INFECTIOUS DISEASE CONSULTANTS

Patient Information and Consent Form					
Name				DOB	
Address			City	State	Zip
Home Phone	Cell Phone			Email	
Please Circle all that apply: Male / Female Employed / Retired / Other Married / Single / Other					
Primary Care Physician			Referring Physician		
Pharmacy			Pharmacy Location and Phone		
Primary Insurance			Secondary Insurance		

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 a 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 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 collection 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 the 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 **Initial _________**

I understand and acknowledge that as a Medicare patient under Medicare law, I must pay a $257.00 annual deductible for Part B services and a 20% co-insurance on claims for services that are submitted after meeting the deductible.

Cancellation Policy **Initial _________**

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

Privacy Policy **Initial __________**

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 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.

Practice Guidelines and Policies

Additional practice guidelines and policies are available per request and are available at our front desk.

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.

Advance Directive

An advance directive, sometimes called a "living will," is a written document that tells your healthcare providers who should speak for you and what medical decisions they should make if you cannot speak for yourself.

Please select advance directive wishes:

- ☐ Does not wish to have a surrogate decision-maker
- ☐ Will not disclose surrogate
- ☐ Surrogate discussed

  Name of Surrogate: ________________________________

Web Enable -Office Policy

It is our office policy that every patient who has an email address be web-enabled through our eClinicalWorks messenger service and our patient portal. We highly recommend this feature as we send all labs and other results along with patient communications through the portal. See "Benefits"

BENEFITS

- Secure Website
- Request Appointments
- Send Request to Cancel Appointments
- View Your Personal Healthcare Record
- Receive Updates on Future Events (Flu Clinic, Physical, Etc.)
- Request Prescriptions Refills
- "Ask" Your Healthcare Provider
- Request a Referral
- View Appointment Confirmation
- View Your Labs Results

By initialing, I give permission to be web-enabled. **Initial** ________

I received my copy of the practice guidelines. **Initial** ________

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

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Name of Patient (Printed) **Signature of Patient**

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Signature of Legal Representative **Relationship to Patient**