Tara Tarantino, DO
PRIMARY CARE & OSTEOPATHIC MEDICINE

BASS MEDICAL GROUP

Welcome to Dr Tarantino's practice! Thank you for choosing us as your partner in health and wellness. It is very important that you share the following before your appointment or bring to your first appointment:

1. Completed Patient packet including registration forms and signed agreements
2. Insurance Card(s)
3. Picture Identification (such as a driver's license or passport)
4. You might also like to bring a current medication list and any imaging or blood test results that may not be in your John Muir Health/BASS Medical Group chart

At your visit:

- You will be asked to pay any required copay or identifiable deductible when you check-in for your appointment. We accept cash, checks and credit cards.
- Please arrive fifteen minutes before your scheduled appointment so that we can confirm your information and verify your insurance.
- If you are unable to keep your appointment, please notify us as soon as possible. We do have a 24-hour cancellation policy and No-Show or Late Cancelation fees may apply.
- This practice uses an electronic medical record system (EPIC). Your record will be established at your first visit. When checking out, you will be given an After Visit Summary (AVS) which will include instructions to create a login to access your personal health records (MyChart). Ask at the desk for help if you need it!
- Please call your insurance company/Medicare to confirm that they contract with our office.
- If you are enrolled in an HMO insurance program, please be aware that we can only accept HMO insurances through the John Muir Provider Health Network and your card must have Tara Tarantino, DO identified as your Primary Care Physician (PCP). If you are not in John Muir PHN, we will be happy to see you as a self-pay patient, but we cannot bill any other HMOs outside of John Muir.

If you have any questions about the practice or your visit, please let us know.

We look forward to seeing you!

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BASS MEDICAL GROUP

New Patient Registration

Social Security Number _____ - _____- _____ Email Address _____

Patient's Name: _____
Last name First name MI Preferred Name

Date of Birth: _____ Marital Status: ☐ S ☐ M ☐ P ☐ W ☐ D ☐ Decline to answer Age: _____

What is your current gender identity? (Check ALL that apply):☐ Male ☐ Female ☐ Gender Queer ☐ Decline to answer
☐ Transgender (please specify):_____ ☐ Additional category (please specify): _____

What sex were you assigned at birth? (Check one) ☐ Male ☐ Female ☐ Other ☐ Decline to answer

What pronouns do you prefer that we use when talking about you? (check all that apply)
☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify:_____

Race:_____ Are you Hispanic? ☐ Yes ☐ No Language:_____ Interpreter needed?☐ Yes ☐ No
Religion:_____ ☐ Decline to answer
Patient's Address:_____City:_____State/zip code:_____
Home Phone Number: (_____)_____ - _____ Cell Phone Number: (_____)_____ - _____
Driver'sLicense#:_____ Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Not Working

Patient's Employer:_____Work Phone Number: (_____)_____ - _____
Employer's Address:_____City:_____State/zip code:_____

Preferred Pharmacy Name: _____ Address: _____
Phone Number: (_____)_____ - _____ Fax Number: (_____)_____ - _____

May we text you with appointment reminders? ☐ Yes ☐ No Cell phone: (_____)_____ - _____
May we leave messages on your home or cell phone with results/personal health information or appointment reminders? ☐ Yes ☐ No
If yes, choose one or both: ☐ home or ☐ cell phone
May we email you with test results or communication re: your health or appointments? ☐ Yes ☐ No
Is there someone you would like to authorize to receive messages on your behalf?

Name: _____ Relationship: _____ Phone number: (_____)_____ - _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone number: (_____)_____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other Date of Birth of Insured:_____

SECONDARY INSURANCE CARRIER: _____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other Date of Birth of Insured:_____

Minor patient: Parents are: ☐ Married ☐ Divorced ☐ Other: _____Custodial Parent: _____

Custodial Parent's Home Phone: (_____)_____ - _____Work Phone: (_____)_____ - _____

Custodial Parent's SS #: _____ Date of Birth: _____

ACKNOWLEDGEMENTS

You, the responsible party, certify that the above information is true and correct to the best of my knowledge. You understand that you are financially responsible for all charges regardless of delays in insurance payments or denial of insurance coverage. It is your responsibility to understand and personally verify that your insurance is contracted with the practice/doctor that you are seeking services from. You have the right to request services by out of network providers by obtaining an NSA consent form for services in an Ambulatory Surgical Center and Hospital setting by agreeing to the financial/estimate amounts disclosed.

You hereby authorize BASS Medical Group to apply for benefits and submit insurance claims for reimbursement on your behalf for covered services rendered. They may also disclose any or all parts of your clinical record to any insurance company covering services for the purpose of satisfying charges billed. You also understand that if any insurance payments are sent to you directly, it is your responsibility to send to BASS Medical Group immediately upon receipt. You, the patient, or the patient's representative, understands that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board or California. You can verify this by contacting the Medical Board at (800) 633.2322 or via internet website: www.mbc.ca.gov. You further agree to pay collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

_____ _____ _____

Signature of Patient, Parent or Legal Guardian Relationship to Patient Date

You acknowledge that you are the owner of the phone numbers (whether associated with mobile or landline) and email addresses that you provide to us. If you are not the owner, you represent that you are authorized by the respective owner(s) to authorize the use of those phone numbers and email addresses as described below, on the owner's behalf. You authorize us and any third party, such as our independent contractors, business associates, agents and/or affiliates, who we may authorize, to: (1) call you at any of the numbers that you provide to us, using an automatic telephone dialing system and/or using a recorded message upon being answered, or another similar method, such as an artificial or pre-recorded voice; (2) text messages to you at any of the numbers that you provide to us; and/or (3) send email communications to you at any of the email addresses that you provide us; for any of the following purposes: confirming appointments, providing registration or clinical instructions, communicating about post-service follow up, billing, communicating about your account, insurance and payments, and collecting debts that you owe to us. You do not have to give us permission to call, text or email you. Giving us permission to call, text, or email you is not required in order to receive services, to purchase any property or goods. You have the right to opt out of these types of communications.

Signing below grants us permission to proceed with these types of communications.

_____ _____ _____

Signature of Patient, Parent or Legal Guardian Relationship to Patient Date

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPAA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

Policy: It is the right of all patients to receive full consideration of privacy and confidentiality with regard to all information and records about their care. Health plans and reviewers acting as their agents, however, do have certain rights of access to patient medical information for quality-of-care purposes.

Procedure:

1. All employees, contractors, consultants and anyone who may have access to Individually Identifiable Health Information (IIHI) will sign a statement not to disclose or release confidential information for any reason not medically indicated to any persons other than those legally authorized to receive the same. (Business Associate Agreement)
2. Except when required in the regular course of business, the discussion, use, transmission, or narration, in any form, of any patient information, which is obtained in the regular course of job functions, is strictly forbidden.
3. Temporary placement of patient records in unattended areas shall be avoided and all records are to be maintained in secured files and in a manner that allows access to authorized individuals only.
4. Facsimile transmission of patient data should be limited to documents necessary for the purpose of completing a transaction or communicating specific patient data to an authorized individual to whom it is addressed.
5. Electronic access to patient data shall be password protected to limit data retrieval to what is needed for job functions.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent *via* fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses/disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.
- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., *via* telephone, text message or email).
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.
- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a text message or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent *via* Text, *via* email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

MINORS: We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ AND DATE OF BIRTH: _____

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:

This authorization to Release Health Information is voluntary.

☐ OK to Family Members: Please list name(s), alternative address, phone numbers, & email addresses of Family Member(s), as applicable:

_____

_____

☐ OK to Others (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone numbers, and email addresses of authorized person(s) or entities:

_____

_____

☐ OK to leave health information on answering machines, voicemail, telephone text, or email.

☐ DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:

Address: _____Phone:_____ Email: _____

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ AND DATE OF BIRTH: _____

☐ DO NOT RELEASE TO (Please list names, as applicable):_____

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature:_____ Date:_____

Patient's Name:_____Date of Birth:_____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name:_____ Capacity and/or Relationship to patient:_____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below. Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

Tara Tarantino, DO
PRIMARY CARE & OSTEOPATHIC MEDICINE

BASS MEDICAL GROUP

Practice & Financial Agreements

We appreciate the opportunity to serve you and pledge to provide you our best medical care in a safe environment with compassion and attention to detail. In order to make our relationship with you the best that it can possibly be, please be familiar with the following policies:

Administrative Policies

- We promise to inform you at check-in if Dr Tarantino is running late.
- We promise to treat you with respect and dignity in a professional and caring manner. In return we expect you to refrain from using verbally abusive language, threatening any employee or provider, or any otherwise hostile behavior. Using such is cause for immediate dismissal from this practice.
- Many appointments require collection of a urine sample so please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be set to vibrate mode while in our office and that you step out of the waiting room if you must take a call. Please let us know if you step outside.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Please see our fee schedule below, as we do reserve the right to charge for no-showing and last minute cancellations. Missing three appointments without notice will result in dismissal from this practice.
- If you are over 15 minutes late, we reserve the right to reschedule your appointment.

Insurance & Billing Policies

- If you have insurance, **please bring your card to every appointment**; without it we cannot bill your carrier. We are required to collect copayments and coinsurance at your visit and reserve the right to reschedule or cancel appointments to comply with insurance company agreements. You will notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.
- It is your responsibility to verify with your carrier if this practice and Dr Tarantino is a contracted provider. Your health insurance policy is an agreement between you and your carrier. **You are responsible for understanding your own coverage.** Your insurance company makes the determination of your eligibility.
- You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any coinsurance amounts. You agree to pay for services rendered within the limits of this care provisions policy. You are responsible if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.
- If you do not have insurance or choose not to file a visit with your insurance, a minimum payment of $100 at time of service is required. The remaining balance for services received will be addressed following the delivery of service.
- Many insurance companies have lists of approved drugs that they cover. Dr Tarantino will prescribe the medication that she feels will best address your needs. We will do our best to respond to prior authorization requests from your insurance company, but this process may delay your prescription. **You are responsible for contacting your health plan provider with any questions or requests concerning approved medications.**

Financial Acknowledgement for Testing and Services

You are responsible to know your Health Plan/Medicare coverage, benefits and deductibles prior to us ordering laboratory or testing services. While we order tests based on your health history and condition, there is no guarantee that your health plan will cover these tests or services, even if we believe that they are medically necessary.

KNOW YOUR COVERAGE:

- **UNDER NO CIRCUMSTANCES WILL WE CHANGE OR RESUBMIT DIAGNOSIS CODES AFTER TESTING IS COMPLETE.**
- **MOST HEALTH PLANS AND MEDICARE DO NOT PAY FOR "PREVENTATIVE" TESTING.**
- **MOST DIAGNOSTIC TESTING WILL NOT BE COVERED AS A "PREVENTATIVE" SERVICE.**
- Our staff does not verify codes or coverage with your Health Plan/Medicare for services ordered.
- We may still require lab work based on your medical history, medications and symptoms.

- John Muir Physician Network HMO patients must use LabCorp facilities or pay all charges for not doing so.
- PPO patients please do your price comparison research, as cost can vary greatly between facilities, resulting in significant savings/costs if you have a high deductible plan. Call your health plan to get rates across facilities.
- Some plans cover only certain LabCorp or imaging locations. Please check with your health plan to confirm.
- With high deductible health plans, you will pay for all services incurred until reaching your deductible.

ACTIONS TO ENHANCE COVERAGE:

- Call your Health Plan/Medicare representative to verify what is covered and what portion you need to pay.
- Confirm the testing is under a "diagnostic" code, not a "preventative" code.
- Be sure that no other doctor has ordered these same tests as "preventative" for you this year.
- Check that you have met your insurance deductible before the testing is completed.
- Go to the specific "preferred lab/facility" that your Health Plan/Medicare required.
- **WE ARE NOT ABLE TO TELL YOU WHICH TESTS YOUR INSURANCE COVERS.**
- Disability, FMLA, sports physicals and other form completion and letters written by the doctor require an appointment or a charge of $15.00. Forms greater than one page that are not received and completed at the time of visit (DMV, Disability, FMLA...) will be $25.00. Copies of your medical record will be a minimum charge of $15.00 and then 25 cents per page thereafter.
- Payment in full is due within 30 days of your first statement unless other arrangements have been made. We send two statements at 30-day intervals. You understand and agree that if we are forced to send your account to collections, a fee of 35% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement. We offer a financial aid program to patients who meet the criteria.
- You understand that the clinic may take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.
- If you need an in-office surgical procedure, you may give verbal or written consent at the time of procedure, our coordinators will assist you in scheduling. Although we may seek prior authorizations, insurance carriers state that they are not a guarantee of payment. You must call your insurance carrier to verify that they will cover your procedures.
- If you get lab or imaging tests as part of your appointment, remember that some tests/labs are performed by outside parties; in such cases they bill separately. If you know your insurance carrier only covers certain labs or facilities, please notify our office in advance.

NON-COMPLIANT POLICY

No Show and Cancellation Policy:

We sincerely request 24-hour notice when canceling or rescheduling an appointment.

- A **$50.00** NO SHOW/LATE CANCELLATION Fee will be charged for all failed/late cancellations for standard office visits (15 minute appointments)
- A **$100.00** NO SHOW/LATE CANCELLATION Fee will be charged for all failed/late cancellations for physicals and extended visits (30 minute or longer time slots)..

Returned Check Fee:

- A **$35.00** fee will be charged for all checks returned from the bank for Non-Sufficient Funds.

Insurance Rebill Fee:

- A **$20.00** fee will be charged if current insurance information is not provided thereby causing a delay in payment and requiring a 2nd insurance claim to be processed.

You understand the above and accept full responsibility for any costs for medical services that you have incurred both at the office of Tara Tarantino, DO and outside facilities. You are aware that we cannot guarantee coverage, nor verify network or

coverage status for tests ordered. You understand that we will not change or resubmit codes for tests with coverage issues. You understand that a high deductible plan means that you are responsible for all incurred expenses until that deductible has been met.

By signing below, you agree to the terms of service provided herein.

_____ _____

Signature Date

_____ _____

Print Patient's Name Relationship to Patient

Open Payments Database Notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers **of** drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

My signature below confirms that I have read and understand that notice above.

Signature: _____ Date: _____

Patient or patient representative