Welcome to TLC Medical, LLC!

Office Locations: 5106 N Armenia Ave, Suite 1, Tampa FL 33603
Phone: (813) 874-1852 Fax: (813) 227-8526
And
10866 Sheldon Rd, Tampa FL 33626
Phone: (813) 920-4402 Fax: (813) 227-8526
And
103 Southern Oaks Dr, Plant City FL 33563
Phone: (813) 920-4402 Fax: (813) 227-8526
And
2240 Twelve Oaks Way, Wesley Chapel FL 33544
Phone: (813) 920-4402 Fax: (813) 227-8526

Office Hours: Monday – Thursday 8:00am to 5:00pm
Friday 8:00am to 12:00pm

Our Providers: Charles Talakkottur, MD & Laura Talakkottur, APRN & Sara Graves, FNP-C, Taylor Nesbit, PA-C and John Ashley FNP-c

In the event of office closure and you need medical care:
Call the office, press 4 for the answering service for an urgent message for the Doctor

If you need to be seen here are a few Urgent care clinics we recommend:
MedExpress Urgent Care – 2801 W Dr. MLK Jr Blvd, Tampa FL (813) 877-8450
BayCare Urgent Care – 3440 W Dr. MLK Jr Blvd, Tampa FL (813) 559-1888
TGH Urgent Care (Fast Track) – 11969 Sheldon Rd, Tampa FL (813) 925-1903
Walk-in Care (BayCare) – 7835 Gunn Hwy, Tampa FL (813) 926-5256

We look forward to serving you soon!

TLC Medical Meaningful Use Patient Registration Form

In compliance with the HITECH ACT (EHR) to attain Meaningful Use we are required to capture demographic data including language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Please provide copy of FL State Driver's License or other proof of ID and FL address

Please provide insurance ID card

Patient Name: _____ Phone: _____

SSN: _____ DOB: _____

Address: _____ Zip Code: _____

Marital Status: Divorced/Married/Never Married/Widowed

Email Address: _____

Race: _____ Ethnicity: Not Hispanic or Latino / Hispanic or Latino

Primary Language: _____

Insurance Coverage:

Primary Insurance: _____ ID: _____

Secondary Insurance: _____ ID: _____

Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

Preferred Method of Contact: Phone Email Portal

Can we leave a voicemail to confirm appointments? Yes / No

Can we email to confirm appointments? Yes / No

_____ _____ _____

Patient name (print) Patient signature Date

PHOTO CONSENT FOR CHART IDENTIFICATION

This form authorizes TLC Medical to take a photo and place in the chart for identification purposes only. We will not use your photo in any other matter without your permission.

_____ _____ _____

Patient name (print) Patient signature Date

LATE /NO SHOW POLICY

Time is valuable to everyone, and we at TLC Medical respect the right of all patients to be seen in a timely manner. Patients who arrive late to an appointment can affect the smooth flow of the office visits for other patients. In an effort to prevent this, any patient who is late, more than 15 minutes, up to 29 minutes will be charged a **fee of $10.00**. The patient can still be seen the same day, provided we are able to work you into the schedule.

We request a minimum of 2 hours' notice of your scheduled appointment if you must miss your appointment. Failure to provide 2 hours' notice will count as "NO SHOW" and will result in a **$50 "NO SHOW" Fee**. There will also be a "NO SHOW" fee if you arrive 30 minutes or later to your appointment.

By signing below, I have read and understood the late/no-show terms and my obligations. Please let us know if you have any additional questions or concerns.

_____ _____ _____

Patient name (print) Patient signature Date

DISMISSAL POLICY

Effective 9/20/17, the practice has created a new policy which will be strictly enforced. We will no longer tolerate rude or inappropriate behavior. This includes but no limited to cursing, yelling, demanding controlled substances.

Also, if you have a total of either 3 cancellations, no shows, or re-schedules (not issued by the practice) in a 6-month period, you will be dismissed from the practice.

Due to a high number of cancellations and no shows by a small number of people repetitively doing this, we are obligated to enforce this rule. Thank you for your understanding and choosing TLC Medical for your medical needs.

_____	_____	_____
Patient name (print)	Patient signature	Date

REFERRAL REQUEST POLICY

Sometimes you may need to see a Specialist, this is a discussion you will need to have with your Primary Care Physician. Your PCP may approve or deny this request based on several factors: have you been seen within the past 90 days, is the Provider aware of the problem, can the Provider take care of this in office, and will your insurance authorize a Specialist. Talk to your Provider about any referral needs and if you have any questions.

TLC MEDICAL FINANCIAL POLICY

Payment for service rendered is part of the patient's responsibility in the patient-physician relationship. Therefore, we would like to share our payment policy expectations with you to ensure understanding and compliance.

- **Insurance Payments:** We participate with multiple insurance companies. We will file claims on your behalf directly to the insurance carrier for payment, less any co-payments, coinsurance, deductibles, and non-covered benefits. Please note, some services may not be covered in part or in full by your insurance company. However, if these services are deemed necessary, the patients will be responsible for paying any balance not covered by their insurance. Payment is expected at the time of service. If you're unable to make that payment, you will not be seen.
- **Payment policy:** TLC Aesthetics, TLC Medical, Dr. Charles Talakkottur and any subsidiary have a STRICT payment policy that is enforced. There are no refunds, cancellations, returns, or credits under any circumstances whatsoever unless a financial error was made on the medical practice's side. Purchasing a medical/cosmetic service and then after part or all of the procedure was done and then asking for a refund or credit will not be allowed under any circumstance. Whatever you agree upon in terms of the services you are getting and at the price you are getting, will need to be STRICTLY adhered to and no deviation thereof.
- **Medical form policy:** TLC Medical has a general policy that any form requiring Dr. Talakkottur to complete will be assessed a **$50.00 fee** and a stamped self-addressed envelope (or it will be available for pick up). After the payment has been made, the form will be sent out within seven (7) business days.

By signing below, I have read and understood the terms and obligations. Please let us know if you have any additional questions or concerns.

_____ _____ _____

Patient name (print) Patient signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, how you can access this information. Please review it carefully. At TLC Medical, we will always keep your health information secured and confidential. Laws within the Health Insurance Portability and Accountability Act (HIPAA) require us to continue maintaining your privacy, to give you this notice and to follow terms for this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. We may share your medical information with our business associates, such as billing services. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you're not home, we may leave your appointment information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become property of the new owner. Except as described above, the practice will not use or disclose your health information without your prior written authorization. You may request in writing that we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address and telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will send your files for you only after you have signed a form granting consent for release of your medical records. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge a reasonable fee for copies. You have the right to request an amendment or change your health information. Give us your request to make changes in writing. We may or may not make changes you request, will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes in writing.

You may file a complaint with the department of health and human services, 200 Independence Ave. SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However before filing complaint, or for more information/assistance regarding your health information privacy, please contact the Office Manager, phone number 813-874-1852. This legislation went into effect as of April 14, 2003.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have read and greed to TLC Medical's Notice of Privacy Practices.

_____ _____ _____

Patient name (print) Patient signature Date

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize TLC Medical to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

_____ _____ _____

Patient name (print) Patient signature Date