TOTAL ACCESS PHYSICIANS, PSC

REGISTRATION FORM

(Please Print)

Today's date:	**Email:**

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Race:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	Zip Code:	Work phone no: ( )

Occupation:	Employer:	Cell phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Total Access Physicians, PSC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

Total Access Physicians, PSC

Office Financial Policy

Total Access Physicians believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. This is necessary to continue to provide the level of care and compassion that we desire to achieve.

1. Payment: Payment is expected at the time of your visit. This includes your co-pay, deductible, co-insurance, or any other non-covered services. We accept cash, check, and all major credit cards.

2. Insurance: We are a participating provider with most major insurance carriers. We will file all of these claims. Please be sure, however, to check with your insurance to verify that we are in network. With so many insurance products out there, we cannot guarantee your eligibility and coverage. It is ultimately your responsibility to provide us with the most current information at each office visit. There may be a charge if a claim has to be resubmitted due to the wrong information given at the time of appointment.

3. Late charges: A 10% late charge will be applied to all patient balances 90 days old or greater.

4. Returned checks: You will be charged $30 for any check that is returned for non-sufficient funds. If your check is returned, all future payments must be paid with cash or credit card.

5. Accounting Principles: Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. Paperwork: Any paperwork that needs to be filled will be a charge of $20 (there is no charge to our total access patients). Filling out these forms such as disability, insurance forms, letters, etc., requires office staff time and time away from patient care. Please allow 7-10 for the completion of these forms.

7. No insurance: Payment will be due at the time of service. If you are unable to pay in full, please make arrangements prior to your visit.

8. Lab Work: We contract with Quest as our lab provider. Any lab services not covered will be billed by Quest, not our office. Please contact the customer service number on your lab bill for questions.

9. Total Access Patients: To receive the full benefits that you receive, we do expect that your account is current and up to date. If it is not, we cannot provide the full benefits of the Total Access patient until it is paid in full.

Initial_____

10. Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. If you believe you received a bill in error or have questions, please contact our office.

11. Late Cancellations/"No Shows": We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee; this will not be covered by your insurance company.

Acknowledgement

I acknowledge that I have received and read a copy of the Total Access Physicians Financial Policies

Name_____

Date_____

Patient Request for Email Communications

Patient Name: _____

Date of Birth_____

Phone Number: _____

Email Address: _____

Communications over the Internet and / or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicated via email. To request that your provider communicate with you via email you must complete this form.

Please be advised that TAP will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS, substance abuse, mental health information) via email.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated this way.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold TAP and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via e-mail.

Signature of patient or personal representative:_____

Date:_____

TOTAL ACCESS PHYSICIANS
NOTICE OF PRIVACY PRACTICES – SUMMARY SHEET

THE ATTACHED 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.

A federal law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") creates new rights for patients of health care organizations. One of those patient rights is to information regarding the health care provider's privacy practices. Under HIPAA, we must provide you with a copy of our **Notice of Privacy Practices** (or "Notice") and we must request that you **sign at the bottom of this document** stating that we gave the Notice to you. You are not required to sign this document, but we must make an effort to request that you do so. You may review our Notice now or at a later time. At some point **you should read it carefully** because it explains:

1. Generally how we use health care information about you.
2. That we, like other health care providers, may use and disclose health information about you as part of your treatment, to arrange for payment for services provided, and for our internal operations. We are not required to have separate permission for these uses and disclosures.
3. Other circumstances where we may use or disclose information about your health where we are not required to get your permission first.
4. The rights you have with respect to health information we have about you, namely:
   - Your right to have a copy of our privacy notice;
   - Your right to review and copy health information that we may have about you;
   - Your right to an accounting for how we use and disclose your health information, other than for treatment, payment or health care operations;
   - Your right to request that we communicate with you at alternative locations, mailing addresses or telephone numbers;
   - Your right to request restrictions on how we use your health care information;
   - Your right to request an amendment to information in our records that you think is in error; and your right to file a complaint if you think your privacy rights have been violated.

We take your confidentiality very seriously. We encourage you to read our Notice of Privacy Practices and keep a copy of it for your records. THE POLICIES IN OUR NOTICE BECOME EFFECTIVE December 8, 2011.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this receipt, you acknowledge that you have reviewed, or have been given the opportunity to review, our Notice. As provided in our Notice, we may change the terms of our Notice. If we change our notice, you may obtain a revised copy by contacting Total Access Physicians or the Contact Person indicated on page one of the Notice. If we substantially change our Notice, the changed Notice will be provided to you without your having to request a new Notice.

_____ _____

Patient's printed name Patient's Signature (or signature of personal representative)

Notice Provided by:_____ Date Notice Provided:____/____/____

If no acknowledgement signature obtained, employee must indicate why signature not obtained:_____

Total Access Physicians, PSC

1838 Florence Pike, Suite B

Burlington, KY, 41005

Tel: (859) 334-0217, Fax: (859) 918-0306

http://www.tapnky.com

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Pursuant to 45 CFR 164.508

_____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Address

_____

City

_____

State

_____

Zip Code

_____

Patient Name

_____

Date of Birth

_____

Social Security Number

I authorize and request the disclosure of all protected information for the purpose of change of physician. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All Medical Records, meaning every page in my record, including but not limited to: Office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission

records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/history's, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All Physical, Occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catherization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills and records of billing to third party payers and payment or denial of benefits for the period listed below

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records.

Total Access Physicians, PSC

Name of Representative

Primary Care Physicians Office, Records Requestor

Representative Capacity (eg Attorney, records requestor, agent, etc)

1838 Old Florence Pike, Suite B

Address

Burlington

City

KY

State

41005

Zip Code

I understand the following: See CFR 164.508(c)(2)(i-iii)

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____

Signature

_____

Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____

Witness