LIFESPAN MEDICAL SERVICES, LLC
HARSHA TANKALA, MD
1125 Forrest Avenue Suite 203, Dover, DE 19904
Phone: 302-346-0100 Fax: 302-346-0103

New Patient Policies And Forms

At Lifespan Medical Services, LLC, we do our best to give you and each patient the best quality care possible. However, to do so everyone must do their part, including staff, to make sure everything runs smoothly. Here is a list of patient policies that must be followed thoroughly:

- Patient is expected to arrive for their appointment on time. There is a grace period of **15 minutes** given to each patient. Arrival later than 15 minutes will result in having to be rescheduled until next visit available time and date. **No exceptions.**
- Patient is responsible for bringing medication bottles or an updated medication list to each appointment.
- All prior authorization may take up to 24-48 hours. To be completed and processed through the insurance.
- ANY MEDICAL PAPERWORK THAT NEEDS TO BE FILLED OUT NEEDS TO BE DROPPED OFF, EXPECT TO PICK UP IN 10-14 DAYS. FEES ARE $25.00 OR HIGHER BASED ON THE FORMS TO BE COMPLETED.
- Medical Records: If requesting records to be transferred it is subject to a fee per page, accordance with the State of Delaware Regulatory fees.
- No show fee and all copays are due before the visit, and balances need to be paid at your appointment.
- When leaving a message your call will be returned within 48 hours. If you are calling in a prescription, please contact your pharmacy within two to three hours to make sure they received it. Any new medications, medication changes, not previously prescribed by Lifespan will require an appointment to review.
- We do not prescribe NARCOTICS that will have to be via a pain management doctor.
- You can give our office a call at (302) 346-0100 or text our office (302) 551-3487

Please sign below stating that you read and acknowledge the policies:

Name: _____

Signature: _____**Date:** _____

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Date: _____ Email: _____

Name: _____ Date of Birth: _____ Social Security #_____

Address: _____Apt #: _____ City: _____ Zip: _____

Phone number: _____ Race: _____ Ethnicity: _____ Sex: Female/Male

Married: _____ Widowed: _____ Divorced: _____ Separated: _____ Single: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Emergency Contact: _____Relation: _____Phone: _____

Person Responsible for Account: _____ Phone # _____

Relationship to Patient: _____ Birthdate: _____

Insurance Company _____ ID # _____ Group # _____

Secondary Insurance _____ ID # _____ Group # _____

Whom may we thank for referring you? _____

I certify that I, and/or my dependents, have coverage with: _____

And assign directly to Dr. Tankala all insurance, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above – named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Guardian, Or Personal Representative **Date**

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_____ _____

Print Patient, Guardian, Or Personal Representative Name **Date**

DIAGNOSTIC PROCEDURES:

Procedure	Month	Year	Normal	Abnormal
EKG				
Echocardiogram				
Stress Test				
Chest X-Ray				
Mammogram				
Pap				
Bone Density				
Stool Occult Blood				

IMMUNIZATIONS:

Name	Month	Year	Comments
Flu			
Tetanus			
Pneumonia			
Hepatitis B			
Hepatitis C			
Zoster			

FAMILY HISTORY:

Relation	Age	Age of Death	Heart Disease	Cancer	Other
Mother					
Father					
Sister					
Sister					
Brother					
Brother					

SOCIAL HISTORY:

Lifestyle	Start Date	Use	Quit Date	Comments

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Tobacco				
Alcohol				
Recreational Drugs				

Illness	Yes	No	Date of Onset	Comments
Acid Reflux/Ulcer				
Anemia				
Asthma				
Bleeding Disorder				
Breast Cancer				
Colon Cancer				
COPD/emphysema				
Diabetes				
Enlarged Prostate				
Gout				
Heart Attack				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Nasal Allergies				
Seizures				
Stroke				
Thyroid Disorder				

SURGERY HISTORY:

Surgery	Yes	No	Date	Comments
Mastectomy				
Lumpectomy				
Prostate				
Colon				
Heart				
Orthopedic				
Any other surgeries				

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ALLERGIES: _____

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

Name	Dosage (MG)	How many times per day

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No Show Agreement

Due to recent high volume of no shows and same day cancellations, there will be a $50.00 charge effective immediately.

When you leave the office, please ensure that you mark your calendar for your future office visits. Our office staff may call 24 hours in advance to confirm appointments. Please remember that reminder calls are **courtesy calls**. If you can't make your appointment, please call **24 hours in advance to avoid the $30.00 fee.**

Please keep in mind when you cancel last minute or don't show, you have filled a spot that could have been given to a person in need of seeing the doctor.

_____ _____

Signature **Date**

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AUTHORIZATION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To**: (Previous Primary Care Doctors Name/Specialists)**

_____ **Phone #** _____ **Fax #** _____

_____ **Phone #**_____ **Fax #** _____

_____ **Phone #** _____ **Fax #** _____

Persons authorized to receive information

Information listed below will be disclosed to:

Lifespan Medical Services

1125 Forrest Avenue, Suite 203

Dover, DE 19904

Phone: 302-346-0100 Fax: 302-346-0103

Purpose of disclosure

Information listed above will be disclosed for the following purpose:

Transfer of entire medical records

Expiration date of authorization

This authorization is effective 180 days after date unless revoked or terminated earlier by the patient (or patient's representative).

Right to terminate or revoke authorization

You may revoke or terminate this authorization by submitting a written revocation to Lifespan Medical Services.

_____

Name of patient (print) **Date of birth**

_____

Signature of patient or guardian **Date**

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HIPAA CONSENT FORM

Test results:

I give permission to release to the following person (s), any labs results, medical records, or general medical information from my physician at Lifespan Medical Services, LLC

Name (s) Please Print:

1. _____ Relation/Phone Number _____
2. _____ Relation/Phone Number _____

Prescriptions:

I give permission for the following named person (s) listed to call in for any prescription refills by my physician at Lifespan Medical Services, LLC

Name (s) Please Print:

1. _____ Relation/Phone Number _____

Pharmacy:

I give permission for Lifespan Medical Services, LLC, and his representatives to call in prescriptions to my named pharmacy.

Name: _____

Locations: _____

Acknowledge of the Receipt of Notice of Privacy Practices:

I hereby acknowledge that I received a copy of the "Notice of Privacy Practices" adopted by Lifespan Medical Services, LLC. I understand that if I have any questions about the "Notice of Privacy Practices". I may contact the Delaware Department of Health and Social Services.

_____ _____

Patient Signature **Date**