ROBINSON & ASSOCIATES POLICIES & PROCEDURES

Please initial your agreement and understanding beside each of the following policies

Initial each policy:

CONSENT FOR TREATMENT: I consent to treatment deemed medically necessary by my physician, including but not limited to lab procedures, exams, medical treatment or procedures rendered for me. ☐

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I accept personal responsibility for payment of the charges for services rendered to me. I authorize payment of medical insurance benefits to Robinson & Associates and authorize the release of any medical information that may be necessary to process the claim. I will be responsible for the fee in excess of my insurance reasonable and customary and/or collection costs and legal fees incurred in any attempt to collect said balance. ☐

MEDICAL RELEASE AUTHORIZATION: I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to obtain/release any information requested with regard to processing my claim or for purpose of evaluation and/or comparison with examination and testing being performed on me. ☐

OCCUMED POLICY FOR FILING INSURANCE AND YOUR FINANCIAL RESPONSIBILITY: Many services provided in this office are covered and paid by your insurance company. We gladly file the claims for you, and recent federal laws require that we submit every claim to an insurance company accurately, reporting the exact services performed and the exact reason for performing them. Unfortunately, not all services are paid by the insurance company. In cases where the service has not been paid, you will be personally responsible for the bill. If you are not sure if a service is covered by your plan, you will need to call your insurance company in advance to see if you are going to be responsible for the bill. We cannot change the information on an insurance claim just so the claim will be paid by the insurance company. We recommend that every patient have an "annual exam" at which time we will update all of your known conditions, as well as look for any new problems. Unless there is some major new finding during this exam, we must submit the service to your insurance as an annual examination, which may not be paid by your insurance company. Along with the examination, we may suggest that some "screening" test be performed. These services also may be considered non-covered by your insurance company, and you will be expected to pay for them yourself. Even if the results of these tests show a problem, we must submit these tests as a screening to your insurance company. ☐

TENNCARE WAIVER: I understand that Robinson & Associates (dba OccuMed) does not accept Tenncare plans. ☐

AUTHORIZATION TO RELEASE MEDICAL INFORMATION VIA TELEPHONE: I hereby authorize the physicians and/or staff of OccuMed to leave a message regarding pending appointments, tests and/or account information at my residence. You may notify me of lab/test results, matters relating to prescriptions, my physician or a Robinson & Associates/OccuMed representative by leaving a message (check all that apply) on my ❑ answering machine/home voicemail, ❑ with my spouse, ❑ or a family member (please specify name of family members with whom we may speak) ☐

_____.

PRIVACY: I have received the privacy notice located on the back of the Welcome Letter. ☐

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Print your name If you are signing as the patient's representative, describe your authority

PERSONALIZED HEALTH HISTORY, continued- please specify details of any boxes that are checked

MEDICAL HISTORY

Mark if you've experienced:

- ☐High blood pressure
- ☐High cholesterol
- ☐Angina
- ☐Low HDL
- ☐Heart disease (CAD)
- ☐Heart attack
- ☐Heart failure
- ☐Heart murmur
- ☐Atrial fibrillation
- ☐Stroke
- ☐TIA
- ☐Diabetes
- ☐Cancer _____
- ☐Lymphoma
- ☐Melanoma
- ☐Glaucoma
- ☐Migraine
- ☐Seizures
- ☐Arthritis
- ☐Back pain
- ☐Osteoporosis
- ☐Anemia
- ☐Blood clots
- ☐COPD
- ☐Asthma
- ☐GERD
- ☐Peptic ulcer
- ☐Kidney problems
- ☐Bladder problems
- ☐Liver disease
- ☐Colon problems
- ☐Anxiety
- ☐Depression
- ☐Alzheimer's disease
- ☐Blood transfusion
- ☐Exposure to hazardous substance
- ☐Positive TB skin test
- ☐Colonoscopy
- ☐Sigmoidoscopy
- ☐Prostate exam
- ☐Cystitis
- ☐Eating disorder
- ☐Hernia
- ☐Rheumatic heart disease
- ☐Group B streptococcus
- ☐Hepatitis B
- ☐Hepatitis C
- ☐HIV
- ☐HPV
- ☐Tuberculosis
- ☐Exposed to TB
- ☐Genital herpes (Pt or partner)
- ☐Toxoplasmosis
- ☐Allergic rhinitis
- ☐Environmental allergies
- ☐Bronchopulmonary dysplasia
- ☐Eczema/Atopic dermatitis
- ☐Nasal polyps
- ☐Abdominal aortic aneurysm
- ☐Atherosclerosis
- ☐End stage renal disease
- ☐Hyperparathyroidism
- ☐Diabetic eye exam
- ☐Echo w/doppler
- ☐Obesity
- ☐Hyperthyroidism
- ☐Hypothyroidism
- ☐Liver failure
- ☐Sarcoidosis
- ☐Amyloidosis
- ☐Epilepsy
- ☐Inflammatory bowel disease
- ☐Rheumatoid arthritis
- ☐STD
- ☐Carpel tunnel syndrome
- ☐Diabetic retinopathy
- ☐Hematoma perineum
- ☐Kidney stones
- ☐Mastitis
- ☐Urinary incontinence
- ☐Illnesses/accidents
- ☐Apnea
- ☐Gastroenteritis
- ☐Iron deficiency anemia
- ☐Sickle cell disease
- ☐Sinusitis, acute
- ☐ADD
- ☐ADHD
- ☐Alcohol abuse
- ☐Constipation
- ☐Joint dislocation
- ☐Leukemia
- ☐Meningitis
- ☐Mental disorder
- ☐Sleep disorders
- ☐Stomach or intestinal disorders
- ☐Syncope
- ☐Tonsillitis, acute
- ☐Ulcerative colitis
- ☐Adenomyosis
- ☐Goiter
- ☐Graves' disease
- ☐Pancreatitis, acute
- ☐Urinary tract inf., recurrent
- ☐Hodgkin's disease
- ☐Other:_____

_____

_____

Female Only:

Last Menstral Cycle_____
Last Mammogram_____
Last PAP Smear_____
# of Children by Vag. Del._____
# of Children by CSection_____
# of Miscarriages_____
Pregnancy Difficulties:_____
Female Problems:_____

_____

_____

SOCIAL HISTORY

- o Current Smoker
- o Former Smoker
- o Never Smoked
- o Other Tobacco Use
- o Alcohol Use
- o Past Drug Use_____
- o Current Drug User
- o Use Seat Belt
- o Exercise Regularly
- o Eat healthy
- o Use Caffeine
- o Lives Alone
- o Children in home(#):_____
- o Pets
- o Employed
- o Receive Disability Payments
- o Abused
- o Sexually Active
- o > 1 sex partner in last yr
- o Sexual relations with someone who had a blood transfusion
- o Sexual relations with someone who used intravenous drugs
- o Sexual relations with someone who is homosexual or bisexual
- o Sexual relations with someone who had a STD

FAMILY HISTORY

Has anyone in your family had:

- ☐Alcoholism
- ☐Anemia
- ☐Arthritis
- ☐Asthma
- ☐Cancer _____
- ☐Colon polyps
- ☐Depression
- ☐Diabetes
- ☐Glaucoma
- ☐Heart disease (CAD)
- ☐High cholesterol
- ☐Hypertension
- ☐Osteoporosis
- ☐Pulmonary embolism/DVT
- ☐Stroke
- ☐Thyroid disease
- ☐Blindness, early onset
- ☐Deafness, early onset
- ☐Endometriosis
- ☐Fibroid tumors
- ☐Psychiatric condition
- ☐Epilepsy
- ☐Tuberculosis
- ☐Cerebral palsy
- ☐Cleft lip/cleft palate
- ☐Congenital heart defect
- ☐Congenital abnormalities
- ☐Cystic fibrosis
- ☐Down's syndrome
- ☐Hemophilia
- ☐Huntington's disease
- ☐Immunodeficiency
- ☐Infertility
- ☐Mental retardation
- ☐Multiple gestation
- ☐Muscular dystrophy
- ☐Neurofibromatosis
- ☐Niemann-Pick disease
- ☐Osteogenesis imperfecta
- ☐Other inherited genetic or chromosomal disorder
- ☐PKU
- ☐Prader-Willi syndrome
- ☐Recurrent prgncy loss/stillbirth
- ☐Sickle cell disease
- ☐Sudden infant death syndrome
- ☐Spina bifida, anencephaly, or meningomyelocele
- ☐Allergies
- ☐Eczema/Atopic dermatitis
- ☐Nasal polyps
- ☐Rhinitis
- ☐Sinusitis
- ☐Angioplasty
- ☐Cardiac stents
- ☐Coronary artery bypass graft
- ☐Heart attack
- ☐Postpartum depression
- ☐Cerebral vein thrombosis
- ☐Antithrombin III deficiency
- ☐Protein C deficiency
- ☐Protein S deficiency
- ☐ADD/ADHD
- ☐Atopic diseases
- ☐G6PD deficiency
- ☐Kidney disease
- ☐Mental health issues
- ☐Substance abuse
- ☐Exposure to TB
- ☐Coagulation disorder
- ☐Graves' disease
- ☐Systemic lupus erythematosus
- ☐Uterine fibroids
- ☐Von Willebrand disease
- ☐Anderson-Fabry disease
- ☐Benign Familial Hematuria
- ☐Chronic kidney disease
- ☐Familial focal segmental glomerulosclerosis
- ☐Familial renal amyloidosis
- ☐Medullary cystic kidney dis.
- ☐Polycystic kidney disease
- ☐Hearing loss
- ☐Other:_____

_____

_____

Signed_____ Date_____

MEDICAL HISTORY & INFORMATION REVIEW

Payment is due at time of service. It is patient's responsibility to furnish current, correct insurance information at the time of service.

Last Name: _____ First Name: _____ MI: _____ Date of Birth: ____/____/____

Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Never Married ❑ Annulled ❑ Domestic Partner

❑ Male ❑ Female SSN: _____ Preferred Language_____ Race_____

Address: _____ City/State/ZIP:_____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Check which is preferred contact #: ❑Home ❑Work ❑Cell Which doctor do you see? __Cleveland, FNP __ Robinson

Employer: _____ Employer's Address:_____

✓Pharmacy Name: _____ ✓Pharmacy Phone:_____

✓List all drug allergies and the reaction: _____

Reason for Today's Visit: _____

✓E-Mail:_____ **CONTACT INFO**_____

Spouse/Guardian Name:_____ SSN:_____ DOB:_____

Daytime # _____ Evening #_____ Alternative#_____

Emergency Contact Not Living With Patient: _____ Relationship: _____

Daytime # _____ Evening #_____ Alternative#_____

PRIMARY INSURANCE _____

ID #_____ GROUP #_____

CLAIMS ADDRESS _____

POLICY HOLDER'S NAME_____

RELATIONSHIP TO PATIENT_____

POLICY HOLDER DATE OFBIRTH ____/____/____

IS THIS THROUGH YOUR EMPLOYMENT? _____

SECONDARY INSURANCE _____

ID #_____ GROUP #_____

CLAIMS ADDRESS _____

POLICY HOLDER'S NAME_____

RELATIONSHIP TO PATIENT_____

POLICY HOLDER DATE OFBIRTH ____/____/____

IS THIS THROUGH YOUR EMPLOYMENT? _____

PERSONALIZED HEALTH HISTORY

To help us better care for you, let us know your entire health history. Please be specific in your answers below:

MEDICATIONS

List medications you take regularly, including birth control:

Medication	Dosage	#Times/Day

SURGICAL HISTORY

List any hospital stays/ surgeries, starting with most recent

DATE	REASON	HOSPITAL

Check any immunizations received and list date:

❑ Measles_____ ❑ German Measles_____ ❑ Mumps_____ ❑ Smallpox_____

❑ Hemophilus_____ ❑ Pnemonia_____ ❑ Hepatitus_____ ❑ TB Skin Test:_____

❑ Tetanus Series _____ ❑ Other _____

OVER ⇨

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT.

Uses and disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- Treatment
- Payment
- Health care options
- When release is required by law, including in judicial settings, to health oversight regulatory agencies and law enforcement
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences (or a positive indication).
- To contact you about appointment reminders, treatment alternatives and other health related benefits and services
- To the sponsor of your health care plan
- All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide.

Your Rights: You have the following rights concerning your PHI:

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, you must contact our privacy officer or the contact person. We are not required to grant your request.
- **Confidential Communication**: To receive correspondence of confidential information by alternate means or location. To do this, you must contact our privacy officer or the contact person.
- **Access:** To inspect or receive copies of your protected health information. To do this, you must contact our privacy officer or the contact person.
- **Amendments:** To request changes by made to your PHI. To do this, you must contact our privacy officer or the contact person. We are not required to grant your request.
- **Accounting:** To receive an accounting of the disclosures by us for your PHI in the last six years prior to your request. To do this, you must contact our privacy officer or the contact person.
- **This Notice:** To get updates or reissue of this notice, at your request.
- **Complaints:** To complain to us or to the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. To register a complaint with us, please contact our privacy officer. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update OF THIS NOTICE.

Privacy Contact/Officer: For more information about our privacy practices, please contact:

Pam Alexander	**3249 West Sarazen's Circle Memphis TN 38125**	**901-620-6157 or 901-756-5565**
Kristie Jordan	**1785 Nonconnah Blvd. Suite 120 Memphis TN 38132**	**901-345-6700 ext 24**

Revised : 02.20.2018

OccuMed

Lloyd E. Robinson, M.D.
Ajigne Cleveland, FNP.

1785 Nonconnah Blvd., Suite 120 · Memphis, TN 38132 · (901) 345-6700 · Fax (901) 345-6755

Thank you for choosing OccuMed! Our goal is to provide you with safe, sound medical care that is sensitive to your unique needs. We know how important good health is and desire to treat your illnesses as well as help prevent them.

Your health and well-being depends on a partnership between you and your physician and others on the healthcare team. Our partnership is of greatest benefit to you when you bring your medical problems to our attention in a timely fashion, provide information about your medical condition to the best of your ability, ask questions about your care and treatment, and actively participate in your health care management. We want you to feel comfortable in our office and have written this letter to include information that should help answer some of your questions about our practice. Please feel free to discuss any of the following topics with our staff:

Office Hours and Appointments: The office hours are 8AM to 4:30PM, Monday through Friday. Appointments are scheduled using three categories. 1) Urgent – within 24 hours of the call. 2) Routine or non-urgent – within two weeks. 3) Physical exams – within six weeks. We ask that you make every effort to arrive on time (or a few minutes early) for your appointment. If it is necessary to cancel an appointment, call the office as soon as possible to reschedule. This will allow others to get an earlier appointment.

Emergencies: Our physicians are available 24 hours a day to meet your needs when emergencies occur. **If you need urgent attention, please go to the nearest emergency room or call 911 for assistance.** The emergency room physician will evaluate your medical problem and consult with our on-call physicians when necessary. If you are uncertain what to do, please call our office and a nurse can give you advice on how to proceed. If the office is closed, you can call the office number at **901-345-6700**, and the answering service personnel will have the "on-call" physician call you back.

Consultations and Procedures: There may be times when the physician must refer you to a specialist. When you are referred to a specialist in consultation or when you have a medical/surgical procedure scheduled, many insurance companies require pre-authorization. Please let us know each time your insurance company requires pre-authorization.

Annual Physical/Preventive Health: As a rule, an annual physical exam and most screening tests are not covered by insurance. However, some insurance companies specifically pay for an "annual" physical examination and some preventive medicine services (like mammography). In most of these situations, the insurance company will pay 100% of the cost for these preventive services, even if you have not yet met your deductible. If you have health insurance that does pay for an "annual" physical examination or other preventive services, make sure your physician or nurse is aware of this information.

Prescription Refills: Many medications require ongoing refills; however, it is possible to run out of your medication refills before your next appointment. It is important not to miss any doses of certain medications. Please call during our normal business hours for a refill when you have at least **seven days** of the medication remaining to avoid waiting unnecessarily at the pharmacy or missing any of your doses. If you have any confusion about whether or not to continue a medication that has no more refills, please call our office and we will give you the proper advice. ***Please make sure you have your pharmacy number available when calling for refills.*** Your prescription will be filled within 24 hours of your request.

Payment Policies Billing: You will receive a bill from our office after your charges have been processed by your insurance carrier(s) or if we have not heard from your insurance carrier after an extended period. It is your responsibility to contact your insurance company if you have not received an "Explanation of Benefits" (or EOB). All non-covered charges and remaining charges after your insurance has been paid are due and payable within 30 days of billing. If you do not have insurance and special arrangements are necessary for the payment of your bill, please contact our business office at **901-756-5565** to make payment arrangements quickly and easily.

Insurance: Our office will file your charges to two insurance carriers for you. Please keep the business office informed of any changes in your insurance status. Although we will assist you in processing your claim, payment of the bill is ultimately your responsibility.