PATIENT REGISTRATION FOR TRAVEL PATIENTS

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

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

**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**

**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.