Infectious Disease

Professionals

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Patient Information:
Title: Mr.|Mrs.|Ms.|Miss. Circle one Date: _____

Name (Last, First): _____Middle Int: _____

Date Of Birth: _____/_____/_____ SSN: ____/_____/_____ Sex: Male/Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____
Ok to leave a voice message: yes/ no
Email Address: _____

Marital Status: Single| Married| Widowed| Divorced (circle one)

Ethnicity: Caucasian| African American | Asian | Hispanic (circle one)

Primary Care Doctor Name_____
Phone Number: _____ Fax: _____

Referring Doctor: _____ Phone Number: _____

Pharmacy Name: _____Phone Number: _____

Emergency Contact:

Name: _____ Phone Number: _____
Relationship: _____ OK to leave a voice message yes/no

Current Medications: List the name and dose

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies: List allergies and what type of reaction you have

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Immunization: Check all that apply

____ Zoster Vaccination
____ Flu Vaccination this year.
____ Hepatitis A Vaccination
____ Hepatitis B Vaccination
____ Covid-19 Vaccination; If yes How many ____ Initial Doses and ____ Boosters.
____ Pneumococcal Vaccination within the past 5 years.
____ HPV (Women)
____ HPV (Men)
Other: _____

HIPPA Right of Access Form for Family Member\Friend

I, _____, direct my health care and medical services providers and payers to disclose my protected health information described below to:

Name: _____ Relationship: _____

Ok to leave a voice message Yes | No

Contact information: _____

Health Information to be disclosed upon request of the person named above:

(Check either A or B):

- ☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) or
- ☐ B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate)
    - o Mental health records
    - o Communicable including (HIV and AIDS)
    - o Alcohol/drug abuse treatment

    Other (please specify) _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard Copy
- ☐ Phone

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods, or
- ☐ Date or event: _____

Unless I revoke it. (NOTE: you may revoke this authorization in writing at any time by notifying your health care providers)

_____ _____

Name of the individual giving this authorization — Date of Birth

_____ _____

Signature of the individual giving this authorization — Date

Infectious Disease Professionals Financial Policy

* For the convenience of our patients, we participate with Medicare, Medicaid, and most major insurance companies. We will file with your insurance; however, any applicable co-payments are due at the time of service. The patient is responsible for any non-covered charges incurred.
* If your insurance requires a referral from your primary care physician, you must provide the information that we may bill charges to your insurance carrier.
* In the event you are not covered by insurance, payment is due when services are rendered unless other arrangements have been made in advance. Self-pay price is $150.00 for initial visits, and $75.00 for follow-up visits: Please note this does not include any lab work or radiologic procedures.
* Patients please be advised that if your insurance does not cover Lyme Disease treatment, you will be responsible for all non-covered charges.
* A $35.00 fee will be charged to patients for returned checks.
* A $50.00 fee will be charged for all No-Show appointments.
* By signing this, you agree with the policies stated above and the medical information release below.

To our patients: All physician offices must now confirm patients' demographic information and verify patients' identity at each visit under the Federal Government's Identity Theft Red Flags and Address Discrepancies Rule. A photograph will be taken of you in the exam room. You must provide us with a photo ID, such as a driver's license that shows your current address. The photo ID will be used at all future visits to confirm your identity and to identify any reg flags for both financial and medical identity theft. Infectious Disease Professionals, LLC is committed to protecting our patients' information and prohibits illegal misrepresentation. Thank you for cooperating with us to keep you and your information safe!

I Understand/agree that Infectious Disease Professionals may leave medical/ financial information by the following methods: home telephone, home answering machine, cell phone, work telephone, and work voicemail. I consent to Infectious Disease Professionals (the Practice) using or disclosing my protected health information (PHI) for the purpose of providing treatment to me or to carry out the treatment activities provided by another health care provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my PHI in order for assessment and reviewing the competence of health care professionals, The following people are also authorized to receive a copy of my PHI.

Patient Signature: _____ Date: _____