



KINRISE

MEDICAL CENTRE

Clinic Policies

We appreciate your partnership in maintaining a respectful, efficient, and safe environment for all. By signing this acknowledgment, you agree to the following policies. Non-compliance may result in the termination of the doctor-patient relationship.

Doctor-Patient Relationship

1. I will treat all clinic staff—including physicians, front desk, and allied health providers—with respect during in-person and phone interactions. Disrespectful behavior (e.g., raising voice, inappropriate remarks, or threats) may result in termination of the doctor-patient relationship.
2. I will seek care from my family doctor whenever possible. For urgent needs that cannot wait, I will visit Urgent Care or the Emergency Department.
3. When consulting other healthcare providers, I will name my family doctor to ensure they receive consultation notes for appropriate follow-up.
4. I will communicate openly and honestly about my health needs.
5. I understand that refusal to follow these policies may result in termination of the doctor-patient relationship.

Managing Medications and Health Concerns

6. My doctor can address 1-2 issues per visit for thorough care. If I have more, I will discuss and book follow-up appointments as needed.
7. I will book prescription renewals 1-2 weeks before refills run out. I understand I can request an emergency supply from my pharmacy and will not book urgent/same-day appointments solely for refills.
8. Cancellations require 24 hours' notice. I agree to pay a fee for missed virtual or in-office appointments.
9. I understand fees apply to "Doctor's Notes," "Sick Notes," insurance forms, and other documents requiring medical input.
10. If prescribed controlled medications (e.g., opioids, stimulants, benzodiazepines), I agree to provide a random urine sample within 24 hours upon request. Failure to do so may delay, reduce, or stop the prescription.



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Health Records, Privacy, and Communication

11. I consent to communication with my doctor and staff via phone, email, or other electronic methods, understanding these are not fully secure and may involve sensitive health information. I accept the risks of interception or unauthorized disclosure.

12. I understand virtual care (phone, email, video, or audio) has limits and cannot replace physical exams or in-person visits for certain conditions. For urgent issues, I will seek Emergency Department care.

13. I consent to my family doctor obtaining records from other doctors, allied health providers, and facilities, and sharing information with them as needed for my care.

14. I consent to my doctor accessing my medical information via services like Medinet, PharmaNet, and CareConnect.

Infection Control

To protect patients, staff, and doctors:

15. All patients must wear a mask while in the clinic.

16. Patients with cough, cold, or flu-like symptoms may wait outside or in their vehicle. The doctor may conduct assessments there if safest.

By signing below, I acknowledge that I have read, understood, and agree to these clinic policies.

Name of Patient: _____

Name of parent or guardian (if patient is under 16 years old): _____

Signature of patient (16 years and older) or parent/guardian: _____

Date: _____