CRIMSON
INTERNAL MEDICINE

NANCY TACTUK, MD

INSTRUCTIONS FOR NEW PATIENT REGISTRATION FORMS

1. Notice of Privacy Practices – Please read, you may print out to keep for your record. You do not need to give this back to us. This is for your information only.

2. Receipt of Notice of Privacy Practices – Please complete and sign the first section only. This is a receipt for us saying that you received a copy of our Privacy Policy.

3. Consent – Please read, sign and date.

4. Patient Registration Form – Please fill in completely, sign and date

4. Patient Contact Information – Please fill in completely, sign and date.

5. Control Substance – Although you may not use any controlled substances, we ask all patients to read and sign.

6. Contact Info Update – Please fill in completely, this will help us to know the best way to contact you and also be able to send you appointment reminders if you would like to receive one.

7. Office Policies – This is just some information about us for you, you do not need to give this back to us.

When you complete all documents, you may mail them to us, email them or bring them in at your appointment time.

If you have been seeing another physician that has records that would benefit Dr. Tactuk in your plan of care, there is a Release of Medical Records on the website that you can print, sign and mail to that physician ahead of time so that we will already have those records available.

On the day of your first visit please be sure to bring the following:

1. Your registration forms if you have not already sent them to us.

2. Your Driver's License

3. All current medical insurance cards

4. All medications in the bottle that you are currently taking, including over the counter medications and Vitamins.

5. If you have a co-pay or deductible, you must pay this by check, cash or credit/debit card before seeing Dr. Tactuk, she will not be able to see you without this payment.

If you have any questions please call the office, we will be glad to help you. We hope that getting these things finished beforehand will help you to have an easier and faster first visit with us.

Thank you,

Crimson Internal Medicine, LLC

1015 Rice Valley Road North, Tuscaloosa, Alabama 35406
Phone: 205-349-1606 • Fax: 205-349-3263
www.crimsoninternalmed.com
email: adm@crimsoninternalmed.com

NOTICE OF PRIVACY PRACTICES **CRIMSON INTERNAL MEDICINE, LLC**

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.

This Notice is effective as of January 1, 2016

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is **Sharon Gilliland**. You can contact the Privacy Officer at **205-349-1606.**

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are <u>required</u> to make without your permission

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are <u>allowed</u> to make without your permission

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible health care fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

We may contact you to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
CRIMSON INTERNAL MEDICINE, LLC

PLEASE COMPLETE THE FIRST SECTION ONLY

Patient _____

Given to patient on: _____ Version/Effective Date: 01/01/2016_____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

Modified version given: _____ Version/Effective Date: _____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

Modified version given: _____ Version/Effective Date: _____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name _____ Patient ID No. _____

Person or Organization Granted this Consent:

Crimson Internal Medicine, LLC
1015 Rice Valley Road North
Tuscaloosa, Alabama 35406

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

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NANCY TACTUK, M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patients Full Name

_____

Last First Middle

_____

Street City State Zip

Phone # Home: _____ Business: _____ Cell: _____Email:_____

Birthdate: _____ Sex: M F Ethnicity: _____ Marital Status: M S D W Race:_____
Month/day/year

Social Security # _____ Drivers License # _____ Primary Language:_____

Patients Employer: _____ Position Held: _____

Employers Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Name: _____ Relationship: _____

_____

Street City State Zip

Employer:_____ Address: _____

Phone # _____ Position Held: _____ S.S. # _____

INSURANCE INFORMATION

Name of Company Subscribers Name Date of Birth Policy #

_____

_____

Medicare: _____ Medicaid: _____

Blue Cross Blue Shield: Contract # _____ Group # _____ Subscribers Name: _____

Referred By:_____ In Case of Emergency Notify:_____Phone:_____

FULL PAYMENT DUE WHEN SERVICE RENDERED UNLESS COVERED BY BLUE CROSS BLUE SHIELD PMD OR SELECTCARE PLAN. THIS PROVISION APPLIES TO ALL PATIENTS UNLESS WAIVED BY THE PHYSICIAN. IN THE EVENT THE ACCOUNT IS NOT PAID IN FULL THE UNDERSIGNED AGREES TO PAY ALL EXPENSES AND COSTS OF COLLECTION, INCLUDING ATTORNEYS'S FEES, WHETHER BY SUIT OR OTHERWISE. THE UNDERSIGNED HEREBY ASSIGNS TO AND AUTHORIZES THE RELEASE AND PAYMENT OF ANY INSURANCE BENEFITS FROM ANY INSURANCE COMPANY OR GOVERNMENT AGENCY DUE ME DIRECTLY CRIMSON INTERNAL MEDICINE, LLC IN AND FURTHER AUTHORIZES CRIMSON INTERNAL MEDICINE, LLC TO RELEASE ANY INFORMATION ACQUIRED IN EXAMINATION OR TREATMENT TO ANY INSUROR OR GOVERNMENT AGENCY.

_____ _____

DATE PATIENTS SIGNATURE

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CONTACT INFO UPDATE

Name: _____

Date of Birth: _____

If we need to contact you, how would you like for us to try you first? (phone, cell phone, mail, etc.) _____

What is your best contact number? :_____

If by phone, may we leave a message:

Answering machine____ other person____

If there is someone else that you would like for us to contact, please list them here with their information.

_____

_____

Would you like to receive an appointment reminder by text? Y or N, if yes please list your cell carrier _____

Would you like to receive an appointment reminder by e-mail? Y or N

Please be sure that all contact information with us is correct. If you have a change in this information at any time, please let us know as soon as possible.

_____

Signature

_____

Date

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PATIENT CONTACT INFORMATION
CRIMSON INTERNAL MEDICINE, LLC

The federal Privacy regulations are designed to protect and ensure the confidentiality of your protected health information.

Please assist us by naming those persons we may contact or communicate with on your behalf. For example, a relative or friend that picks up medical supplies or prescriptions for you or someone that brings you to your appointments.

The Privacy regulations permit us to communicate with your other physicians or specialists, your pharmacy and insurance company's; therefore, you do not have to list these individuals below.

I give my permission for Crimson Internal Medicine, LLC, physicians and staff, to communicate with the following person(s) on my behalf:

_____ _____ Add_____ Delete_____
Name Relationship

_____ _____ Add_____ Delete_____
Name Relationship

_____ _____ Add_____ Delete_____
Name Relationship

_____ _____ Add_____ Delete_____
Name Relationship

You may add or delete contacts from this list at any time by simply asking a member of our staff for a new form. We will update our files accordingly. Any request for changes must be in writing.

Phone Numbers:	Okay to call?	Okay to leave message?
Home: _____	Y or N	Y or N
Work: _____	Y or N	Y or N
Cell: _____	Y or N	Y or N
Other: _____	Y or N	Y or N

Person to call in case of Emergency: _____ Phone: _____

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name or Patient or Personal Representative

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CONTROL SUBSTANCE USE CONTRACT

I understand that treatment by Crimson Internal Medicine, LLC may include an attempt to manage my pain and that some of the medications needed may carry a risk of causing addiction. Because of this, special care must be taken in their use.

As a result, I, _____ agree to the following:
PLEASE PRINT NAME

1. That controlled substances prescribed will be taken exactly as directed, with adjustments made only if and as instructed.

2. There are no early refills or replacement of lost prescriptions, as federal law prohibits the writing of more than a certain number of pills at a time, and doctors and pharmacists are held accountable.

3. Attempts at altering prescriptions, selling medications, or obtaining narcotics from sources other than Dr. Tactuk will end treatment immediately.

4. Medications are given as part of an overall treatment program, and I will do all in my power to cooperate and participate in the range of nonmedicinal efforts to be undertaken.

5. When there are no alternatives other than to manage my symptoms with long term use of controlled substances, I agree that regular attempts to reduce dosage and/ or develop alternative approaches to functional comfort will be part of the plan, and I will cooperate with them.

6. I may be tested randomly for controlled substance that was prescribed to me. If the test results show that I have not been taking my medications correctly, I will be dismissed as a patient of Crimson Internal Medicine, LLC.

7. No controlled substances will be refilled on Friday or on weekends.

I have read, understood, and agree to these statements.

_____
Signature Date

_____
Witness

WE ASK ALL PATIENTS TO SIGN THIS FORM, EVEN THOUGH YOU MAY NOT BE CURRENTLY TAKING A CONTROLLED SUBSTANCE.

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OFFICE POLICIES/ PATIENT RESPONSIBILITIES

1. To be able to accommodate sick patients on a work-in basis, we have a **NO SHOW** policy as follows:

Appointments that are not cancelled 24 hours in advance will be charged a **$35.00** fee; if you are unable to reach the office, you may leave a message with our answering service after hours or on weekends.
If you cannot make it here on time for your appointment, please call the office, you may be asked to reschedule your appointment. If you get here and are already late, you also may be asked to reschedule.

2. Many insurance companies **require** a **referral** to be either written or sent electronically if the patient sees **another physician** or the **Emergency Room** or other **Emergency facility**. If **your insurance requires** this referral, it is **your responsibility** to let us know this **every** time one is needed. We will be **glad** to do it for you, but **you** have to **notify us** that it is needed.

3. There will be a **$30.00** charge on all forms completed including FMLA, Life Insurance, Disability, etc. This fee **must be paid** when the form is **picked up** or **before** it is mailed or faxed. There is also a **fee** for **copies** of any test results. We will be glad to send a copy of your lab or x-ray results to your **patient portal** at no charge.

4. There is a **$15.00 fee** for all returned checks.

5. All **Labs** are drawn between **8:30 – 9:30** each morning Monday thru Friday. If you cannot come to the office during this time, you may ask for a lab form to take to LabCorp or DCH or Quest during their business hours. If your insurance **requires** you to use **a particular lab** other than **LabCorp**, please **do not** have it drawn here, you may request a lab order to take to the other lab.

6. All **co-pays must be paid** at the time of your office visit. Some insurances also have a deductible that will need to be paid. If you are **unable** to pay, we will be glad to reschedule you for another day.

7. If you have a **new insurance card**, please give to the receptionist when you check in.

8. If you have had any **changes** to any of your information such as Insurance, Name, Address, Phone, please give these changes to the receptionist when you check- in, please make sure that we have your **correct** contact information!

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9. Bring **all** of your current **medications** with you in the bottle to **every** visit.

10. Please turn **off** your cell phones when speaking to **Dr. Tactuk** or any member of the staff.

11. If you need refills on your medication, please call your pharmacy they can send these to us electronically. Remember that if you are taking a controlled substance that has to be **written,** you will have to see your physician **every 3 months**. For all other controlled substances **every 6 months**. Please make sure that you call about these by Thursday evening to be able to pick-up before the weekend. **Controlled substances will not be refilled on weekends or on Fridays.**

12. We are now sending **appointment reminders by text or email**, if you would like to receive either or both please give your information to the receptionist. There is a form available for you to complete. If you have **already** given us the information but are not receiving reminders, please check with the receptionist to be sure we have your **information correct**.

13. We have a **website, Crimsoninternalmed.com**. Please look at the website for upcoming dates that we will be closed, forms, and other information. We are also on **Facebook.**

14. As your physician, I want to provide you with the best care possible. There are services that I feel are **necessary** for the treatment of your condition and maintenance of good health that **may or may not** be covered by your insurance. You are expected to **pay** for those services in **full**, if not covered. Let me reassure you that I will order **only** the tests and treatments that I feel are **necessary** for your treatment and care. Some of these tests are as follows: Ear irrigation, Hemoccult, Glucose, Urinalysis, TB skin test, EKG, Tetanus, Pneumovax.

15. If you have any questions regarding these policies', please feel free to ask. If you have any complaints about these or anything else related to our office, please ask to speak to the Office Manager, Sharon Gilliland.

I, _____ have read and agree to the policies above

_____ Date: _____
Patient Signature

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