CRIMSON
INTERNAL MEDICINE

NANCY TACTUK, M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patients Full Name

_____

Last First Middle

_____

Street City State Zip

Phone # Home _____ Business _____ Cell: Cell Carrier:

Email:_____ Would you like to receive appointment reminders by Text? Y or N Email? Y or N

Birthdate: _____ Sex: M F Ethnicity: _____ Marital Status: M S D W Race:_____
Month/day/year

Social Security # _____ Drivers License # _____ Primary Language:_____

Patients Employer: _____ Position Held.

Employers Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Name: _____ Relationship: _____ DOB: _____

Employer:_____ Address: _____

Phone # _____ Position Held: _____ S.S. # _____

INSURANCE INFORMATION

Name of Company Subscribers Name Date of Birth Policy #

_____

_____

Medicare: _____ Medicaid: _____

Blue Cross Blue Shield: Contract # _____ Group # _____ Subscribers Name: _____

Referred By:_____ In Case of Emergency Notify:_____Phone:_____

FULL PAYMENT DUE WHEN SERVICE RENDERED UNLESS COVERED BY BLUE CROSS BLUE SHIELD PMD OR SELECTCARE PLAN. THIS PROVISION APPLIES TO ALL PATIENTS UNLESS WAIVED BY THE PHYSICIAN. IN THE EVENT THE ACCOUNT IS NOT PAID IN FULL THE UNDERSIGNED AGREES TO PAY ALL EXPENSES AND COSTS OF COLLECTION, INCLUDING ATTORNEYS'S FEES, WHETHER BY SUIT OR OTHERWISE. THE UNDERSIGNED HEREBY ASSIGNS TO AND AUTHORIZES THE RELEASE AND PAYMENT OF ANY INSURANCE BENEFITS FROM ANY INSURANCE COMPANY OR GOVERNMENT AGENCY DUE ME DIRECTLY CRIMSON INTERNAL MEDICINE, LLC IN AND FURTHER AUTHORIZES CRIMSON INTERNAL MEDICINE, LLC TO RELEASE ANY INFORMATION ACQUIRED IN EXAMINATION OR TREATMENT TO ANY INSUROR OR GOVERNMENT AGENCY.

_____ _____

DATE PATIENTS SIGNATURE

1015 Rice Valley Road North, Tuscaloosa, Alabama 35406
Phone: 205-349-1606 • Fax: 205-349-3263
www.crimsoninternalmed.com

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

Name	Relationship	Add / Delete
_____	_____	Add_____ Delete_____
_____	_____	Add ____ Delete_____
_____	_____	Add_____ Delete_____
_____	_____	Add_____ Delete_____

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 or Patient or Personal Representative

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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

_____ Date: _____
Signature

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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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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, Hemoccult, 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

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