INFECTIOUS DISEASE ASSOCIATES

380R Merrimack St • Suite 2B • Methuen, MA 01844
Ph: (978) 689-2510 • Fx: (978) 689-3510
Venugopal Saddi, MD • Karolyne Stimpson, NP • Tanya Lamoureux, NP

General Consent for Care and Treatment

Section I: Authorization and Consent for Treatment

I voluntarily consent to the rendering of medical care, treatment, and diagnosis, including such diagnostic, therapeutic, or medical procedures to be performed by my health care provider(s), their designee(s), and their assistant(s) as deemed necessary by the provider's judgement.

I understand that medical diagnosis and treatment may involve substantial risk. I understand that, absent emergency or extraordinary circumstances, major therapeutic or diagnostic services will not be ordered for- or performed on me, unless, or until, I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction with my physician or other practitioner, and have given my express consent for these procedures.

I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made to me promising any specific result or outcome from any diagnostic or therapeutic treatment provided to me in the course of my care.

Further, I understand that medical, nursing, and other healthcare personnel in training may participate in my care and treatment as part of their training unless I request otherwise.

I understand that I have the right to refuse, revoke, or withhold my consent to any proposed or ordered diagnostic or therapeutic procedure(s).

Section II: Use and Release of Information

I understand that Infectious Diseases Associates, PC, will keep records that contain my medical, personal, and other information related to my diagnosis, care, and treatment in electronic, paper, and/or other forms. I understand that Infectious Diseases Associates, PC, may release any information about me, my health, the health and medical services provided to me, or payment for my health services, that may be necessary:

1. For my treatment (to other health care providers or facilities that require the information for my continued care)
2. For any purposes related to payment by me or a third party for services provided
3. For the coordination of care and treatment with other health care providers from whom I am receiving care and treatment

Section III: Telemedicine

I understand that Infectious Diseases Associates, PC, may use telemedicine during the course of my care and treatment. Telemedicine uses audio and video to permit a two-way, real-time, interactive communication between a patient and a physician or other practitioner who may be located at a distant site. The information gathered during a telemedicine encounter will be maintained in my medical record, and the privacy and confidentiality of my record will be maintained at all times. Infectious Diseases Associates, PC, will not record any audio or video transmission, unless otherwise specified by my physician or other practitioner.

I understand that I have the right to withdraw my consent for telemedicine at any time. I also understand that alternative methods may be available to me, and I may choose these options at any time.

Section IV: Signature

My signature below constitutes my acknowledgement that I have read and understand the above information, that any questions I have asked have been answered to my satisfaction, and that I agree to this consent of care and treatment herein.

× _____ _____

Patient Signature (or signature of other authorized representative) Date Signed

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INSURANCE & BILLING AGREEMENT AND ACKNOWLEDGEMENT FORM

SECTION I: AUTHORIZATION OF PAYMENTS AND BENEFITS

I hereby assign to Infectious Diseases Associates, PC, the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Infectious Diseases Associates, PC. I agree to cooperate and provide information as needed in a timely manner to establish my eligibility for such benefits.

SECTION I: ACKNOWLEDGEMENT OF RESPONSIBILITY

I understand that my health insurance coverage is a contract between myself and my health insurance carrier, and that payment for services rendered by the health care providers at Infectious Diseases Associates, PC, **across all dates of service**, is ultimately my responsibility.

SECTION II: ACKNOWLEDGEMENT OF INSURANCE REFERRAL POLICY

I understand that, if my health insurance plan requires a referral, it is ultimately my responsibility to ensure that my primary care/referring provider provides one to Infectious Diseases Associates, PC, in a timely manner, and that failure to do so may result in denial of coverage by my health insurance carrier. I understand that payment for all services rendered by providers at Infectious Diseases Associates, PC, **across all dates of service**, will then become my responsibility.

SECTION III: ACKNOWLEDGEMENT OF NON-COVERED CHARGES

I understand that some expenses are not covered by my health insurance carrier. I agree to pay all copay, coinsurance, and deductible amounts in full in a timely manner.

I understand that certain visit types and procedures may not necessarily be covered by my health insurance carrier, and agree to pay for all associated expenses incurred **across all dates of service** in that event, except for those services in which billing a patient is prohibited by law.

I understand that certain expenses may not be assigned to my personal responsibility by my health insurance carrier before the end of my care with Infectious Diseases Associates, PC. In such events, I agree to have a bill for any outstanding balance **discretely** sent to my address on file, or acknowledge that I have arranged alternate/electronic invoicing methods with the office staff at Infectious Diseases Associates, PC.

I understand that failure to ensure all billed charges assigned to my responsibility are paid to the charged, contracted, or agreed total may result in my account balance being transferred to a collections agency, except where prohibited by law.

SECTION V: ACKNOWLEDGEMENT OF ENTITLEMENT

I understand that any questions I may have regarding a bill can be directed toward the billing and management staff of Infectious Diseases Associates, PC, and that I am entitled to an explanation of charges upon receiving a bill for an outstanding balance of any amount.

SECTION VI: SIGNATURE

My signature below constitutes my acknowledgement that I have read and understand the above information, that any questions I have asked have been answered to my satisfaction, and that I agree to the policies and terms listed.

× _____ _____

Patient Signature (or signature of other authorized representative) Date Signed

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PERSONAL HISTORY SELF-REPORTING QUESTIONNAIRE FORM

SECTION I: PATIENT INFORMATION

Patient Name: _____ **DOB:** _____/_____/_____ **Sex:**____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Alt:** _____

Email Address: _____

I would like access to the healow PATIENT PORTAL using the email address I have provided. ☐ Yes ☐ No

Preferred Name: _____ **Preferred Pronouns:** _____ ☐ Prefer to Not Answer

Primary Language: _____ ☐ Translator Needed **Race:** _____ ☐ Prefer to Not Answer

Ethnicity: _____ ☐ Prefer to Not Answer **Nation of Origin:** _____ ☐ Prefer to Not Answer

SECTION II: EMERGENCY CONTACT INFORMATION

Contact Name: _____ **Relation:** _____

Street Address: _____ ☐ Same as Patient

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Alt:** _____

I authorize **IDAPC** to share details related to my case with my emergency contact. ☐ Yes ☐ No

SECTION III: CARE TEAM AND PHARMACY INFORMATION

Primary Care Provider: _____ **City:** _____

Referring Provider: _____ ☐ Same as Primary Care Provider

Other Provider: _____ **Specialty:** _____

Other Provider: _____ **Specialty:** _____

Other Provider: _____ **Specialty:** _____

Pharmacy: _____ **Street:** _____ **City:** _____

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Section IV: Medical History

Please indicate with a ✓ if any of the following apply to your medical history.

Condition	Current	Past	Notes
Bone Infections	☐	☐	
Cancer	☐	☐	
Congestive Heart Failure	☐	☐	
Diabetes	☐	☐	
Frequent Urinary Tract Infections	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure/Hypertension	☐	☐	
HIV/AIDS	☐	☐	
Kidney Failure	☐	☐	
MRSA/Staph Infections	☐	☐	
Pneumonia	☐	☐	
Skin Infections	☐	☐	
Tuberculosis	☐	☐	
Other	☐	☐	
	☐	☐	
	☐	☐	

Section V: Medications

Please list all medications you are currently taking, including prescriptions and over-the-counter. ☐ Separate List Attached

Medication Name	Dosage	Frequency

Section VI: Allergies

Please list all known allergies, including allergies to any medications. ☐ No Known Allergies

Allergy	Reaction

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Section VII: Procedures & Testing

Please list all recent procedures, including CAT scans, MRIs, blood tests, urine tests, and x-rays.

Procedure	Date	Location

Section VIII: Hospitalizations

Please list all recent inpatient hospital admissions, regardless of length of stay.

Reason for Admission	Date	Location

Section IX: Surgeries

Please list all surgeries you have undergone, including emergency, reparative, cosmetic, and transplants.

Surgery	Date	Location

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Section X: Family History

Please indicate with a ✓if any members of your immediate family have suffered from any of the below.

✓ All That Apply	Mother	Father	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify								

Section XI: Social History

Please indicate with a ✓to any of the following that apply.

Marital Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed		
Employment Status	☐ Unemployed	☐ Full-Time	☐ Part-Time	☐ Contract	☐ Student	☐ Retired	☐ Disability
Occupation							
IV Drug Use	☐ Yes	☐ No	☐ Former	Specify:			
Recreational Drug Use	☐ Yes	☐ No	☐ Former	Specify:			
Marijuana Use	☐ Yes	☐ No	☐ Former	Specify:			
Tobacco Use	☐ Yes	☐ No	☐ Former	Specify:			
Alcohol Use	☐ Yes	☐ No	☐ Former	Specify:			
Have you recently been in contact with children?	☐ Yes		☐ No				
If yes, were any of the children sick?	☐ Yes	☐ No	☐ Unknown	☐ N/A			
How many people live in your home?	☐ 1	☐ 2-4	☐ 5-8	☐ 9+			
Please list any places you have travelled to				☐ N/A			
Do you spend time outdoors?	☐ Yes		☐ No				
Have you noticed any recent bite marks or attached insects?	☐ Yes		☐ No				
Have you recently experienced any physical trauma or lacerations?	☐ Yes		☐ No				
Please list any pets you spend time with.				☐ N/A			

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Section XII: Review of Systems

Please indicate with a ✓ if any of the following apply to you.

Constitution				
☐ Fever	☐ Chills	☐ Night Sweats	☐ Weight Loss	☐ Swollen Lymph Nodes

Eyes			
☐ Visual Changes	☐ Pain Behind Right Eye	☐ Pain Behind Left Eye	☐ Pain Behind Both Eyes

Ears			
☐ Decreased Hearing	☐ Ringing	☐ Pain	☐ Drainage

Nose		
☐ Sinus Troubles	☐ Hay Fever	☐ Seasonal Allergies

Mouth & Throat			
☐ Sore Throat	☐ Thrush	☐ Oral Ulcers	☐ Recent Dental Work

Cardiac				
☐ Chest Pain	☐ Palpitations	☐ Heart Murmur	☐ Pacemaker	☐ Artificial Valve

Pulmonary		
☐ Coughing	☐ Shortness of Breath	☐ Emphysema

Gastrointestinal				
☐ Nausea	☐ Vomiting	☐ Abdominal Pain	☐ Diarrhea	☐ Decreased Appetite

Gastrourinary					
☐ Urinary Pain	☐ Blood in Urine	☐ Frequent UTIs	☐ Discharge	☐ Urinary Frequency	☐ History of STDs

Back		
☐ New Back Pain	☐ History of Back Pain	☐ Chronic Back Pain

Musculoskeletal			
☐ Joint Pain	☐ Joint Swelling	☐ Muscle Weakness	☐ Muscle Pain

Hematology			
☐ Easily Bruised	☐ Unexplained Bruises	☐ Bleeding Disorder	☐ History of Blood Transfusions

Skin				
☐ Psoriasis	☐ Itching	☐ Rashes	☐ Recent Tattoos	☐ Recent Piercings

Psychology			
☐ Depression	☐ Anxiety	☐ Suicidal Ideation	☐ Suicidal Actions

Endochrine		
☐ Diabetes	☐ Hypothyroidism	☐ Hyperthyroidism

Neurology			
☐ History of Seizure Disorder(s)	☐ History of Stroke(s)	☐ Dizziness or Vertigo	
☐ Lightheadedness	☐ Numbness or Tingling	☐ Leg Weakness	☐ Headaches or Migraines

Section XIII: Signature

My signature below constitutes my acknowledgement that the information provided is both correct and accurate to the best of my knowledge and ability.

× _____ _____

Patient Signature (or signature of other authorized representative) Date Signed

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