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Patient and Family Request for Asheville Medicine & Pediatrics Patient Portal

The Asheville Medicine & Pediatrics Patient Portal is intended to provide our patients with enhanced access to the staff and providers at Asheville Medicine and Pediatrics. The Portal is a convenience allowing the ability to schedule appointments, request refills, view laboratory results, request referrals, access medical histories, and to communicate with nurses, staff, and providers on-line.

I understand that the Patient Portal should never be used for urgent or emergent messages, discussions, or requests. If an issue demands immediate attention I understand that I must call the office by phone directly.

The health summary represents any problem or issue you may have ever addressed with your provider and may not represent a current assessment of your medical issues. If you would like to make changes to your health summary, medicine list, or demographic information you can notify our office through the Portal.

Asheville Medicine and Pediatrics will do its best to respond to all requests or messages sent through the portal within 24-hours during regular business hours. Our Portal messages will not be checked during holidays, weekends, or other days when the office is not open. I understand that I must call Asheville Medicine & Pediatrics if I have not heard a response to a message within 48 hours. I must inform Asheville Medicine & Pediatrics if I have not received laboratory results within 2 weeks of the time of blood draw.

Asheville Medicine & Pediatrics has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information. All messages are encrypted and stored in a secure web based portal. You can only access your protected information by entering a user name and password.

I understand that it is my responsibility to safe keep the sign-on and password that I am assigned. I understand that I should never share this password and accept full responsibility if this information is given to other people. If for any reason, I feel this sign-on/password combination has been compromised, I will either change the password using the tools provided and/or notify Asheville Medicine & Pediatrics immediately.

I understand that Asheville Medicine & Pediatrics Patient Portal should allow me to view the records for myself or my children only. If for some unforeseen reason I gain access to another patient's information, I am not allowed to view this information and must notify Asheville Medicine & Pediatrics immediately. I agree that Asheville Medicine & Pediatrics will not be liable for inappropriate disclosure of information due to unauthorized use of my sign-on and password.

Asheville Medicine & Pediatrics will do its best to assure adequate technical support for the Patient Portal but can not take responsibility for unforeseen technical issues that may compromise functionality of the Portal. If, at any point, there is a question about potential technical problems you should contact Asheville Medicine & Pediatrics immediately.

I understand that the Patient Portal is an optional service and may be terminated at the request of the patient at any time. The yearly access fee will be refunded in full if a request to terminate is received within 3 months of the signing of this agreement. If the request to terminate is not received within 3 months then the fee is forfeited.

I understand that violation of this agreement may result in loss of access to the Asheville Medicine & Pediatrics Patient Portal System.

By signing below, I agree to abide by these rules.

Patient requesting portal access:
(Must be 18 or Older)

____
Name of Patient **Date of Birth**

____
Patient's Signature

____
Date

Dependents of patient requesting portal access:
(Must all live in the same household)

1) ______________________________
Name of Dependent **Date of Birth**

2) ______________________________
Name of Dependent **Date of Birth**

3) ______________________________
Name of Dependent **Date of Birth**

4) ______________________________
Name of Dependent **Date of Birth**

5) ______________________________
Name of Dependent **Date of Birth**

____
EMAIL ADDRESS

PLEASE ENCLOSE A PAYMENT OF $20 PER PERSON OR $75 PER FAMILY WITH THIS COMPLETED FORM AND RETURN IT TO OUR OFFICE.