


CRIMSON
INTERNAL MEDICINE
NANCY TACTUK, M.D.

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 Contact Information – Please fill in completely, sign and date.
5. Patient Registration Form – Please fill in completely, sign and date.
6. Control Substance – Although you may not use any controlled substances, we ask all patients to read and sign.
7. 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.
8. Patient Medical History, Family History, Social History – Please fill in completely.
9. 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, drop them off at the office or bring them in at your appointment time, if you bring them in on the day of your appointment, please come in 30 mins before 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 question's please call the office, we will be glad to help you. We hope that getting this paperwork 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

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 required 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 allowed 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: _____

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 of Patient or Personal Representative


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**CONTROL SUBSTANCE USE CONTRACT/CONSENT TO OBTAIN ELECTRONIC
MEDICATION HISTORY**

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, 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, or if substances that I have not been prescribed and were not disclosed to Dr. Tactuk are detected, or if there are any illegal substances detected, I will be dismissed as a patient of Crimson Internal Medicine, LLC.
7. No controlled substances will be refilled on Friday or on weekends.

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Crimson Internal Medicine physicians to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

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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ADDITIONAL CONTACT INFORMATION

Name: _____ Date of Birth: _____

In case of an EMERGENCY, we need to have someone that we can call to notify on your behalf. THIS SHOULD BE A TELEPHONE NUMBER OTHER THAN THE NUMBERS WE HAVE ON FILE FOR YOU!

PLEASE DO NOT LEAVE THIS BLANK!

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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.

NAME: _____ PHONE: _____

Would you like to receive an appointment reminder by TEXT? Y or N, if yes please list your cell carrier _____. You should receive this text 2 days before your appt. **PLEASE respond to the text!**

TO CONFIRM: OK

TO CANCEL: CX

TO RESCHEDULE: R

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. You can check your information in your Patient Portal. You can also send us a message to change any information that is not correct or that has changed through your Patient Portal. There is a direct link to the Patient Portal on our website: www.crimsoninternalmed.com

Signature

Date: _____

PAST SERIOUS ILLNESS:

ILLNESS	DATE

FAMILY HISTORY:

Is your Mother still living? **Yes/ No** If deceased, at what age? _____ Cause of Death: _____

Any other health problems: _____

Is your Father still living? **Yes/ No** If deceased, at what age? _____ Cause of Death: _____

Any other health problems _____

Does/did any other close blood relative have any health problems such as heart disease, high blood pressure, diabetes, cancer, etc? _____

Social History:

Relationship Status: (Please Circle) **Single Married Divorced Separated Widowed**
Caffeine (Cups per day) **Coffee** _____ **Tea** _____ **Soda** _____ **Energy Drinks** _____
Exercise Regularly? **Yes/ No** Do you use any Recreational Drugs? **Yes/No**

TOBACCO HISTORY:

Do you currently use tobacco? **Yes / No** _____Cigarettes _____Cigars _____Pipe _____Smokeless _____Vape

Have you used Tobacco in the past? **Yes /No** How much do/did you smoke per day? _____ How long? _____

ALCOHOL HISTORY:

Do you drink alcohol: **Social/ Occasionally** * **Daily Weekly** How Much _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my physician's office of any changes in my medical status.

Patient's Signature

Date


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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 at least **24 hours** in advance will be charged a **\$50.00** 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 **8:00 – 9:00** 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 to be able to pick-up before the weekend. **Controlled substances will not be refilled on weekends or on Fridays**. If you call our office please have the **name of your medication, the milligram, and how you are taking it**, the staff will **not** be able to take your message without **all** of this information.
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 and Instagram**.
14. Please take advantage of your **Patient Portal**, you can see your test results, make copies of your results, check your medications and information, send us messages - **NO EMERGENCY MESSAGES PLEASE**, these messages are not always answered on the day sent. There is also other information available to you in your Patient Portal.
15. 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, Hemocult, Glucose, Urinalysis, TB skin test, EKG, Tetanus, Pneumovax. You also have the right to refuse.
16. 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