Tatum Internal Medicine & Associates, PLLC

REGISTRATION FORM

(Please print, use black ink & fill this form out COMPLETELY)

Today's date: | PCP:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	I prefer to be called:	Former Name:

Marital status (circle one): Single / Married / Divorced / Separated / Widowed	Social Security #:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Home Phone #: ( )	OK to Leave Message: ☐ Yes ☐ No	Cell Phone #: ( )

P O Box:	City:	State:	ZIP Code:	Work Phone #: ( )

Email Address:	Employer/Occupation:	Employer Phone #: ( )
	Employer Address:	

How did you hear about us (Please list their name): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other:

Other family members seen here: Student Status (circle one): Full-Time Part-Time

INSURANCE INFORMATION

(Please give your insurance card(s) and photo ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )
Is this person a patient here? ☐ Yes ☐ No		Social Security #:	
Occupation:		Employer address:	Employer phone #: ( )
Employer:			

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate **primary** insurance: ☐ Aetna ☐ BCBS ☐ Cigna ☐ Healthnet ☐ Humana

☐ Medicare ☐ PacifiCare/Secure Horizons ☐ TriWest/Tricare ☐ United HealthCare ☐ Other:

Subscriber's name:	Member ID#:	Birth date: / /	Group Name:	Group #:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **secondary** insurance (if applicable):	Subscriber's name:	Member ID#:	Group Name/#:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I hereby authorize payment directly to Tatum Internal Medicine for surgical and/or medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. I also agree to pay all charges and/or co-payments at the time of service. In the event of default, I agree to pay all legal fees, collection costs, and/or medical records which may be necessary in my medical care.

Patient/Guardian signature *Date*

PATIENT HISTORY

Name:	Date of Birth:	Age	Occupation:

Have you or a blood relative ever had or now have problems with:

	Yes	No	Who		Yes	No	Who
Anxiety / depression				Heart Trouble			
Asthma				Kidney Disease			
Bleeding Tendencies				Mental Illness			
Blood Clots				Valley Fever			
Cancer				Rheumatic Fever			
Diabetes				Seizures			
Glaucoma				Tuberculosis			
High Blood Pressure				STD's			
High Cholesterol							

Other-

Relative	Age	Alive	Deceased	Present health or cause of death:
Father				
Mother				
Brothers No: ____				
Sisters No: ____				

Have you ever had any operations? Y ☐ N ☐ **If yes, please list:**

Year Operation	Year Operation	Year Operation

List other illnesses not requiring an operation for which you were hospitalized:

Do you have any **allergies** or sensitivities to medicines or other substances? Y ☐ N ☐
If yes, please list with type of reaction:

Do you have any religious or cultural beliefs which may affect your care Y ☐ N ☐
If yes, please explain:

Medications, name or otherwise identify over the counter, herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:

Do you have an Advance Directive (Living Will) in place? Y ☐ N ☐

Current tobacco use Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:
Current alcohol use Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:
Current marijuana or street drug use Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:

Check the diseases against which you have been immunized: Hepatitis B ☐ Hepatitis A ☐ Pneumovax ☐ MMR ☐ Tetanus ☐ Polio ☐ Diptheria ☐ Influenza ☐ Other:

Date / last Pap smear: Date / last Mammogram:

Are you sexually active? Y ☐ N ☐

Have you ever had a blood transfusion? Y ☐ N ☐ Date:

Is there any confidential issue that you would like to discuss with your physician? Y ☐ N ☐

Patient Signature: Date:

Provider Signature: Date:

Tatum Internal Medicine and Associates, PLLC

Patient Guidelines

Please Note: Any changes written in will not be upheld!

Insurance Coverage

- Tatum Internal Medicine & Associates, PLLC will file a claim with your insurance, if we are a contracted provider.
- If you are unable to provide verifiable insurance information (including but not limited to Identification number, Group number, Mailing address, etc.) prior to visit with the physician, charges will be due at the time of service.
- If we are not contracted with your insurance, charges will be due at the time of service and we will provide you with documentation to file for reimbursement.
- We reserve the right to bill for a physician's phone call to patient, which may or may not be covered by insurance. We will bill the insurance, but if charges are not covered by the insurance, the patient will be responsible and may have the option to schedule an appointment if they prefer.
- We do not accept any AHCCCS plans in any position in the office. This includes any authorizations or referrals for those patients.

Payment for Services

- We provide Acupuncture and Photonic Stimulation, which is not covered by most insurance companies, so charges will be due at the time of service.
- All co-pays must be paid at the time of visit. **NO EXCEPTIONS!!**
- We accept **CASH** only for co-pays. No checks accepted.
  Only exception is a Health Savings Account Visa or MasterCard.
- Motor Vehicle Accidents (MVA) are fee for service only. We do not accept 3rd party payers or liens. Payment is due on the date of service.
- Any paperwork completed by the physicians will have a fee starting at $25 due upon receipt.
- Patients may request a year end statement from the billing department for taxes.
- All refunds must be requested within one year of the date of service.

Appointments

- There is a $25 Late Cancellation Fee (less than 24 hour notice).
- There is a $50 No Show Fee.
- There is a $100 Same Day In-Office Cancellation Fee.
- If you are late for your appointment (more than 15 minutes) you may need to reschedule your appointment if we are unable to work you in with the scheduled patients.
- Patients are responsible for appointment times. As a courtesy, the office will make a confirmation call, if you do not receive a call it does not excuse a Late Cancel or No Show Fee.
- Please note, continuous Late Cancellation's or No Show's to scheduled appointments may result in dismissal from the office.

Medication Refills

- If you need a refill on an existing prescription, please call your pharmacy directly 48-72 hours prior to running out of the medication. **Please Do Not Run Out!**
- An appointment may be required for a new prescription or to refill an existing prescription.
- Any request after 12 Noon on Friday will not be filled until Monday, as we are closed on Friday afternoons and no provider will be available to approve them.

- For Mail Order prescriptions, please contact us one week prior to the date of mailing.
- Please be advised we do not mail or fax prescriptions to patients.

Diagnostic Testing

- Lab, X-ray, etc. result(s) will be called back to the patient after the physician has reviewed the information.
- Patients may be asked to make an appointment to see the provider to review the results.
- For your convenience, we provide certain labs, procedures and injections in our office. The charges for these services will be billed to your insurance company. If these charges are not a covered benefit, you will be responsible for these charges.
- All labs done outside of our office are billed separately by the lab. If you do not have a current copy of your insurance card with you, the lab may choose to bill you directly. These charges are not the responsibility of Tatum Internal Medicine & Associates, PLLC.

Messages

- Patient phone calls to the physicians MA's during other patient appointment times may be directed to voice mail.
- Routine messages will be answered by the end of business day in most cases.
- If further information is required, the call may be returned by the end of the following business day.

Referrals

- Many insurance plans require a written request (with authorization) before patients can see a specialist or obtain a procedure outside of the office.
- An appointment with physician is required to receive a referral.
- Referrals may take 7-14 business days.
- Please be advised that if the patient makes an appointment with a specialist that requires a referral, and is seen without one, the patient may be responsible for the charges. These charges are not the responsibility of Tatum Internal Medicine & Associates, PLLC.

Collections

- Statements will be sent mid-month for any account having a patient balance.
- We ask that payment be made **within 30 days** of the first statement.
- If unable to make payment in full, please contact the billing department to discuss payment options.
- All account balances over 90 days may expect a letter.
- Accounts with balances over 120 days may be referred to an outside collection agency and any fees associated with this collection attempt will be the responsibility of the patient.

I have read and understand the above guidelines set forth by Tatum Internal Medicine & Associates, PLLC. My signature indicates my acknowledgement of my responsibility for payment of fees and the acceptance of the terms outlined above. Any changes written in will not be considered by Tatum Internal Medicine & Associates, PLLC.

Patient Signature: ______________________________ Date: __________

TATUM INTERNAL MEDICINE & ASSCOIATES, P.L.L.C.

4729 E. Union Hills Dr., Suite 111
Phoenix, Arizona 85050
Phone 602-482-5444 Fax 602-482-5666

Vincent P. Cariati, MD
George W. Landrum, MD

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient Name_______________________________ Date of Birth _____/_____/_______

I authorize Tatum Internal Medicine & Associates

_____Obtain my Medical records from: Fax # (_______) ____________________
_____Release my Medical records to:

Doctor's Name________________________ Phone # (_______) ____________________

Address_____________________ City ____________ State ________ Zip ________

Please release the following information form my medical records:
___Complete Records ____ All Pertinent Information ____Date(s) of Service_____________

I hereby consent to the release of records pertaining to treatment/ diagnosis of the following:
Confidential Alcohol or Drug Abuse-Related Information (as defined in 42CFR Section 2.1 SEQ)
Confidential HIV-Related Information (as defined in A.R.S. Section 36-661)
Confidential Mental Health Diagnosis/ Treatment Information
Confidential Communicable Disease-Related Information (as defined in A.R.S. Section 36-661

Except as follows: ____

The purpose of this is for: **(Check ALL that apply)**
___Further Medical Care ____Legal ____Insurance _____Disability/Worker's compensation
___Other (specify) ____

In understanding that this authorization shall expire, without express revocation, six (6) months from The date written below (sixty [60] days for drug/alcohol abuse treatment records). I understand that A photocopy of the authorization is considered acceptable in lieu of the original.

Signature of Patient ________________________________ Date ______/______/______

Parent/Legally Auth Representative ___________________________ Relationship ____________

Signature of witness ____

Information Prepared and Released By___________________________ Date _____/_____/______

In the case of a patient who is physically unable to sign the authorization, he/she should place an "x" on The signature line and have his/her assent witness.

TATUM INTERNAL MEDICINE AND ASSOCIATES

PRIVACY NOTICE ACKNOWLEDGEMENT

I have received a copy of the NOTICE OF PRIVACY that was given to me by **Tatum Internal Medicine and Associates**. Please check one of the following areas.

○ I have read and agree to the terms of this Notice of Privacy.

○ I have read and want to limit the disclosure of my information regarding the following area:

____

____

____

____

Date: ____

Signature: ____

Name : ____
(please print)

To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

Military and Veterans. If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.

National Security and Intelligence Activities. We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you or another person; or (iii) for the safety and security of the correctional institution.

USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION

Except for the purposes already identified we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so **In writing**. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already taken some action in reliance upon your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information. You may exercise each of these rights, **In writing**, by providing us with a completed form that you can obtain from **Tatum Internal Medicine and Associates**. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from **Tatum Internal Medicine and Associates.**

Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend You have the right to request an amendment of you health information that is maintained by or for our clinic and is used to make health care decisions about you. We may deny your request if it is not properly submitted or does not include a reason to support your request. We may also deny your request if the information sought to be amended: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our clinic; (c) is not part of the information which you are permitted to inspect and copy; or (d) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of the disclosures of your health information made by us. This accounting will not include disclosures of health information that we made for purposes of treatment, payment or health care operations or pursuant to a written authorization that you have signed.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.

Right to Request Confidential Communications. You have the right To request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

QUESTIONS OR COMPLAINTS

If you have any questions regarding this notice or wish to receive additional information about our privacy practices please contact our Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with our clinic, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

TIMA

NOTICE OF PRIVACY INFORMATION PRACTICES

Effective Date: **April 14, 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THE NOTICE

Tatum Internal Medicine and Associates is committed to pre-serving the privacy and confidentiality of your health information that is created and/or maintained at our clinic. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinic, including any information that we receive from other health care providers or facilities. The Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We will abide by the terms of this Notice, Including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, which will identify its effective date, in our clinic.

The privacy practices described in this Notice will be followed by:

Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic.

All employees, students, residents, volunteers and other service providers who have access to your health information at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment, and health care operations, as further described in the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

<u>Treatment, Payment and Health Care Operations</u>. The following section describes different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

<u>Treatment</u>. We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, medication aides, technicians, medical and nursing students, rehabilitation therapy specialists, or other personnel who are involved in your health care.

<u>Payment</u>. We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.

<u>Health Care Operations</u>. We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance, and business functions of our clinic.

USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures.

<u>Appointment Reminders</u>. We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment. This includes leaving a message on your telephone or with the person answering your telephone.

<u>Treatment Alternatives & Health-Related Products and Services</u>. We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a diabetic condition, we contact you to inform you of a diabetic instruction class that is offered at out clinic

<u>Family Members and Friends</u>. We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We also may share your health information with a family member or friend who calls us to request a prescription refill for you.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

<u>As required by law</u>. We may disclose your health information when required by federal, state, or local law to do so.

<u>Public Health Activities</u>. We may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

<u>Health Oversight Activities</u>. We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

<u>Judicial or administrative proceedings</u>. We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.

<u>Worker's Compensation</u>. We may disclose your health information to worker's compensation programs when your health condition arises out of a work-related illness or injury.

<u>Law Enforcement Official</u>. We may disclose your health information in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

<u>Coroners, Medical Examiners, or Funeral Directors</u>. We may disclose your health information to a coroner or medical examiner for the Purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.

<u>Organ Procurement Organizations or Tissue Banks</u>. If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.

<u>Research</u>. We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purPoses until the particular research project for which your health information may be used r disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients With specific health are needs who may qualify to participate in the research project. Any use or disclosure of your health information that is done or the purpose of identifying qualified participants will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.

Hearing from Tatum Internal Medicine is Just Five Easy Steps Away!

Your doctor will tell you the approximate date your information will be available.
If your information is ready sooner than expected, you'll be called.

Just Follow this Simple Guide to Retrieve Your Information:

Step 1

Using a "Touch-Tone" Telephone
(A phone that beeps when you dial) Call:

480-425-5362

Step 2

To Listen to the Prompts in English, Press 1.

Step 3

Dial Your Identification Number.
ID#:_______-_____-______

Step 4

Record Your Name. End Your Recording by Pressing 1.

BE SURE TO LISTEN TO YOUR ENTIRE MESSAGE

Step 5

After Listening to Your Message, Press 1 to Repeat, 2 to Delete or 3 to Save.

You Can Now Hang Up Your Phone! That's All There is to It!