

**Tatum Highlands Medical Associates
Established Patient - Yearly Update**

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **Last 4 Digits SSN:** _____

Circle one option for each below:

Gender: Male Female

Marital Status: Married Divorced Widowed Single

Race: White American Indian Asian Black/African American Other Decline

Ethnicity: Not Hispanic/Latino Hispanic/Latino Decline

Address: _____ **Unit/Apt. #:** _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Pharmacy: _____ **Major Cross Streets:** _____

RELEASE OF MEDICAL INFORMATION AND PATIENT COMMUNICATION

I authorize Tatum Highlands Medical Associates to relay any and all communication regarding my lab results, medical testing, referral information, billing/account information, and other pertinent health information in the following manner.

Home Phone: _____ **May we leave a detailed message?** **Yes** **No**

Cell Phone: _____ **May we leave a detailed message?** **Yes** **No**

Email Address: _____ @ _____

I give Tatum Highlands Medical Associates permission to disclose medical and billing information to the following individuals on my behalf. If left blank, we will speak with patient only.

Name: _____ **Relationship to Patient:** _____ **Phone:** _____

Name: _____ **Relationship to Patient:** _____ **Phone:** _____

PATIENT PORTAL

Our patient portal is used as a means of communication with our patients. Our portal is a secure communication link between you and our practice. You may utilize the portal to send messages to our staff, view health records, and lab and diagnostic tests. In addition, you can view medication history and request refills on existing prescriptions.

The patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions. Information left on the portal will be addressed within 48 hours. ***Patient Initials*** _____

PRIVACY PRACTICES:

I had the opportunity to review and/or receive a copy of our Privacy Practices. ***Patient Initials*** _____

If I wish to change this release at any time, I must complete and sign a new release and communication form.

Signature of Patient or Legal Guardian

Date

Tatum Highlands Medical Associates

OFFICE AND FINANCIAL POLICIES

Thank you for choosing Tatum Highlands Medical Associates and trusting us with your healthcare needs. Please review the following office and financial policies in its entirety. Tatum Highlands Medical Associates participates with many health care plans as a convenience to our patients. Knowing what your insurance plan covers and does not cover is the patient's responsibility.

1. **FINANCIAL POLICY:** Please bring your insurance card to each office visit and have it when scheduling appointments over the phone. If your insurance changes, please verify that we are contracted with your new plan. If your insurance plan requires a copayment for office visits or you have an unmet deductible, **payment is due at the time of service**, and no exceptions will be made. Your insurance company may not cover all your healthcare costs, and your policy is a contract between you and your insurance company. It is your responsibility to know your policy and benefits, and know that **you are required to pay out of pocket for non-covered or denied services**. In addition, if you have an unpaid account balance for more than 90 days and your account is turned over to our outside collection agency, a collection transfer fee of \$45.00 will be added to your account.

2. **CANCELLATION POLICY:** Patients are seen by appointment only and that time is reserved for you. When you don't show for an appointment or cancel with less than 24 hour notice, it is a financial loss for our practice and more importantly it is an appointment we could have used for another patient. **Therefore, if we do not receive 24 hour notice for a cancellation or you no show for an appointment, you will be charged \$25.00.**

3. **MEDICATION REFILLS:** We do not prescribe medications over the phone. You must be a patient of record and be seen by one of our providers in order to receive a prescription. It is your responsibility to keep track of your medication supply. For refills of existing prescriptions, you should call your pharmacy directly or call our office during normal business hours. **Messages left for our Medical Assistants will be handled within 48 hours.** If a request is left after normal business hours, it will be addressed the next business day.

Please note, many medications and all controlled substances require an appointment with your provider at least every 90 days, so scheduling routine visits will be necessary if you are prescribed any of these medications.

4. **PATIENT PORTAL:** Our online patient portal is available for you to access patient information, ask clinical questions, and request prescription refills. However, **the patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions.** Information left on the portal will be addressed within 48 hours. If a request is left after normal business hours, the request will be addressed on the next business day.

5. **AFTER HOURS:** The provider on call is available for urgent and emergent problems only, and is not available for routine matters such as discussing labs, x-rays, or refilling prescriptions. If you require urgent medical attention you should call 911 or go to your nearest Emergency Department or Urgent Care.

6. **TREATMENT OF MINORS:** Patients under 18 must be accompanied by their parent or legal guardian.

7. **MEDICAL RECORDS:** If you request copies of your medical records, we provide the first 5 pages free of charge. However, if your records exceed 5 pages you will be charged a \$25.00 fee.

8. **FORMS:** Your provider is willing to complete medical forms you may need for FMLA, Worker's Compensation, Disability, and other necessary medical and legal forms, however there will be a \$45.00 fee to complete these forms and payment will be collected when forms are dropped off. Completed forms will be available 72 hours after the forms and the payment is received in our office.

I acknowledge that I have read and understand Tatum Highlands Medical Associates' Office and Financial Policies and agree with the policies as outlined above.

PRINT Patient's Name

SIGNATURE of Patient or Guardian

Date



Civility Policy

To our valued patients,

At Tatum Highlands Medical Associates, we train our staff to be respectful and courteous to each other and to our patients. Our employees play an important role in your care and as an extension of our providers they too need to be treated with respect.

Our *Civility Policy* is intended to promote a culture based upon mutual respect and professional communication. As your healthcare team we understand the importance of our relationship with our patients. Our goal is to provide exceptional patient care for the overall health and well-being of our patients and to provide a safe and respectful work environment for our staff and patients.

Our *Civility Policy* has no tolerance for disrespect. Therefore, we expect all parties to speak and act in a respectful manner. This policy does not permit the use of disrespectful or condescending language to staff, providers, or patients. Minor issues will be addressed in the spirit of conflict resolution, but egregious violations may result in patients or staff being dismissed from our practice.

We recognize you have a choice in your healthcare provider and we appreciate that you have chosen our practice. However, to continue our healthcare relationship we need our patients and staff to agree to our policy. If for some reason our *Civility Policy* is not agreeable for you, we will be happy to forward your records to a practice that is more suitable to your needs.

We look forward to working together and addressing the healthcare needs for you and your family.

Respectfully,

Peter F. Levins, M.D.

Peter F. Levins, M.D.
Medical Director
Tatum Highlands Medical Associates

I acknowledge that I have read, understand, and agree to abide by Tatum Highlands Medical Associates' Civility Policy. Failure to abide by the policy as outlined above may result in dismissal from this practice.

PRINT Patient's Name

SIGNATURE of Patient or Guardian

Date