



AT THE SOUTHERN NEVADA HEALTH DISTRICT

**SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE**

DIVISION:	FQHC	NUMBER(s):	CHCA-019
PROGRAM:	Division Wide	VERSION:	1.00
TITLE:	Patient Dismissal from Practice	PAGE:	1 of 3
		EFFECTIVE DATE: Click or tap here to enter text.	
DESCRIPTION:	Procedure for dismissing a patient from SNCHC and termination of the physician/patient relationship.	ORIGINATION DATE: Click or tap here to enter text.	
APPROVED BY:		REPLACES: Click or tap here to enter text.	
FQHC OPERATIONS OFFICER:			

Randy Smith	Date		
DISTRICT HEALTH OFFICER:			

Fermin Leguen MD, MPH		Date	

I. PURPOSE

Establish a written policy and procedure with a standardized process that addresses interventions prior to ending the relationship and the steps to take if it becomes necessary to dismiss a patient.

II. SCOPE

This policy applies to all Workforce members within the scope of their practice.

III. POLICY

All requests for patient dismissal must be approved by the FQHC Operations Officer or their designee. In consultation with the patient’s provider, a decision to dismiss a patient from the entire SNCHC practice or removing the patient from practitioner’s panel will be made.

All dismissals must be in writing.

IV. PROCEDURE

- A.** Any incident that may result in a warning or dismissal letter must be documented in an Incident Report.
- B.** A patient can be dismissed from the Southern Nevada Community Health Center (SNCHC) for several reasons, such as non-compliance and/or inappropriate behavior.
- C.** The potential termination should be discussed between the patient's provider, Medical Director, and Operations Officer.
 - 1. Discuss the incident(s) that resulted in the dismissal request.
 - 2. Come to a decision regarding continued care or dismissal.
- D.** If the patient is **NOT** dismissed from the practice:
 - 1. A warning letter is mailed to the patient regarding the incident(s). The letter will outline the following:
 - a. A high-level summary of the incident(s) or non-compliance.
 - b. Repercussions if incident happens again.
 - 2. Scan a copy of the letter to the patient's electronic health record (EHR).
 - a. Select "Patient Docs"
 - b. Select "Misc" folder.
 - c. Save
- E.** If the patient **IS** dismissed from the practice, the FQHC Administrative Manager will ensure the following occurs:
 - 1. Draft dismissal letter to patient for signature of FQHC Operations Officer or designee.
 - a. Notification of dismissal from practice.
 - b. Effective date of dismissal. Dismissal will be at least thirty (30) days from date of letter.
 - i. To maintain continuity of care, if a patient makes an appointment prior to dismissal date and has medication that will need renewal in the next thirty (30) to sixty (60) days, as clinically appropriate, a bridge prescription will be provided.

- ii. In certain circumstances where there are concerns for the safety of health center employees, patients, and visitors, a dismissal without a thirty (30) day period can be made. In such instances, the FQHC Operations Officer will be notified of the request to dismiss without thirty (30) days' notice and will make the final decision.
 - c. Include the Authorization to Disclose Patient Health information form.
 - d. If the patient is uninsured, a list of available primary care providers and/or other Federal Qualified Health Centers (FQHC) will be provided.
 - i. If a patient has medical insurance, the provider relations department at the insurance company will be contacted to notify them of the dismissal and complete any required documentation.
 2. Mail the dismissal letter to the patient via regular United States Postal Service (USPS) AND via certified mail via USPS.
 3. Scan a copy of the following into patient's EHR of all the materials: the dismissal letter, the original certified mail receipt (showing that the letter was sent), and the original certified mail *return* receipt (even if the patient refuses to sign for the certified letter).
 - a. Select "Patient Docs"
 - b. Select "Misc" folder.
 - c. Save
 4. Place an alert in the patient's electronic health record (EHR) noting the dismissal and the effective date.
 5. Notify Security of patient's dismissal.

V. DIRECT RELATED INQUIRIES TO

FQHC Operations Officer
FQHC Administrative Manager
SNHD General Counsel

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 0		First issuance

VI. ATTACHMENTS

Attachment No. CHCA-019 ATT-1, Warning and Dismissal Letter Template

Attachment No. CHCA-019 ATT-2, Authorization to Disclose Patient Health Information Form

Attachment No. CHCA-019 ATT-3, List of Nevada Federally Qualified Health Centers

To [patient name]

Please be advised that (clinic) will no longer be able to treat you as a patient. The termination of our physician/patient relationship will be effective in 30 days from the date of this letter. Your medical condition requires continuing medical supervision, and it is important that you select another healthcare provider as soon as possible.

Contact your health insurance company or (other referral services) for the names of other healthcare providers and/or clinics. Upon written authorization, a copy of your medical record will be sent to your new healthcare provider. A medical record release form is enclosed.

Sincerely,

Email completed form to legal@snhd.org or fax to (702) 759-1412



Authorization to Disclose Patient Health Information

For Office Use Only:

Approved: _____

Date: _____

Southern Nevada Health District – PO Box 3902 – Las Vegas, NV 89127 – Tele: 702-759-1364

Patient/Client Name (please print): _____ Male/Female (circle one) Birthdate: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____

I authorize the disclosure of the above named individual's Protected Health Information (PHI) and request the **Southern Nevada Health District** to release the requested information to: (Note: There is a \$0.60 per page photocopy fee)

Name (please print): _____

Address: _____

Release of Information may be (indicate **one**): _____ Mailed; Faxed to a **secure** Fax # _____;
 _____ Call for in-person pickup; Emailed encrypted to: _____

The purpose for this requested information is:

- Continuity of Care Personal use Consultation School Transfer Attorney Insurance
 Other, specify: _____

The following information is requested:

- | | |
|--|--|
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Sexual Health Clinic |
| <input type="checkbox"/> TB Clinic Records | <input type="checkbox"/> HIV Case Management |
| <input type="checkbox"/> Lab Test (specify type of test) _____ | <input type="checkbox"/> Family Planning Records |
| <input type="checkbox"/> Refugee Clinic Records | <input type="checkbox"/> Outreach HIV/STD screening |
| <input type="checkbox"/> Food handler/Health Card Testing | <input type="checkbox"/> Healthy Kids Exam/Maternal Child Health Records |
| | <input type="checkbox"/> Other, specify: _____ |
| | <input type="checkbox"/> Specify dates of services, if known: _____ |

I acknowledge and hereby understand that releasing my health records may contain information relating to HIV or AIDS, treatment for alcohol and/or drug abuse, and/or sexually transmitted disease.

I consent to release: HIV or AIDS, treatment for alcohol and/or drug abuse, and/or sexually transmitted disease. _____ (INITIALS).

This authorization will expire on the following date or event: _____ or 180 days from date of signature.

I understand that:

1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization except where the treatment is for the purpose of research or solely for purpose of creating a health record for disclosure to a third party.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.

The Southern Nevada Health District, its employees and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Patient's Legal Representative_____
Today's Date_____
Print Name of Legal Representative (if applicable)_____
Relationship to Patient (if not the Patient)

Note: Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork

Enviar el formulario completo por fax al
(702) 759-1412 A/A. Dpto. Legal

Solo para uso oficial:
Aprobado: _____
Fecha: _____



Autorización para divulgar
Información de salud del paciente

Southern Nevada Health District (Distrito de Salud del Sur de Nevada) - PO Box 3902 - Las Vegas, NV 89127 -
Tel.: 702-759-1364

Nombre del paciente (en imprenta): _____ Masculino/Femenino (encierre uno en un círculo) Fecha de nacimiento: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código postal: _____

Teléfono: _____

Autorizo la divulgación de la Información de salud protegida (PHI, por sus siglas en inglés) de la persona antes mencionada y solicito al **Distrito de Salud del Sur de Nevada** que entregue la información solicitada a: (Nota: se cobrarán \$0.60 por página fotocopiada)

Nombre (en letra de imprenta): _____

Dirección: _____

La divulgación de información puede hacerse (marque de uno): _____ Por correo postal; Por fax a un número **seguro** _____; _____ Llame para recogerlo en persona;

Por correo electrónico cifrado a: _____

El propósito de esta información solicitada es:

- Continuidad de atención
- Uso personal
- Consulta
- Transferencia escolar
- Abogado
- Seguro
- Otros, especifique: _____

Se solicita la siguiente información:

- Reporte de Papanicolaou
- Examen ginecológico
- Imágenes de Radiografías/ Rayos X
- Registros vacunación
- Clínica de salud sexual
- Administración de casos de VIH
- Registros de Planificación familiar
- Registros de Programa de Exámenes de Niños Sanos/ Programa de Salud Materno-infantil
- Otro, especifique: _____
- Especifique las fechas de los servicios, si las conoce: _____

Por este medio reconozco y confirmo entender que la divulgación de mi HISTORIA CLÍNICA podría contener información relacionada con el VIH/SIDA, tratamientos por abuso de alcohol o drogas y/o enfermedades de transmisión sexual.

Doy mi consentimiento para divulgar información sobre VIH/SIDA, tratamientos por abuso de alcohol o drogas y/o enfermedades de transmisión sexual _____ (INICIALES).

Esta autorización vencerá en la siguiente fecha o evento: _____ o 180 días después de la fecha de su firma.

Entiendo que:

1. Autorizar esta divulgación de información es un acto voluntario y puedo negarme a firmar esta autorización.
2. Mi tratamiento, el pago, la inscripción o la elegibilidad para obtener beneficios, no estarán condicionados a la firma de esta autorización, salvo cuando el tratamiento tenga fines de investigación o el propósito exclusivo de crear una historia clínica para divulgar a un tercero.
3. Podré revocar esta autorización, por escrito, en cualquier momento, exceptuando cuando se hayan tomado acciones basadas en este documento.
4. La información usada o divulgada en virtud de esta autorización podría estar sujeta a posteriores divulgaciones y dejar de estar protegida por las regulaciones federales de privacidad.

El Distrito de Salud del Sur de Nevada, sus empleados y proveedores de atención médica quedan por este medio liberados de toda responsabilidad jurídica o general por la divulgación de la información antes mencionada hasta donde se indique y autorice en el presente.

Firma del paciente o de su representante legal

Fecha de hoy

Nombre en imprenta del representante legal (si correspondiera)

Relación con el paciente (si no se trata del paciente)

Nota: Los tutores y los responsables designados por Poder legal duradero deben incluir una copia del documento correspondiente.



Nevada's FQHCs

Carson Carson City

Carson City School-Based Health Center
618 W. Musser 89703

Sierra Nevada Health Center
3325 Research Way 89706

Clark Las Vegas

Las Vegas Location
1735 N Nellis Blvd. Ste. G,
89115

Dental Office
2100 S Maryland Pkwy.
Ste. 5, 89104

Downtown Location
1200 S. 4th St. Ste.
111,89104

All for Health,
Health for All

Aghaby

Community
Health Alliance

Canyonlands
Healthcare

First Person
Care Clinic

FirstMed
Health & Wellness

Hope Christian
Health Center

Nevada
Health Centers

Northern Nevada
HOPEs

Silver State
Health Services

Southern Nevada
Community Health
Center

Tri-State
Community
Healthcare

School-Based Clinic, Valley High School
2839 Burnham Ave. 89169

FirstMed Health and Wellness Center - 3343 S. Eastern Avenue 89169

FirstMed Shadow Lane
400 Shadow Ln. Ste. 106,
89106

Cambridge Family Health Center - 3900 St. Ste. 102,
89119

Eastern Family Medical and Dental Center
2212 S. Eastern Ave. 89104

Las Vegas Outreach Clinic
47 W. Owens Ave. 89030

Martin Luther King Family Health Center - 1799 Mount Mariah Dr. 89106

Enterprise Location
1700 Wheeler Peak Dr.
89106

Silver State Health Services
1909 S Jones Blvd. 89146

Mental Health Clinic
2255 Renaissance Dr.
89119

Medical Health Clinic
2215 Renaissance Dr.
89119

Southern Nevada Health District - 280 S Decatur Blvd.
89106

Interim East Las Vegas
2950 E Bonanza Rd. 89101

Club Christ
1910 Ferrell St. 89106

Mater Academy
3900 E Bonanza Rd. 89110

The Courtyard Homeless Resource Center
1401 Las Vegas Blvd. 89101

Casa de Luz
2412 Tam Dr. 89102

Hope Recuperative Care
1581 N Main St. 89101

Clark Mesquite

Canyonlands Healthcare - Mesquite - 210 N Sandhill Blvd. 89027

Clark Laughlin

Tri-State Community Healthcare Center - 2311 S Casino Dr. 89029

Clark Henderson

Henderson Location
200 E. Horizon Ste. A-B
89015

Bower School-Based Health Center
400 Palo Verde Dr. 89015

Henderson Family Health Center - 98 E. Lake Mead Pkwy. Ste. 103, 89015

Clark Sandy Valley

Sandy Valley
115 N Miami St. 89019

Clark N. Las Vegas

FirstMed North Las Vegas
3940 North Martin Luther King Blvd. 89032



Nevada's FQHCs

Cont.

Clark North Las Vegas	Hope Christian Health Center - 4357 Corporate Center Dr. Ste. 450, 89030	Hope Christian Health Center MLK - 4040 N. Martin L. King Blvd. Ste. A, 89032	CP Squires School-Based 1312 Tonopah Ave. 89030
	Aghaby: North Las Vegas 1845 Civic Center Dr. 89030	North Las Vegas Family Health Center - 2225 Civic Center Dr. Ste. 224 89030	
Elko Carlin	Carlin Community Health Center - 310 Memory Ln. P.O Box 400, 89822	Elko Elko	
		Elko Family Medical & Dental Center 762 14th St 89801	
Elko Jackpot	Jackpot Community Health Center - 950 Lady Luck Drive, 89825	Elko West Wendover	
		Wendover Community Health Center - 925 Wells Ave PO Box 3520, 89883	
Lander Austin	Austin Medical Clinic 121 Main St P.O. Box 225, 89310	Nye Amargosa	
		Amargosa Valley Medical Clinic - 845 E. Amargosa Farm Rd. HCR 69, Box 401-V 89020	
Nye Pahrump	SSHS Pahrump 1560 Java St 89048	Storey Virginia City	
		Virginia City Community Health Center - 175 E. Carson Street Ste. A, 89440	
Washoe Lemmon Valley	Community Health Alliance North Valleys Health Center - 280 Vista Knolls Pkwy. Ste 107, 89506	Washoe Reno	
		Wells Avenue Medical/Dental Center - 1055 S Wells Ave. 89502	
Washoe Reno	Center for Complex Care 330 Campton St. 89502		
	Community Health Alliance Outreach Medical Center 335 Record St. Ste 250, 89512	Community Health Alliance Neil Road Health Center 3915 Neil Rd. 89502	
	Hope Springs 1920 E 4th St. 89512	Northern Nevada HOPES 580 W 5th St. 89503	
		Bell Steet 595 Bell St. 89503	
Washoe Sparks	Sparks Health Center 2244 Oddie Blvd. 89431	Washoe Sun Valley	
		Community Health Alliance Sun Valley Health Center - WIC Office 5295 Sun Valley Blvd Ste 8.	Sun Valley WIC Office 5295 Sun Valley Blvd Ste 8.

-  All for Health, Health for All
-  Aghaby
-  Community Health Alliance
-  Canyonlands Healthcare
-  First Person Care Clinic
-  FirstMed Health & Wellness
-  Hope Christian Health Center
-  Nevada Health Centers
-  Northern Nevada HOPES
-  Silver State Health Services
-  Southern Nevada Community Health Center
-  Tri-State Community Healthcare