Consultants in Infectious Disease, LLC

Diagnosis, Treatment, & Prevention of Infectious Diseases

PATIENT INFORMATION

Referring MD_______________________________ **Primary Care MD**________________________________

____
Patient Last Name

_________________________________ ______
Patient First Name **MI**

____
Social Security Number

_____ /_______/ ________
Date of Birth (MM/DD/YY)

Male **Female** **Transgender** (circle one)

Single **Married** **Divorced** **Separated** **Widowed** (circle one)

Employer:______________________________________

Preferred Language:____________________________

Race:____

____
Street Address

____
City

__________________________ _______________
State **Zip Code**

____
Email

Patient Home Phone:____________________________
Do you have voicemail? Yes NO

Patient Cell Phone_____________________________
Do you have texting? Yes NO

Patient Work Phone_____________________________

Need Interpreter:_______________________________

Ethnicity:_____________________________________

RESPONSIBLE PARTY INFORMATION

(Will be self unless patient under age of 19 years)

__________________ ________________________
Last Name **First Name**

__________________ ______________ __________
City **State** **Zip Code**

Responsible Party Home Phone______________________

Responsible Party Cell Phone______________________

EMERGENCY CONTACT NAME:____________________________________**RELATIONSHIP:**_________________________________

PHONE:______________________**ADDRESS:**____

INSURANCE

Please present insurance card(s) and photo ID to be copied.
IF THE PATIENT IS NOT THE POLICY HOLDER * INFORMATION MUST BE FILLED OUT

PRIMARY Insurance______________________________

*Policyholder’s Name______________________________

*Policyholder’s Birth Date__________________________

*Patient’s relationship to insured______________________

*Policyholder s Employer___________________________

SECONDARY Insurance____________________________

*Policyholder’s Name______________________________

*Policyholder’s Birth Date__________________________

*Patient’s relationship to insured______________________

*Policyholder s Employer___________________________

PHARMACY INFORMATION

Preferred Pharmacy is____Location__________________________________

Mail Order Pharmacy ____ID #_____________________________________

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ADVANCED DIRECTIVE

I have an advanced directive outlined: ______ NO _______YES *(please get us copy of your directives for you file)*

NOTICE OF PRACTICE SPECIALTY
Consultants in Infectious Disease physicians are Board Certified Board Eligible in Infectious Disease. Infectious Disease is a consultative practice dealing with the diagnosis, treatment and prevention of infectious diseases. Due to some of our patient's diagnoses, their physician in this practice may be a frequent provider of their medical care, however, we are not to be considered a Primary Care provider. The majority of our physicians' time is required in the hospital setting which does not allow them the time to maintain daily office hours and staffing that are required of a primary care physician's practice.

APPOINTMENT NO SHOW, RESCHEDULE, AND CANCELLATION POLICY
Missed appointments, without notifying us at least 24 business hours in advance are considered a "No Show" appointment. In the even of a No Show, a $25 fee will be assessed to your account that will need to be paid in full prior to scheduling any further appointments. After the first No Show you will receive a letter notifying you of the No Show and the missed appointment will be documented in your account ledger and records. After two No Shows, CIDLLC reserves the right to no longer provide patient care services in either the clinic or hospital inpatient outpatient settings. The patient will then be advised of discharge from CIDLLC via certified letter.

We track reschedule and cancelled appointments. If you reschedule or cancel more than 3 times in a 12 month period, you may not be allowed to schedule further appointments.

LATE ARRIVAL
Late arrival for a scheduled appointment leads to inadequate time to see other patients on the schedule. If you are more than 10 minutes late, you may be asked to reschedule.

FINANCIAL RESPONSIBILITY
I hereby authorize payment of medical benefits directly to Consultants in Infectious Disease, LLC (hereinafter,"CIDLLC") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV").

I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to CIDLLC. I understand that my COPAY is part of my insurance contract and is due at the time of the appointment. I further understand should my account become delinquent; I shall pay the attorney fees or collection expenses of CIDLLC, if any. If my account is past due and sent to a collection program a $15 late fee may be applied to my balance due. If my account does go to full collection I understand I will no longer be a patient in this practice as allowed by Nebraska law.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient Signature:____**Date**:__________________________________

INSURANCE RELEASE OF INFORMATION

I request that payment of authorized insurance benefits be made to me or on my behalf to Consultants in Infectious Disease LLC for any service furnished to me by CIDLLC. I authorize CIDLLC to release any medical information to my insurance and its agents to determine these benefits or the benefits payable for related services.

Patient Signature:____**Date**:__________________________________

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MEDICARE RELEASE OF INFORMATION

I request that payment of authorized Medicare benefits to be made either to me or on my behalf to Consultants in Infectious Disease LLC for any service furnished to me by CIDLLC. I authorize release to the Center for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services

I further request that payment of authorized MediGap benefits be made either to me or on my behalf to CIDLLC for services rendered. I authorize CIDLLC to release any medical information about me to my MediGap insurer and its agents to determine these benefits or the benefits payable for related services.

Patient Signature:____**Date**:________________________________

MEDICATION HISTORY RECONCILIATION

The physicians of Consultants in Infectious Disease, LLC believe that knowing your full medication history is essential in helping to decide your treatment plan. They need to know what medications and dosages you have taken in the past or might currently be taking to assist them in arriving at your care plan. Most medication history as well as ordering most medications can now take place electronically through our electronic medical record.

I agree that CIDLLC may request and use my prescription medication history that is now often available electronically. The access of this information is for treatment purposes and to strength continuity of care.

Patient Signature:____**Date**:________________________________

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Patient's Name :____

ACKNOWLEDGMENT OF THE RECEIPT OF CONSULTANTS IN INFECTIOUS DISEASE, LLC NOTICE OF HEALTH INFORMATION PRACTICES
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Consultants in Infectious Disease, LLC is furnishing you the opportunity to review the notice or have a copy of your own, which provides information about how CIDLLC and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have had a chance to review or received a copy of CID's Notice of Health Information Practices.

Patient Signature:____**Date**:______________________________

Due to the HIPAA regulations, if you are wanting us to be able to talk to a friend or any family members (this includes spouse) regarding your care or any financial issues, we will need you to indicate whom these persons are below.

<u>I Authorize CIDLLC to speak with or release documents/information regarding my care to:</u>

____ __________________________ ________________
Name Relationship Phone

____ __________________________ ________________
Name Relationship Phone

<u>Specific authorization for release of information protected by state or federal law.</u>

I specifically authorize the release of data and information relating to: (check appropriate box below)

1. Substance Abuse (alcohol/drug abuse) _______YES _______NO _______NOT APPLY
2. Mental Health _______YES _______NO _______NOT APPLY
3. HIV Related Info (AIDS related testing) _______YES _______NO _______NOT APPLY

Patient Signature:____**Date**:______________________________