PATIENT REGISTRATION FORM

PLEASE GIVE YOUR INSURANCE CARD(s) and GOVERNMENT ISSUED PHOTO ID TO RECEPTIONIST

DEMOGRAPHIC INFORMATION	DEMOGRAPHIC INFORMATION
Patient Name (Last, First, Middle)_____ Patient Address:_____ Apt #:_____ City_____ State_____ Zip_____ Home Phone#_____ Cell Phone#:_____ Email Address: _____	May we leave a message on your answering machine? YES / NO Marital Status: Single / Married / Separated / Divorced / Widowed Social Security # _____ DOB: _____ Race: _____ Ethnicity: _____ Language: _____
	EMERGENCY CONTACT (Provide Different Phone Number)
Employer: _____ Occupation: _____ Address: _____ Work Phone: _____	Name: _____ Address: _____ Cell Telephone: _____ Work Telephone: _____ Relationship to Patient: _____
MEDICAL PROVIDER INFORMATION	PHARMACY INFORMATION
Family/Primary Care Physician: _____ Address: _____ Telephone: _____ Who referred you to our office? _____	Name of Pharmacy: _____ City, State Zip Code: _____ Telephone Number: _____
MISCELLANEOUS	
	Identity Verified □ Driver's License □ Government Photo ID □ Utility Bill

CONSENT TO OBTAIN PHARMACY INFORMATION ELECTRONICALLY:
I hereby consent to allow Infectious Diseases Associates, PC to obtain my pharmacy information which includes medications, dosages, and prescriptions filled from participating pharmacies. I consent to their sending electronic prescriptions. This helps to reduce medication error while providing your physician with your most up-to-date mediation profile.

X_____ DATE: _____
PATIENT AND/OR GUARDIAN SIGNATURE

Advance Care Plan (This section only needs to be completed if you are 65 years or over)

An advanced care plan is a legal document which advises someone of your wishes in the event that you are unable to make your own health care decisions and gives them permission to carry out your wishes.

1. Does the patient have Advanced Directives? Yes _____ No _____

To Whom Do You Want to Consent For Our Office to Discuss Your Medical Condition

1. Name: _____ Relationship: _____ Telephone: _____

2. Name: _____ Relationship: _____ Telephone: _____

3. Name: _____ Relationship: _____ Telephone: _____

4. Name: _____ Relationship: _____ Telephone: _____

5. Name: _____ Relationship: _____ Telephone: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I (or designated guardian) authorize Physician to provide treatment and release medical information to my insurance as may be necessary for payment of physician claims. I (or designated guardian) hereby authorize payment directly to Physician of the benefits otherwise payable to me but not to exceed regular charges for physician claims. I (or designated guardian) understand that I am financially responsible to the Physician for charges not covered by my insurance.

X_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE **DATE**

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Physician to supply to another Physician involved in my medical care a copy of necessary medical records and/or test results requested by the Physician but ordered by my Primary Care Physician. I understand this is for the release of medical information only. If I am a managed care subscriber, I authorize my Physician to allow my Managed Care Organization access to my chart for Quality Review Purposes.

X_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE **DATE**

CONSENT TO SEND APPOINTMENT REMINDERS

I hereby consent to Infectious Diseases Associates, PC use of my medical information for the purpose of sending Appointment Reminders, unless and until revoked by me in writing.

X_____ DATE: _____

PATIENT AND/OR GUARDIAN SIGNATURE

MEDICARE PATIENTS (MUST COMPLETE THE NEXT TWO SECTIONS)

MEDICARE BENEFITS Patient's certification, authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct. I authorize any holder or medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for physician claims and other related medical claims. I request that payment of claims be made on my behalf for authorized benefits under my health insurance. I hereby authorize payment directly to my Physician for insurance benefits otherwise payable to me. Payments are not to exceed the balance due of the practice's regular charges for these claims. I understand that I am financially responsible to my Physician for charges not covered by this authorization. I understand that my Physician will bill HCDA using the term "signature on file" and am aware that my signature as written below constitutes that "on file "signature".

X_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE **DATE**

MEDIGAP BENEFITS I hereby give my Physician permission to ask for Medigap payments for my medical care. I understand that my Medigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my Medigap Insurer. I request that payment of authorized Medigap benefits be made to Infectious Diseases Associates, P.C. on my behalf for any services furnished me by my Physician. I authorize any holder of medical information about me to release Medigap Insurer any information needed to determine these benefits of the benefits payable for related services.

X_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE **DATE**

CONSENT OF TREATMENT FOR MINOR/INCAPACITATED PATIENTS

I hereby authorize Physician to provide treatment to _____. Patient is unable to consent
to medical treatment because minor child/other_____.

X_____ X _____ X_____

SIGNATURE OF GUARDIAN **NAME OF GUARDIAN** **WITNESS SIGNATURE**

DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I. I acknowledge receipt of Notice by signature

_____
Patient/Guardian Name (Printed)

_____ _____
Patient/Guardian Name (Signature) Date

II. Signature Unable to be Obtained due to:

- ❑ Patient Refused
- ❑ Patient Incapable of Signing (explain_____

_____

- ❑ Other (explain)_____

_____

_____ _____
Office Staff Signature Date

NOTE: We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. We may use your PHI for purposes of calling your home or alternate location and leaving a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Health Care Operations), such as appointment reminders, insurance items and any calls pertaining to your clinical care, including laboratory results among others, unless or until revoked by you in writing. We may mail to your home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, unless or until revoked by you in writing.