Dr. Daniel Cannon
Dr. Gary Curran
Maggi Ormand, PA

6 Brooklet Street
Asheville, NC 28801
P: 828.250.0898
F: 828.251.4671
www.CannonFamilyHealth.com

Policies and Procedures

Thank you for choosing Cannon Family Health as your Primary Care Practice. The staff at Cannon Family Health strives to make this office a welcoming medical home for you. We want to make your experience with us as comfortable and stress free as possible. This hand out will tell you about who we are and how we operate. Please feel free to contact our office if you have any questions concerning our policies.

Office Hours: Mon – Thurs 8:30am – 5:00pm Fri. 8:30am – 12:00pm
(We are closed daily for lunch 12:30pm – 1:30pm)

Phone Hours: Mon- Thurs 8:00am – 12:30pm, 1:30pm – 5:00pm Friday 8:00am – 12:00pm

Our office Phone Number is **828-250-0898.** An on-call physician is available to assist you after scheduled office hours if necessary. That number is 828-251-4848. In the event of an emergency do not call the on-call physician, please call 911. If you need to make an appointment, please call us during our regular offices hours.

- ***APPOINTMENTS***

Scheduling

When calling for an appointment, please provide our staff with your name, date of birth, telephone number, chief complaint/reason for visit, and any *updated contact or insurance information*. If you have regular follow-up visits please make sure to schedule your next visit at check out. ****If you scheduled an appointment for an illness, please note that a full check-up cannot be done at that appointment. Please schedule separate appointments for that purpose.**

Same Day Appointments

As your medical home, Cannon Family Health offers same day/urgent appointments. We reserve 4 spots in the morning and 4 spots in the afternoon for same day/ urgent appointments. On most days, an appointment slot is available for last minute appointments. If an appointment slot is not available, we will schedule you for the next available appointment. If you feel that you cannot wait, please inform the staff and appropriate measures will be taken.

Cancellations

We require a 24hr notice if you need to cancel or reschedule your appointment. If you do not give us 24hrs notice or you are a no show for the appointment, you will be charged a ***$30 no-show fee***.

Late for an appointment

We are a very busy practice and the provider's time is very valuable. It is important for our office and other patients that you be on-time for your appointment. If a patient is 15 minutes late for an appointment, you will be rescheduling for the next available appointment time.

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Missing an appointment

We cannot stress enough how important it is that you come to your appointments. We try to call and remind you of the appointments 1-2 days prior to your appointment as a courtesy. However, you are still responsible for keeping your appointment time even if we cannot reach you. You will be charged a no show fee of $30 if you don't show up for a scheduled appointment and do not call. After 2 "no-shows" you will be dismissed from the practice.

Appointment notes – We do our best to run on schedule. There are many ways you can assist us in staying on time:

- ✓ Please be on time for your appointment
- ✓ Walk-in appointments are strongly discouraged.
- ✓ If you schedule a visit for one patient, please make it for that patient only. If you have two siblings that need to be seen, for instance, please be sure to schedule two appointments.
- ✓ Remember that SICK/URGENT appointments do not allow enough time for a physical to be done.

***** We do make all efforts to stay on time but emergencies do occur from time to time and we might run behind as a result. We will try very hard not to waste your valuable time.*****

- ***Check In***

When you arrive at the office please sign in at the front desk. We will verify all of your contact and insurance information. ***You must bring your insurance card and photo ID to every appointment.*** It is your responsibility to provide us with any changes to your medical coverage. Full payments for all co pays are expected at the time of service.

We accept cash, check, or credit card.

Returned Checks – A fee of $30 will be charged for all returned checks.

Co pays

As part of our contract with the insurance companies, we are legally required by the terms of the contract to collect any co-pays from you at the time of service. If you do not have your co-pay, we will reschedule your visit.

Paperwork

All new patients will need to complete a new patient packet for Cannon Family Health. The new patient packet can be accessed on our website at ww.CannonFamilyHealth.com. If you do not have internet access we can mail or fax the packet to you. All forms in the new patient packet should be completed before your scheduled appointment; otherwise new patients must arrive 15 minutes early to fill out the packet. In addition we will need a **current copy of your insurance card and a photo ID**.

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Insurance

As a courtesy to our patients, Cannon Family Health is happy to file insurance claims on your behalf. If you also have a secondary insurance please let our staff know. We will need a copy of all cards. It is your responsibility to call your insurance company before your first appointment and make sure our office is In-Network with your insurance.
It is also your responsibility to inform our office of any changes in insurance coverage. Failure to do so will cause delays or denial of insurance payment.

You will be billed for any deductible or co-insurance amounts, and/or fees for services not covered by your insurance (as stated in your insurance contract). If we are unable to verify insurance coverage prior to scheduled appointments, patients will be responsible for fees associated with office visits at the time of service.

Medicaid Patients

If you or your children are on Medicaid, your Medicaid card must have **Cannon Family Health** listed as your provider. We are unable to see patients until the card is corrected.

Medicare Patients

If you are a Medicare patient please remember to bring your Medicare Card to every appointment as well as any supplemental insurance cards you may have.

Please contact our billing department with any billing questions you may have – 828-250-0898

- ***PRESCRIPTIONS***

Cannon Family Health strongly recommends *using only one pharmacy for all of your prescription needs*. Please be sure the pharmacy and Cannon Family Health are aware of any possible drug allergies you may have.

If you need a prescription refill, please call your pharmacy and have them fax the request to our office at (828) 251-4671. Requests received after 3:00pm will be processed the next business day.

Please note that narcotic medications require a paper prescription signed by Dr. Cannon. Early refills will not be given.

Changes and/or new prescriptions can only be completed by the physician. Please be aware that you may have to be seen to receive a new prescription. Please do not ask staff to alter your medication(s) or dosing instructions.

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- ***Lab Services***

Cannon Family Health has an in house lab for our patients' convenience. Patients with insurance coverage will be billed directly from the lab for any lab services performed. Medicare patients may be asked to sign an Assignment of Benefits.

- ✓ Our lab is open from 8:30am – 12:30pm M-TH.

Check Out - Follow up and routine appointments will be made at the desk during check out.

- ***REFERRALS***

Referrals can only be made by the physician. If you haven't been seen for this complaint in this office, the referral will require an office visit. Once a referral has been created by Dr. Cannon please allow 3 business days for processing. Once we send the referral to the appropriate facility, that facility will contact you directly to schedule your first appointment. Please contact our office if you have not heard about your referral within 4-5 business days.

- ***MESSAGES***

All phones messages received before 3pm will be followed up on the same day. If we receive your message after 3pm we will follow up with you on the next business day. All messages sent from the patient portal will be responded to within 24hrs of receiving the message.

- ***AUTOMATED CALLS***

Cannon Family Health uses an automated reminder system for appointment reminders, lab results, outstanding balance reminders, and important messages from our office. By signing below you agree to allow Cannon Family Health to send automated calls to your preferred contact phone number.

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AS A PATIENT, YOU HAVE CERTAIN RIGHTS AT CANNON FAMILY HEALTH:

1. You have the right to be treated with respect, consideration and dignity.
2. We will strive to greet you with a smile and a warm welcome.
3. You have the right to high-quality medical care delivered in a safe, timely, efficient and cost-effective manner.
4. We will keep your medical information private as laid out in the guidelines by HIPPA.
5. You have the right to be a participant in your healthcare along with your doctor.
6. No procedure or treatment will be undertaken without your informed consent.
7. You have the right to know the services available at the facility.
8. You have the right to know what fees are expected and what the payment policies are.

YOU ALSO HAVE CERTAIN RESPONSIBILITIES AS A PATIENT

1. You have the responsibility to accurately and completely provide all clinical personnel with the health information they need including any medications that you are taking.
2. You have the responsibility to follow the directions of the nurse or physician with regard to diet and/or medication.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you and that you have not revealed to our nurse or physician.
4. You have the responsibility to abstain from the use of alcohol as directed by your nurse or physician.
5. You have the responsibility to inform the nurse or physician if you do not understand any directions or if you do not understand the course of treatment planned for you.
6. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive from any insurance company for our services.

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POLICIES & PROCEDURES ACKNOWLEDGMENT

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Cannon Family Health, PLLC Office Procedures and Policies Packet

_____
PRINTED NAME

_____ _____
SIGNED NAME DATE

Thank you!
Cannon Family Health, PLLC

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Please answer ALL questions

Patient Name:_____ Date of Birth:_____ SS#_____

Address_____ City_____ St_____ Zip_____

Home Phone#_____ Can leave message _____yes _____no

Cell #_____ Can leave message _____yes _____no

E-Mail Address _____
(With our new patient portal on our website www.CannonFamilyHealth.com , patients will be able to request appointments, pay bills, receive appointment reminders, and health education information. Your e-mail address can be listed as your primary contact method.)

Please circle your preferred contact method: Home Phone Cell Phone (Call or Text) E-Mail
Work Phone Postal Mail

Marital Status: Single Married Divorced Widowed Separated Partnered

Are you Hispanic/Latino? Yes or No (please circle one)

Preferred Language:_____

Ethnicity_____ or Declined Comment

Employer_____ Work Phone_____

Emergency Contact_____ Phone#_____

Relationship_____

How did you hear about Cannon Family Health? _____

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Continued to the next page….

Billing:

Current Primary Insurance _____

Secondary Insurance _____

Name on Insurance Card if different from patient:_____

Policy Holders Date of Birth: _____

If patient is a minor please answer the following:

Father:_____ Daytime phone#_____

Mother:_____ Daytime phone#_____

*Legal Guarantor:_____
(Name that bills should be mailed to)

I understand that I am authorizing treatment by Cannon Family Health and that I am financially responsible for all charges for services rendered to me including the balance remaining after payment of possible insurance benefits. I authorize payment of medical expenses to the provider of professional services tendered. I authorize release of any medical information to process claims.

I have been presented with a copy of Cannon Family Health Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my medical information:

_____

_____

Patient Signature_____ Date_____

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Legal Guarantor if patient is a minor: _____

Relationship_____ Date_____

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HIPAA Omnibus Notice of Privacy Practices
Revised Jan. 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANDHOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

(Continued on Back)

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.

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Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

- **You have the right to inspect and copy your protected health information (fees may apply)**
- **You have the right to request a restriction of your protected health information**
- **You have the right to request to receive confidential communications**
- **You have the right to request an amendment to your protected health information**
- **You have the right to receive an accounting of certain disclosures**
- **You have the right to receive notice of a breach**
- **You have the right to obtain a paper copy of this notice**

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

- ***Please sign the accompanying "Acknowledgment" form.*** **Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

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HIPPA Authorization

This authorization outlines who, medical information about you may be shared.
Please read it carefully.

The privacy of your medical information is important to us. Our Notice of Privacy Practices outlines how we may use or disclose your medical information on a regular basis. This authorization is for situations not included in the Notice when you may want us to share your medical information with someone else such as a spouse, other family members, or your caregiver. This Authorization allows the individual(s) listed to have access to all of your information as a patient of this practice and will be all-inclusive unless otherwise specified in the Limitations section below. This Authorization will remain in effect for a period of five years from the date signed.

Who may receive your health information? Who can pick up your prescription at the office?

Name:_____Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Limitations:_____
_____
_____

I understand that once disclosed to the individual(s) named above, Cannon Family Health cannot guarantee that the individual(s) will maintain the confidentiality of such information as described by law.

Revocation

This Authorization will remain in effect for a period of five years from the date signed. However, you have the right to revoke this Authorization at any time as long as the revocation is made in writing and is received and acknowledged by Cannon Family Health. Such revocation will restrict disclosures of your medical information but cannot affect past disclosures or disclosures underway at the time of receipt.

Patient Signature:_____ Date of Birth_____ Date:_____

Legal Guarantor:_____ Relationship:_____ Date:_____

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Medication History Authority

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

I hereby authorize Cannon Family Health to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

_____

Primary Pharmacy & Location ***(* Required)***

_____

Patient Name – PRINT Date of Birth

_____

Patient Signature Today's Date

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Medical Release of Information Form

Patient Name:_____ Date of Birth:_____

Social Security #:_____Any Previous Names: _____

I request and authorize _____
(Name of previous physician/Previous practice name)

Reason for Release: _____

To release the medical record of the above named patient to:

Cannon Family Health
6 Brooklet Street
Asheville, NC 28801

This request and authorization applies to: ***(initial appropriate lines)***

_____ ***Specific*** Health Care information relating to the following treatment condition or dates of treatment: _____

This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

_____ **All Health Care information** ***including*** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

_____ All Health Care information ***excluding*** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

_____ **I understand I have the right to revoke this authorization** by providing a written request to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____

Signature of patient or authorized representative (included relationship) Date

Unless otherwise revoked this authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information I can contact Amanda Hager @ 828-250-0898 ext. 106.

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CANNON FAMLY HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Allergies

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

Primary PHARMACY

_____
Name and Street

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:_____	Meningococcus	Date:_____
Flu Shot	Date:_____	MMR *(Measles, Mumps, Rubella)*	Date:_____
Gardasil/HPV	Date:_____	Pneumonia	Date:_____
Hepatitis A	Date:_____	Tdap *(Tetanus and pertussis)*	Date:_____
Hepatitis B	Date:_____	Tetanus	Date:_____
		Zostavax *(Shingles)*	Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____
Last Mammogram Date _____
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
Cesarean sections If yes, then number: _____

Bleeding between periods
Heavy periods
Extreme menstrual pain
Vaginal itching, burning, or discharge
Wake in the night to go to the bathroom
Hot flashes
Breast lump or nipple discharge
Painful intercourse

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PAST MEDICAL HISTORY

Please circle all that apply:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes - Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandmother (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease

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Grandfather (paternal)	Y/N	_____	Heart disease Hypertension Osteoporosis Stroke Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Father	Y/N	_____	Heart disease Hypertension Osteoporosis Stroke Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Mother	Y/N	_____	Heart disease Hypertension Osteoporosis Stroke Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Brother/Sister	Y/N	_____	Heart disease Hypertension Osteoporosis Stroke Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Brother/Sister	Y/N	_____	Heart disease Hypertension Osteoporosis Stroke Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Other:_____	Y/N	_____	Heart disease Hypertension Osteoporosis Stroke Alcoholism Arthritis Depression Cancer Diabetes Genetic disease

SOCIAL HISTORY

Education Less than 8th grade
High school
2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Sexually active Yes No
Current sexual partner is Female Male
Do you use condoms Yes No
Other Birth control method used:_____

Exercise Level None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Caffeine None Occasional
Moderate Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
Yes No
If so, how often?

Occasionally < 3 times a week
> 3 times a week

How many drinks per week?
_____

Tobacco Do you use tobacco?
Yes No

If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____

Interested in being screened for STD's ? Yes No

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Please add any other information about your health that you would like your provider to know here:

_____ _____

Patient, Parent, Guardian, or Caregiver Signature Date

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Patient Portal Policy and Procedures

DO NOT use Portal to communicate if there is an emergency

Our New Patient Portal gives you 24/7 access to your medical record.

Purpose of this Form

Cannon Family Health offers secure viewing and communication as a service to patients who wish to view their record and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. By accepting your PIN number you accept the risks and agree to the conditions of participation.

How Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right PIN, Date of Birth and phone number to log in to the portal site.

How to participate in our Patient Portal

We will assign you a PIN and give you instruction on how to register on the portal. You will then be able to login using the PIN, your phone number, and your date of birth. Next you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record.

Because the connection channel between your computer and the web site uses "secure sockets layer" (SSL) technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. **We need you to make sure we have your correct email address and you MUST inform us it ever changes.** You also need to keep track of who has access to your email account; so that only you, or someone you authorize, can see the messages you receive from us. If you pick up secure messages from a Web site, you need to keep unauthorized individuals from learning your password.

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If you think someone has learned your password, you should promptly go to the Patient Portal and change it. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including email addresses, without your written consent.

Proper Subject Matter:

· Medical questions, lab results, appointment reminders or requests, routine follow-up questions, etc.

· Sensitive subject matter (HIV, mental health, work excuses, etc.) is not permitted.

· We do not refill narcotics/stimulants through this site.

· Please be concise when typing a message.

Current functionality of Patient Portal:

· Email and secure messaging for non-urgent needs.

· Viewing of lab results that have been sent to you.

· Viewing and printing of "continuity of health record."

· Viewing and "updating" of health information.

· Viewing of selected health information (allergies, medications, current problems, past medical history) **Note - You can make changes/additions to your health records, medication lists, etc. but this will not change your permanent record without our review of the information.*

· Referral Requests

· Appointment requests

· Billing questions

· Update your demographic information (ie address, phone number, insurance)

Other functions are in development to allow easier access!

All communication via Patient Portal will be included in your permanent patient record

Privacy:

· Emails from you to any staff should be through this portal or they are not secure

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· We will keep all email lists confidential and will not share this with other parties

· Any of our staff may read your messages or reply in order to help the Clinician that has been emailed.

*(*Similar to how phone communication is handled*)

· Our system will check when messages are viewed, so you do not need to reply that you have read it.

Response Time:

· **Note -we will not respond directly to your email. All communication occurs through the Patient Portal instead.*

· We will normally respond to non-urgent email inquiries within 24hrs but no later than 3 business days after receipt.

Available Patient Portal Components:

1. *Messages:* This allows you to send and receive secure email to/from our staff. This may include attachments, pictures, or other information. Use of this is very similar to standard email. Here you can also request a referral, ask billing questions, or even make suggestions on how we can improve the site.

2. *Lab/Test results*: Here you can receive copies of labs/tests done in the office, their results, and any explanations or comments done by your provider. This is a read only area, but if you have questions, you can email us in the messages section

3. *Health Summary:* Here you can view information entered into various parts of your electronic health record. These are available for you to review and check for accuracy as well as print for other physicians or to keep for your records. We are going through on a regular basis and updating this with past forms you have filled out in the office. So if it isn't complete, we still have the information but it is not yet entered in a way you can view it through the portal. Here you can also make suggestions/comments on the information added, but it will not be a permanent part of your chart until approved by our staff.

4. *Medications:* Here you can see current and past medications written by our office or entered by our staff.

5. *Appointments:* In this section you can view upcoming appointments or see requested appointments. We have not implemented the ability to request appointments, but hope to do so in the near future.

Our clinic's main website is *www.cannonfamilyhealth.com*

More general information about our clinic and medical links/information are located here.