PROVIDER DR. TANYA UNDERWOOD

DATE ____/____/____ EMAIL ADDRESS _____

PATIENT REGISTRATION INFORMATION

PLEASE PROVIDE AS LEGIBLE AS POSSIBLE THE FOLLOWING INFORMATION

Patient Name:		Social Security Number:	Date of Birth:	Age:
Address:		Sex: Male Female	Phone Number:	
City:	State: Zip:	Marital Staus: Single Married	Alternative Phone Number:	
Referal Source:		Spouse Name:	Work Phone:	
Family Medical Doctor:		Occupation:	Employer:	

RESPONSIBLE PARTY/ PRIMARY CARD HOLDER

Name:	D.O.B.	Social Security No:	Relationship:	Phone:
Address:		City:	State:	Zip:
Employer:		Address:	Phone:	

NOTIFY IN CASE OF EMERGENCY

Name:	Relation:	Phone:	Alternative Phone:
Address:	City:	State:	Zip:

INSURANCE INFORMATION

Primary Behavioral Health Insurance Carrier:	Payor ID No:	Identification No:
Address:		Primary Group Number:
Secondary Behavioral Health Insurance Carrier:		Secondary Group No:
Address:		Phone No:

To protect your privacy,please indicate how you woud prefer to be contacted.(Please choose the following):

- ☐ Call you at your phone number.
- ☐ Leave a message at your phone number.
- ☐ You prefer that staff does not confirm your appointment.

Please read and sign:

I authorize the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treament. I also authorize payment of medical benefit to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any service defined as a non-covered service, I will be responsible for any amount due.

SIGNED: _____ DATE: _____/_____/_____

Name:_____ DOB: _____ Date: _____

Medical History

Fax: _____

Full name of primary care physician: _____ Phone: _____

Date of last physical exam: _____

Name of Pharmacy: _____ Phone: _____

Location (cross streets): _____

Do you have any ALLERGIES to medications? ____YES (list): _____ NO:_____
Medications you are currently taking:

Name _____Dose/Frequency: _____

Name _____Dose/Frequency: _____

Name _____Dose/Frequency: _____

Name _____Dose/Frequency: _____

Name _____Dose/Frequency: _____

Name _____Dose/Frequency: _____

Have you ever had or do you have...	**Yes**	**No**	**List / When**
1. Any operations?			
2. Asthma, allergies, hay fever, or sinusitis?			
3. Diabetes or thyroid problems?			
4. Heart problems or high blood pressure?			
5. Liver, kidney, or lung disease?			
6. Hepatitis or jaundice?			
7. Ulcers or stomach problems?			
8. Epilepsy or strokes?			
9. Bleeding or clotting disorders?			
10. Head injury with loss of consciousness?			
11. Arthritis, painful joints, or skin rash?			
12. Cancer swollen, glands, night sweats?			
13. AIDS or positive HIV test?			
14. Problems with sexual functioning?			
15. Are you on any particular diet?			
16. Women: Are you pregnant?			

_____ _____

Patient Signature Date

_____ _____

Doctor Signature Date

TANYA UNDERWOOD D.O. PLLC
PO Box 248
Cortaro, AZ 85652
PH: (520) 638-5997 FAX: (520)372-2552

COORDINATION OF HEALTH CARE FORM

Dear Dr. _____, Fax Number: _____

Your patient, _____, is receiving behavioral health services. This information may be helpful for you in managing the patient's medical care.

The current diagnosis is _____.

Medications are being managed by Dr. Tanya Underwood_____.

Current medications are: _____.

Treatment goals include: _____

_____.

If you need additional information or have questions, please contact the office.

Sincerely,

_____ _____
Provider's Signature Date

****CONSENT TO RELEASE INFORMATION****

- ☐ Patient refused to authorize communication. Do not send form; place in patient's file.
- ☐ Consent to release/exchange information signed below:

I hereby authorize release and/or exchange of information with my Primary Care Physician to allow for coordination of my care and treatment. I understand this authorization may be revoked by me at any time, except to the extent action has been taken.

_____ _____
Patient/Parent/Legal Guardian's Signature Date

Financial Responsibility Agreement

To our patients:

Provider's fees vary depending upon the type and length of service when you are seeing a Psychiatrist (D.O.). Session time may include interviewing, therapy, planning, reports, dictation, related telephone conversations and any other time spent concerning the patient. There may also be a charge for frequent or lengthy (greater than five minutes) telephone contact with patients.

Self – Pay Fee Schedule

	D.O.
Initial Evaluation	$350
Office Visit 31-59 min	$200-$300
Office Visit 15-30 min	$100- $200
Office Visit Less than 15 min	$100

Many insurance plans have preset fees which are not affected by these rates. Please discuss any concerns with your Doctor/Nurse Practitioner.

No Show or Late Cancellation Policy: **Patient's Initials:** _____

A fee at least **$80** will be charged for appointments not kept or cancelled less than **48 Business Hours** in advance.

We consider follow up appointments necessary for appropriate medical care. If you have not been seen within a year, your chart will automatically be closed. **Patient's Initials:**_____

It is expected that payment be made in full for the appointment fee or insurance co-pay/co-ins at each appointment. If services rendered are not paid by your insurance, you will be responsible for any balance due. There will also be a $35 fee for returned checks.

I have read, understand and will comply with the above agreement.

_____ _____

Signature of Patient/Responsible Party Date

_____

Patient Name (Please Print)

Effective January 1, 2017
NOTICE OF PRIVACY PRACTICES FOR PROVIDER'S OFFICE

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request of copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
The Provider's Office Privacy Officer, PO Box 248, Cortaro, AZ 85652, (520) 638-5997.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our providers and staff – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entitles to assist in their billing and collection efforts.
3. **Health care operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operation, our practice may use your PHI to evaluate the quality of care you received from, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a friend take their child to the doctor's office for treatment. In this example, the friend may have access to this child's medical information.
8. **Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient(including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health oversight activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.
3. **Lawsuits and similar proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law enforcement.** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death, we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process.

HIPAA PRIVACY RULE CONTINUED:

- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
   - **A.** The use of disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a healthy or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
   - **B.** The research could not practicably be conducted without the waiver,
   - **C.** The research could not practicably be conducted without access to and use of the PHI.
7. **Serious threats to health or safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
9. **National security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
10. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: a). for the institution to provide health care services to you, b). for the safety and security of the institution, and/or c). to protect your health and safety or the health and safety of other individuals.
11. **Worker's compensation.** Our practice may release your PHI for worker's compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a request to the Provider's Office Scheduling Department, (520) 638-5997 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care of the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Provider's Office Medical Records Department, (520) 638-5997. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To when you want the limits to apply.

3. **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Provider's Office Medical Records Department, (520) 638-5997 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the review.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Provider's Office Medical Records Department, (520) 638-5997. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Account of disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the staff; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Provider's Office Billing Department, (520) 638-5997. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before January 1, 2017. The list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the cost involved with additional requests, and you may withdraw your request before you incur any cost.
6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Provider's Office Medical Records (520) 638-5997.
7. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Provider's Office Privacy Officer (520) 638-5997. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note: We are required to retain records of your care.*

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Provider's Office Privacy Officer at (520) 638-5997.

I acknowledge I have received a copy of this office's Notice Of Privacy Practices.

PRINT PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____ DATE: _____