Medical Records Release

Name:_____ **DOB:**_____

I authorize the release of, or request access to the information specified below from my medical records.

Reason for information needed:

Transfer of care Continuation of care

Information to be released:

All dates of care Date(s) to be included

Other

Information may be released to:

Priya Tandon MD, LLC
7 Park Ave, Suite 1
Colchester, CT 06415
Phone: 860-537-2309
Fax: 888-297-2226

From:

_____
_____
_____
_____

I understand that my records are confidential and cannot be released without my written consent, accept otherwise permitted by law.
I understand that the specified information to be released may include but is not limited to history, diagnoses and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV/AIDS.
I understand that I may revoke my request in writing at any time except to the extent that action has been taken in reliance upon authorization.
This authorization will expire in 1 year from the signature date.

Date:_____ **Signature:**_____

Patient/Parent/Authorized Rep
Name of Authorized Rep:

_____

Priya Tandon MD, LLC

7 Park Ave, Suite 1
Colchester, CT 06415

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 at the time of service.*** Please be aware that some insurance plans cover a physical exam in full however you may be responsible for a copayment, deductible, or coinsurance if they decide that something other than wellness issues were discussed.

Balances must be paid in full at time of service this includes any deductible, coinsurances, and copayments. The office would be happy to work with you in arranging a payment plan if needed.

Signing this you agree to full payment of financial responsibility your insurance does not cover.

Signature:_____
Date:_____

No Show, Late, and Cancellation Policy:

We schedule our appointments so that each patient receives the right amount of time with Dr. Tandon. That is why it is very important to keep your scheduled appointment with us and arrive on time.
As a courtesy we remind patients 2 business days in advance of their appointment. If you cannot make your appointment, ***please contact the office 24 hours in advance so we can reschedule you, and accommodate those patients who are waiting for an appointment.***

If you do not reschedule or cancel your appointment within 24 hours there will be a fee assessed.

By signing this you agree to cancel or reschedule your appoint at least 24 hours in advance. If less than the 24 hours a fee will be assessed to you.

Signature:_____
Date:_____

Priya Tandon MD, LLC

7 Park Ave, Suite 1
Colchester, CT 06415

The federal government requires medical offices to make all patients aware that they have rights regarding the use of their personal health information. A copy of this Notice of Privacy Practices is available for you at the front desk. We are providing this form to comply with the Health Insurance Portability Act of 1996. (HIPAA)

By signing this form you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices. You have the right to revoke this at any time, in writing. However, such revocation will not affect any disclosures we have already made in reliance on your prior consent. You have a right to request a restriction or limitation on medical information we use or disclose about your for your treatment, payment, or healthcare operation, this request must be done in writing.

The patient understands that Priya Tandon MD

* Will not disclose any information to future doctor, attorney, life insurance Company, and workman's Compensation Company without written consent.
* Protected health information may be used for treatment through your current doctors, payment with your insurance company, or healthcare operations within this office.
* The practice has a copy of the Notice of Privacy Practices that the patient may review at any time.
* The practice has the right to change the Notice of Privacy Practices
* The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
*The patient may revoke this consent in writing at any time and all future disclosures will then cease.
*The practice may condition receipt of treatment upon the execution of this consent

Signature:_____

Date:_____

PATIENT MEDICARE PROVIDER & SUPPLIER INFORMATION
Medicare Required this Information with Medicare Physicals

Patient Name:_____ **DOB:**_____ **chart #**_____

Please list all Physicians that you are seeing: **updated**

Name of Physician	What kind of Dr.	2017	2018	2019	2020	2021	2022
Dr.							
Dr.							
Dr.							
Dr.							
Dr.							
Dr.							
Dr.							
Dr.							

I am not seeing any other Physicians for any medical conditions at this time other than those listed above.

Patient signs_____ **date**_____

SUPPLIERS NAME	PRODUCTS	2017	2018	2019	2020	2021	2022
List suppliers name for each product you receive.	**Products:catheters, needles, blood sugar strips, Diabetes supplies, oxygen tanks, asthma supplies, CPAP**						

I am not getting any supplies at this time other than those listed above.

Patient signs_____ **date**_____

Dr. Priya Tandon, MD
Internal Medicine

Agreement to Receive Chronic Care Management Services

Medicare, effective January, 2015 covers Chronic Care Management (CCM) services.

Dr. Pnya Tandon, MD is now able to provide Chronic Care Management (CCM) services, and I have been informed that I would benefit from CCM services, included those provided in between visits. In addition, I have been informed I meet the clinical eligibility to receive CCM services based on my diagnostic conditions.

The CCM services that Dr. Priya Tandon, MD will provide me under this agreement include the following:

- Access to my care team 24 hours a day, 7 days a week, including telephone access and other non-face-to-face means of communication (e.g., E-Mail),
- The ability to get successive, routine appointments with my designated primary care provider or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including:
  - » Referrals to other health care providers
  - » Follow-up after I visit an emergency department
  - » Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility)
  - » Coordination with home- and community-based providers of clinical services

My signature below indicates my understanding and agreement to receive CCM services and that I understand;

- Dr. Priya Tandon, MD is designated by me for purposes of providing CCM to me and for submitting claims for payment to Medicare for the CCM services
- I will receive a copy of my comprehensive plan of care
- Dr. Priya Tandon, MD is authorized to electronically communicate my medical information with other treating providers as part of the care coordination involved in CCM services
- Medicare will only pay one professional/ practice for CCM services provided to me during a calendar month,
- CCM services are subject to the usual Medicare deductible and coinsurance applied to my Medicare Part B services, and
- I can revoke this agreement at any time (effective at the end of the current calendar month) and can choose to receive these services from another physician or not to receive CCM services at all after the calendar month in which I revoke this agreement.

This agreement is effective as of the date below.

Professional/practice: _____

Patient name (please print): _____

Patient or guardian signature: _____ Date: _____

7 Park Avenue, Suite 1 | Colchester, CT 06415 | 860-537-2309