tandem health

# WELCOME

We are honored that you have chosen Tandem Health for your healthcare provider. It is our responsibility to deliver the best care possible to you and your family. Providing comprehensive primary health and specialty services for all ages is a priority at Tandem Health. Services include family practice, pediatrics, adolescent primary care, women's health, behavioral health and dental services.

Patients are seen by scheduled appointments, including same day work-in appointments, for acute or routine care. Tandem Health provides quality primary care services without regard for a patient's ability to pay and serves as a community resource for eliminating health disparities.

**To Contact Your Provider During Business Hours**: If you need assistance during regular business hours, call the telephone number below that is associated with your provider's site. You may be asked to leave a message for your provider's nurse, but you should expect a call back within 24 hours.

**To Contact a Provider Before or After Business Hours**: If you are ill or need assistance before or after business hours, please call the main phone number at 803-774-4500. When prompted, choose the appropriate department from the stated options to reach the provider on call after hours, on weekends and holidays.

**Adult Medicine/Behavioral Health/Immunology**
803.774.4500
1278 N. Lafayette Drive
Hours: Monday, Tuesday, Wednesday and Friday: 8:00 am – 5:00 pm
Thursday: 8:00 am – 7:00 pm

**Family Medicine Pinewood**
803.774.4501
25 E. Clark Street, Pinewood, SC
Hours: Tuesday - Thursday:
8:00 am – 5:00 pm;
Closed Monday & Friday

**Pediatrics & Obstetrics & Gynecology**
803.774.7337 (Peds) &
803.774.6448 (OB/GYN)
370 South Pike West
Hours: Peds - Monday, Tuesday, Wednesday and Friday:
8:00 am – 5:00 pm
Thursday: 8:00 am – 7:00 pm
OB/GYN - Monday, Tuesday & Wednesday: 8:00 am - 5:00 pm
Thursday: 8:00 am - 7:00 pm;
Friday: 8:00 am - 2:00 pm

**Dental**
803.774.3600
12 Barnette Drive
Hours: Monday - Thursday
Thursday: 7:30 am - 5:30 pm;
Closed Friday

**Family Medicine Sumter**
803.774.4500
319 N. Main Street
Hours: Monday - Friday:
8:00 am – 5:00 pm

**PREPARING FOR YOUR VISIT**

In order to make your first visit more effective, please notify your health insurance company in advance of your appointment and your new primary care provider, *if required by your health insurance plan.*

Also, prior to your first visit please complete the medical records release so your records can be obtained from your previous provider (or office) in order for our provider to have the most complete information about your health prior to your appointment.

Please be on time for your appointments in order to keep your provider on schedule. If you are late, your appointment **MAY** be rescheduled for the next available New Patient opening.

Please arrive 15 minutes early if you have completed the new registration forms prior to your appointment, to allow plenty of time for our staff to get you registered for your appointment.

If you are unable to complete this packet, please arrive 30 minutes early to allow plenty of time to complete your paperwork before your scheduled appointment. You may bring your paperwork to the office prior to your scheduled appointment or mail it to the office at the address above ahead of time.

Please call our office if you have any questions or any time you need to reschedule your appointment.
If possible, please call 24 hours prior to your appointment should you need to reschedule so we can offer your appointment time to someone else who is waiting.

**MINORS**
Please make sure that you fill out the Health Care Designee(s) form if you are the parent or legal guardian of a minor child being treated at Tandem Health. If anyone other than the parent or legal guardian brings a minor to an appointment and they are not listed on the form and/or do not have a picture ID, we may not be able to see or treat the minor.

***When you arrive for your appointment, please bring the following with you:***

1. All of your **health insurance cards -** Payment is expected at the time of service for every visit. If you are unable to make your payment, please contact the Billing Office at least 24 hours prior to you scheduled appointment. You may also speak to a patient account representative when you are in the office. If there is a change in your insurance coverage, please notify us as soon as possible. There are filing deadlines and contractual agreements that we must abide by. If the correct insurance is not filed, it could result in the patient being responsible for the balance for that particular date of services. Your insurance is filed as a courtesy. However, if we are not contracted with your insurance company, we file the claim as an out of network provider. You will be responsible to pay 100% of your visit upon check-out. If your insurance company reimburses the charges for that date of service, we will refund your payment. These guidelines are in place so that every patient receives the best quality of care possible. We are honored that you have chosen us to be your primary care practice and look forward to a long and healthy relationship.
2. **Photo identification:** (current driver's license, state issued ID, student ID, military ID, or Passport)
3. **Medications**: Please bring all medications (prescription and over-the-counter including vitamins) to all appointments. We must compare your medication bottles to our records to make sure you are taking the prescribed medication appropriately and to check for refill needs. If you request a refill, please allow at least 24 hours for us to process your request.
4. Registration forms may be completed ahead of time, but you may be asked to enter the information again in our registration system while you wait.
5. All patients are asked to complete a **sliding fee application** or declare their income level. Please bring any relevant income information including tax documents, child support, food stamps, disability, etc. (this must be renewed annually on or before April 1)
   This information is confidential and only collected for reporting purposes for a federal grant.
   If you have questions about this information, please call a Patient Account Representative at 803-774-4500.

6. In addition to financial information we are also required to gather the following information for reporting:
    - Are you an agricultural worker?
    - Do you consider yourself homeless?
    - Are you a United States Veteran?
    - What do you consider your sexual orientation? What gender with which do you most closely identify? Note: “SEX” is considered your anatomical gender (or gender at birth) which will be used for your care

**LABORATORY TESTING:** We draw labs in our office and depending on your insurance carrier’s preferred lab or your personal preference, your labs will be sent to either LabCorp or Prisma Health Tuomey Hospital. Please fill out the enclosed lab testing form to indicate your preferred lab.

All lab results must be reviewed by the Provider prior to being released to the patient. Please allow 2-3 days for routine lab results to be available. In the event that your lab results need to be discussed with the Provider or a member of the clinical staff, staff will attempt to contact you via telephone. If the clinical staff cannot reach you via telephone, a letter will be mailed to the address on file.

# Release and Consents

Healthcare Designees (Minors and Others) and Release of Information

I,_____(parent, legal guardians/healthcare designee or self) authorize the person(s) named in the list below as noted in the Authorization to act or receive as noted for_____(self, minor child or individual with Healthcare designee). Please check boxes to give them additional specific authorizations.*

| NAME | BIRTHDATE | RELATIONSHIP TO PATIENT | AUTHORIZATIONS |
|---|---|---|---|
| | | | □ **Medical (includes picking up prescriptions and shot records, physical forms, diagnosis and appointment information; consent to treat / bring to appointments)**<br><br>□ **Receive Financial Information** |
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***Any other type of documents to be picked up by someone other than the parent/legal guardian(s) listed above must have written consent from the parent/legal guardian(s).**

*Visits for Preventative Care and Immunizations are an opportunity to address growth and development. Accurate and complete medical history is very important. Providers ask that the parent or legal guardian be present for these visits. However, if this is not possible the visit will occur with one of the above names and approved individuals present.*

I understand that telephone triage and advice services will not be extended to the above persons unless it is regarding direct patient care. When the above listed individuals bring a patient for their medical care at Tandem Health, their identity will be verified by asking for a picture ID. If the individual bringing the patient to the office visit does not have a picture ID and is not listed on this form, we may not be able to see the child and the appointment will be rescheduled.

Do you want results of lab tests/x-rays left on your answering machine or voicemail?
Home: □ Yes □ No Work: □ Yes □ No
(We will still leave generic information on voicemail for an appointment or to call our office.)

Do you want information given to your employer or school if they inquire about appointment absentee information?
School: □ Yes □ No Employer: □ Yes □ No

I understand that staff will contact me by mail or phone (including home/cell answering machines/voicemails) of various reports if necessary.
□ Yes □ No

Should any lab tests or pathology be done during the visit, I would prefer that my labs/pathology be sent to the following labs, if available:

□ Prisma Health Tuomey Hospital □ Labcorp (on site lab)

I understand that I am responsible for making sure that the above chosen lab is my insurance company's lab or choice and if not, I will be responsible for any charges incurred. Tandem Health only bills my insurance company for labs that are CLIA waived (i.e. finger sticks, rapid flu and strep tests, urinalysis, etc.). All other lab tests and pathology are billed to the patient's insurance by the lab selected.
□ Yes □ No

I acknowledge that I have received the Patient Bill of Rights and Notice of Privacy Practices brochure.
□ Yes □ No

I acknowledge that Tandem Health participates in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. If you choose to opt out, your health information will not be shared among health care providers through the HIE. Instead, your providers will continue to share your information by phone, fax, mail or limited computer networks. You may opt-out at any time.
□ Yes □ No

## Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Tandem Health. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient in writing.

I understand by signing this form that I am consenting to medical treatment by Tandem Health.

I understand by signing this form that I am consenting to release of medication history to Tandem Health.

**This authorization shall be reviewed and renewed yearly.**

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Witness – ONLY if patient cannot sign or signs with an "X" Date

_____ _____

(Printed Name of Patient) Relationship of Personal Representative (if signed by personal representative)

## Consent and Conditions of Treatment

In consideration of the care and treatment to be provided to the patient whose name appears at the bottom of this page at Tandem Health (Tandem Health). I/We, the undersigned, consent to and agree to the following conditions.

CONSENT FOR TREATMENT

I/We voluntarily consent to healthcare treatment and diagnostic procedures provided by Tandem Health and its associated physicians, clinicians and other personnel. I/We further consent to testing for infectious diseases, including but not limited to syphilis, AIDS/HIV, hepatitis and testing for drugs if such testing is deemed advisable by my provider. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. _____*Initials*

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I/We consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Tandem Health's Notice of Privacy Practices. _____*Initials*

ASSIGNMENT OF BENEFITS AND PAYMENT

I/We guarantee payment of all charges made for or on account of me/the patient. Unless my/the patient's account is paid in full upon discharge, I/we hereby assign the following to the physician and Tandem Health: 1) my/our rights to any and all insurance benefits I/we have or to which I/we may become entitled; 2) the proceeds for all claims resulting from or relating to the liability of or payments made by a third party so by any person, employer, or insurance company or the third party's behalf to or for the patient; 3) other finding. I /We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/We understand that Tandem Health can obtain my/our credit report for review in collection of this debt.

*For Medicare beneficiaries*: I/We have provided all necessary information for proper assignment of Medicare benefits.

_____ *Initials*

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Witness – ONLY if patient cannot sign or signs with an "X" | Date

_____ _____

(Printed Name of Patient) | Relationship of Personal Representative (if signed by personal representative)

Subsequent year review and reapprove.
New form to be completed every two years.

_____ _____

Parent / Legal Guardian / Self (print) | Relationship to Patient

_____ _____

Parent / Legal Guardian / Self Signature | Date

_____

Witness Signature

**This health center is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).**