

Janet E. Tatman, PhD, PA-C

Associated with Scott Rigden, MD

PATIENT SERVICES AGREEMENT

Name _____ Date of Birth _____

Welcome, I am pleased you have chosen me as your healthcare provider. Please read the following document carefully as it contains important information about my professional services and practice policies.

Sleep Disorders Services

My services will include a thorough initial evaluation of your sleep or daytime sleepiness problems. This is typically accomplished in a one-hour appointment, although in some cases, especially if the problems are complex, it may require a longer time or a second appointment. I will offer you a description of my findings at the conclusion of this initial evaluation and recommend a program of treatment. Treatment recommendations may of course need to be modified as treatment progresses, depending on your progress and any problems that arise. For many sleep problems, especially those that involve excessive daytime sleepiness, I may recommend that we have you schedule a sleep laboratory study. If you agree to this plan, I will refer you to one of the sleep laboratories that I work with. These laboratories are entities with which I have a consulting staff relationship with, but no ownership of, and they are found in various locations around the Valley and in Casa Grande. In almost every case, I will be responsible for interpreting the results of your sleep study and communicating those results to you. Rarely, I may ask another sleep specialist to interpret your results if I am unavailable at the necessary time. Many sleep problems do not require a sleep laboratory study and we will discuss the pros and cons of a sleep study or any other laboratory test that I recommend. I will make every effort to answer any of your questions to the best of my ability and to collaborate with or refer you to other medical or mental health specialists when appropriate. My clinical supervising physician in the office is Scott Rigden, MD. Each sleep laboratory that I work with has its own Medical Director.

_____ Initial Here

Medication Services

Your treatment may include taking medication. There are wide varieties of medications available for sleep or sleepiness problems. A prescription for medication must take into account your personal medical history, other medications that you take, allergies to medicines or other products, and your treatment goals. When I recommend a medication prescription for you, I will inform you of significant benefits and risks, answer any of your questions to the best of my ability, and advise you about appropriate regular monitoring of your use of medication, including any necessary periodic laboratory tests.

_____ Initial Here

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. When I am temporarily unavailable, my telephone is answered by office staff or answering machine. I will make every effort to return your call promptly during my business hours. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room or dial 911. If I will be unavailable for an extended time, another healthcare provider will be available to take emergency calls.

_____ Initial Here

Legal Limits on Confidentiality Protections

The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPAA). If you have been referred by another healthcare provider and I am acting as a consultant to that provider, I may send information back to that other healthcare provider that is pertinent to the reason(s) for the consultation. There are other situations that require only that you

provide written, advance consent, such as releasing records to anyone other than the referring healthcare provider. Additionally, there are some situations in which I am permitted or **required** to disclose information without either your consent or Authorization. These situations are primarily related to danger to yourself or to others and child or elder abuse or neglect. If such situations arise, I will make every effort to discuss them with you before taking any action and I will limit my disclosure to what is necessary. For details on the limits of your confidentiality required by law, please refer to my office form entitled, **“Notice of Healthcare Provider’s Policies and Practices to Protect the Privacy of Your Health Information,” especially Section II (“Uses and Disclosures Requiring Authorization”) and Section III (“Uses and Disclosures with Neither Consent nor Authorization”).** Your signature on this Agreement provides consent for those activities. While this written summary of exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and I do not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

_____ **Initial Here**

Minors & Parents

It is my policy to require that at least one parent or other legally responsible adult attend each appointment with a minor child, unless that child is legally emancipated. Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child’s treatment records. When older children request that some of their communications with me be considered private, it is my policy to consider with the child’s parents their willingness to grant this request, except of course in any case where the child’s safety is at issue. I will ensure that parents are rapidly informed about any safety concerns that come to my attention. This may be done by promptly scheduling a joint appointment to be attended by both child and parents so that the child can personally inform the parents of the safety issue in the context of the support offered in an appointment. Alternatively, if the child is not able to agree to a joint meeting for any reason or if the safety concern is urgent, I may telephone one or both parents to quickly discuss the relevant safety concern. Parents should feel free to clarify this policy or request modifications to it at any time they become aware of a safety concern for their child.

_____ **Initial Here**

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the locations to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

_____ **Initial Here**

CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that Janet E. Tatman, PhD, PA-C carry out diagnostic or therapeutic procedures that now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement.

I understand that Janet E. Tatman, PhD, PA-C provides medical services as a physician assistant working under the supervision of a physician.

_____ **Initial Here**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPPA NOTICE FORM DESCRIBED ABOVE.

Patient or (Authorized Parent/Guardian Name) **Printed**

Date

Patient or (Authorized Parent/Guardian Name) **Signature**

Date