday 8:30am–5pm
- **250 Old River Road, Wilkes-Barre** (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. ****

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

We are a **Teaching Health Center**. During your appointment, you will have your vitals taken by our medical assistants, and may be seen by a resident physician and then by your clinician. 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 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.**

**To Prepare for Your First Appointment:**
Please bring your previous medical records, including immunizations, all medications/supplements; current insurance card; valid photo identification; 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. You will receive a **Patient Agenda** for your next visit. Please 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.

***If you have not been called back to an exam room within 15 minutes of checking in, please notify the front desk staff who can update you on the status of your appointment.***

**Insurance and Co-Pay Information:**
Please bring your insurance card and a valid form of identification to every appointment. **If your insurance has a co-pay, it is due at the time of your scheduled appointment.** 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.

**Contact Information:**
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. **If your phone number or address has changed since your last visit, please notify us so we can update this information.**

**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.

**Check Out/Follow-up Appointments:**
It is best to make follow-up appointments before you leave the office. 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.

**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.

**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 missed appointments without notice, it will be discussed on an individual basis.

**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. Some facilities do not share information with providers. Please request a form to "opt-in" so your records are shared between health care providers.

**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 front desk staff can get you started with a unique activation code. Visit www.thewrightcenter.org, click the down arrow in the top left corner for secure portal access and click **Patient**

**Portal Login.** Choose **Activate Account** and follow the instructions. *You will be able to make changes to your personal information once your portal account is activated.*

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 us at portalsupport@thewrightcenter.org.

**Medical Record Requests:**
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. There is a small processing fee for a copy of your medical records.

**Prescription Refills:**
Please **contact your pharmacy to request a refill electronically or to check on the status of a refill request.** Refill requests for non-controlled medications are completed within 24 hours. Prescription refills can also be requested during scheduled 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. We encourage you to use the Patient Portal to request refills at your convenience if your pharmacy is closed.

**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 clinical site operated by TWCCH.

**Lab Services:**
For your convenience, lab services 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. If you are a Geisinger patient, you may also request a form that will allow you to "opt-in" so your records are shared with our health care providers.

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.

**How did we do today?** If we met or exceeded your expectations, please do not keep us a secret. Referrals are the best compliments we can receive from our current patients**. If we have not met your expectations or you can identify an area where we can do better, please let us know.** Before you leave the office today, please ask a front desk team member to speak with a supervisor or practice manager who will meet with you to ensure we completely understand the issue.

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 Community Health.**



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**Patient Agenda**

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

Name: _____ Date of Birth: _____ Date: _____

The reason(s) and expectations I have for today's visit: _____

_____

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

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

3. 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:
     - Depression/anxiety
     - Substance abuse
   - ☐ Forms
   - ☐ Note for work/school
   - ☐ Weight management
   - ☐ Nutrition
   - ☐ Diabetic education
   - ☐ Verbal and/or physical abuse
   - ☐ Stress related to:
     - Caregiving: children, spouse, parents, friend
     - Work
     - Relationships
     - 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.***



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## Notes from My Visit:

## Medication Instructions:

## To Do:

## Health Goals:



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## 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 for Community Health. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize The Wright Center for Community Health 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 for Community Health 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 name):_____

Signature: _____ Date: _____

Witness: _____ Date: _____



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**Health Care Information Privacy Policy**

Contact TWCCH 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 Community Health 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 for Community Health (TWCCH)**, 111 North Washington Avenue, Scranton, PA 18503

Patient name: _____ Date of birth: _____

**The Wright Center for Community Health** 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 **TWCCH** (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 **TWCCH** 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 for Community Health** 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 fee discount schedule (which is based on Federal Poverty Guidelines for family size and income).

## Financial Responsibility Agreement (2/2)

**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.

**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 for Community Health (TWCCH)** 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 **TWCCH** 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 TWCCH and agree to pay TWCCH the full amount of bills received.**
**I will immediately notify TWCCH of any changes in insurance coverage relevant to patient services. If I do not notify TWCCH 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 **TWCCH** 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 all benefits for services provided to the Patient directly to **TWCCH.**

Signature: _____ Date: _____



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