INFECTIOUS DISEASE ASSOCIATES

Outpatient Diagnosis and Treatment in the Merrimack Valley

PATIENT DEMOGRAPHIC SURVEY

Section I: Patient Information

Legal Name		DOB		Sex	
Preferred Name		Pronouns			
Street Address					
City		State		ZIP	
Phone #		Alternate #			
Email Address					

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

Section II: Emergency Contact Information

☐ No Emergency Contact

Name		Relation			
Street Address					
City		State		ZIP	
Phone #		Alternate #			
Email Address					

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

Section III: Care Team Information

Primary Care Provider (PCP)	☐ None	City			
Referring Provider	☐ Same as PCP				
Other Provider		Specialty			
Other Provider		Specialty			
Pharmacy		Street		City	

Infectious Diseases Associates, PC
380R Merrimack St • Suite 2B
Methuen, MA 01844
Ph: (978) 689-2510 • Fx: (978) 689-3510

Venugopal Saddi, MD
Ekaterina Klevtsova, MD
Karolyne Stimpson, NP

www.infectiousdisease.clinic

INFECTIOUS
DISEASE ASSOCIATES
Outpatient Diagnosis and Treatment in the Merrimack Valley

GENERAL CONSENT FOR CARE & TREATMENT

Section I: Authorization & 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 judgment.

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 & 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 acknowledgment 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 as stated above.

×_____ _____

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

Infectious Diseases Associates, PC
380R Merrimack St • Suite 2B
Methuen, MA 01844
Ph: (978) 689-2510 • Fx: (978) 689-3510

Venugopal Saddi, MD
Ekaterina Klevtsova, MD
Karolyne Stimpson, NP

www.infectiousdisease.clinic

INFECTIOUS
DISEASE ASSOCIATES
Outpatient Diagnosis and Treatment in the Merrimack Valley

INSURANCE & BILLING AUTHORIZATION AND POLICY AGREEMENT

Section I: Authorization of 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 II: Acknowledgment 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 III: Acknowledgment of No-Show Policy

I understand that adhering to my scheduled appointment time, both in-office and via telehealth, is my responsibility. I further understand that if I am unable to keep my scheduled appointment time, it is my responsibility to notify the staff at Infectious Diseases Associates, PC no more than one (1) hour before the scheduled appointment time. I understand that failing to do so before my scheduled appointment time will incur a fee of $50.00 that cannot be billed to my health insurance carrier.

Section IV: Acknowledgment 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 V: Responsibility for Non-Covered Charges

I understand that some expenses are not covered by my health insurance carrier. I agree to pay all copay, coinsurance, no-show fees, and deductible amounts in full in a timely manner.

I understand that certain visit types and procedures may not be covered by my health insurance carrier, and, in those circumstances, agree to pay for all associated expenses incurred across all dates of service.

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. I agree to have a bill for any outstanding balance discretely sent to my address on file, or acknowledge that I have arranged for 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 VI: Acknowledgment 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 VII: Signature

My signature below constitutes my acknowledgment 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

Infectious Diseases Associates, PC
380R Merrimack St • Suite 2B
Methuen, MA 01844
Ph: (978) 689-2510 • Fx: (978) 689-3510

Venugopal Saddi, MD
Ekaterina Klevtsova, MD
Karolyne Stimpson, NP

www.infectiousdisease.clinic