

INFECTIOUS DISEASE — CONSULTANTS —

Patient Consent

For Use And/Or Disclosure of Protected Health Information
To Carry Out Treatment, Payment and Healthcare Operations

Please read the following statements carefully:

By signing this form, I will consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations with those directly involved with my healthcare; i.e. pharmacy, insurance company, healthcare provider, etc. I also give permission for Infectious Disease Consultants to obtain my prescription history from my insurance company.

I understand that insurance will be filed by this office as courtesy and does not constitute a contract between the physician and insurance company for payment of services.

I hereby authorize Infectious Disease Consultants to furnish to my insurance company or to the social security administration and health care financing or its intermediates or carrier any information needed regarding my medical treatment. Regulations pertaining to Medicare assignment of benefits apply. I also authorize my insurance benefits to be paid directly to Infectious Disease Consultants. I understand that I am financially responsible for all services rendered including charges or penalties made to Infectious Disease Consultants for any outside collections assistance. I realize that the physician is not responsible for any financial decisions of non-payment made by an insurance company contracted by the insured to assist in payment of medical services. I authorize an associate from Infectious Disease Consultants to act on my behalf, if necessary, to appeal decisions of non-payment, and to the insurance commissioner governing my insurance company; I permit a copy of this to be used as the original. I understand and acknowledge that I am responsible for payment of any service not covered by my insurance plan and any unpaid balance beyond 30 days will cause finance charges to accrue at ½ % per month or 18% annually.

Medicare Patients

I understand and acknowledge as a Medicare patient under Medicare law, I must pay a annual deductible for Part B services and a 20% co-insurance on claims for services that are submitted after meeting the deductible.

Cancellation Policy

I understand it is my responsibility to cancel and/or reschedule an appointment 24 hours prior to the appointment and if I fail to do so, I may be assessed a cancellation fee of \$75. I understand that this fee is not covered by my insurance plan.

Privacy Policy

I hereby acknowledge that I have been made aware that Infectious Disease Consultants has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Infectious Disease Consultants has made this policy available to me for review by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or common area with patient’s access. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. I am aware that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Request for Alternative Communication Methods

It is permissible to leave messages regarding my appointment and care on the telephone number provided above.

Please disclose my personal health information with the following person listed below:

Name: _____ Relationship: _____

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I also understand that if I do not sign the consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not be obligated to treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient (Printed)

Signature of Patient

Signature of Legal Representative

Relationship

Date