Priya Tandon MD LLC
7 Park Avenue, Suite 1
Colchester, CT 06415
(860)537-2309
(888)297-2226

Office Policies

The following paperwork will remain in affect and honored from the date signed until you notify the office of Priya Tandon MD, LLC in writing that you wish to terminate.

X________________________________Date_________________________.

HIPAA Agreement

I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that I may revoke this authorization in writing at anytime by delivering such written revocation to the Privacy Officer of Priya Tandon MD, LLC. I also understand that such revocation will not be effective as to the disclosure of medical records whose release I have previously authorized, or where other action has been taken in reference on an authorization I have signed. I understand that information used or discussed pursuant to this authorization could be subject to re disclosure by the recipient and if so may not be subject to federal or state law protecting its confidentiality. COPY PROVDED Priya Tandon MD, LLC shall provide a copy of this signed authorization to you upon your request. This information will be disclosed to you form records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific consent of the person to whom it pertains. Connecticut state law requires any individual or the individuals authorized legal representative to give specific consent for the release of protected health information related to certain diseases and conditions. By my signature below, I authorize release of the above medical information that may be held by Priya Tandon MD, LLC information pertaining to my HIV status and records of care and treatment of HIV/AIDS, records of mental health care and records of substance abuse care and treatment.
In addition, Priya Tandon MD, LLC, has provided me with an office copy of their PRIVACY PRACTIVE NOTIFICATION that describes how medical information about me may be used and disclosed and how I access this in accordance with HIPAA federal guidelines. I acknowledge that I have been given the office copy of the Privacy Notice and have been offered a personal copy if so desired.

X________________________________Date:_________________________.

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Statement of Financial Responsibility

The office of Priya Tandon MD LLC will verify your insurance coverage and bill the insurance carrier(s) on your behalf. You are responsible for payment of any deductible, copayment or coinsurance as determined with your insurance plan. The office expects these payments at the time of service. If your carrier denies any part of your claim you will be asked to pay this balance in full. The office will be happy to work with you in arranging a payment plan if needed,

By signing below you agree to full payment of any financial responsibility your insurance carrier does not cover

X______________________________________ Date____________________.

No Show Patient Policy

The office must now implement a policy addressing "No Show Patients" those who fail to show up for their scheduled appointments without informing the office in a timely manner.

If for any reason you need to cancel your appointment please notify the office as soon as possible. If you do not show up for your scheduled appointment or call and cancel less than 24 hours in advance you will be considered a "No Show Patient" and there will be a charge of $40 for a follow up appointment $60 for any physical exam appointment and a $75 for a pulmonary function test appointment.

By your signature below you attest that you have read and fully understand this office policy and agree to pay the above fees if applicable.

X______________________________________ Date____________________.

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Physicals

Please be aware that if your insurance pays 100% for a physical exam you may be charged a co pay, coinsurance or deductible if there are problems discussed during your office visit. Dr. Tandon is willing to make extra time at your physical to discuss your concerns but these are not considered part of a preventative office visit. All co pays will be due at the time of service. Per your specific insurance plan you may need to pay a coinsurance or deductible for your physical.

Signature ____________________ Date __________.

Balances and Co pays

In order for you to be seen all balances need to be paid in full as well as any co pay for your date of service. If you cannot pay your balance or co pay we will gladly reschedule your appointment for anther day when you can pay your balance and/ co pay.

Signature ____________________ Date __________.

Walk In Appointments

Please be aware that if the office tries to accommodate everyone's schedules and with that sometimes we do need to book against previously scheduled appointments. As you can understand this puts our office behind schedule at times. There is a code used for this and walk in appointments that will be used if there is a walk in office visit or an appointment that needed to be booked against another the code is 99058 and the definition of the code is "services provided in office on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service". Some insurance companies do not cover this code and it will be then changed to patient responsibility.

Signature ____________________ Date __________.