INFECTIOUS DISEASES ASSOCIATES, PLLC

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

PATIENT INFORMATION: (Please Print)

PATIENT NAME: _____
(Last) (First) (Middle) (Maiden)

SOCIAL SECURITY NUMBER: _____ Male☐ Female☐

RACE:(optional) African American☐ White☐ Hispanic☐ Asian☐ Other☐

ADDRESS: _____
(Street) (City) (State) (Zip)

PHONE: (_____) _____DOB:_____MARITAL STATUS: Ⓜ Ⓢ Ⓦ Ⓓ

CELL PHONE: (_____) _____WORK PHONE: (_____)_____

EMAIL ADDRESS: _____

EMPLOYER NAME & ADDRESS: _____

REFERRING PHYSICIAN: _____

GUARDIAN NAME: (IF PATIENT UNDER 18) _____

ADDRESS: _____ PHONE: (_____)_____

IN CASE OF EMERGENCY: (NEAREST RELATIVE NOT LIVING WITH YOU)

NAME: _____

RELATIONSHIP: _____ PHONE: (_____)_____

PRIMARY INSURANCE: _____ PHONE: (_____)_____

BILLING ADDRESS: _____

POLICY NUMBER: _____ GROUP NUMBER:_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____

Please provide your insurance card(s) to the receptionist when you register. It is the policy of Infectious Diseases Associates, PLLC to collect co-payments at time of service.

INFECTIOUS DISEASES ASSOCIATES, PLLC

Dr. Anita Fleenor, MD Dr. Carl LeBuhn, MD

Financial Policy and Assignment of Benefits

* For the convenience of our patients, we participate with Medicare, Medicaid, and most major insurance companies. We will file with your insurance, however any applicable co-payments and/or deductibles are due at the time of service. The patient is also responsible for any non-covered charges incurred.

* If your insurance requires a referral from your primary care physician, it is your responsibility to provide that information so that we may bill charges to your insurance carrier.

* In the event you are not covered by insurance, payment is due when services are rendered unless other arrangements have been made in advance.

* Statements will be sent out at the first of each month. When you receive a statement payment is due within 30 days. Any account that becomes past due will be considered for collection procedures, which may include legal proceedings.

* A $25.00 fee will be charged to patients for any returned checks.

* By signing this, you are agreeing with the policies stated above, as well as the assignment of benefits, and medical information release below.

Assignment of Benefits

I request that payment of authorized benefits be made to the above named doctor(s) on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, and any other governmental or private payer responsible for paying such benefits, and information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

_____ _____

Signature of patient or guardian Date

INFECTIOUS DISEASES ASSOCIATES, PLLC

Patient History Form

NAME: _____ GENDER: Male☐ Female☐

DOB:_____ AGE:_____

SOCIAL HISTORY

MARITAL STATUS: ■ M ☐ S ☐ W ☐ D CHILDREN: ☐ No ☐ Yes, how many _____

TOBACCO USE?: ☐ No ☐ Yes, how many packs per day _____

ALCOHOL USE?: ☐ No ☐ Yes, how much per day _____

DRUG USE (other than prescribed medications)?:

☐ No ☐ Yes, what kind, how often used _____

FAMILY HISTORY (Parents, siblings, grandparents)

☐ Cardiac Disease (list family member) _____

☐ Cancer (list type and family member) _____

☐ Hypertension (list family member) _____

☐ Diabetes (list family member) _____

☐ Other (list family member) _____

_____

_____

Drug Allergies

List Name of Drug(s) below:	What type of allergic reaction?

Current Medications Current Medications (both Rx and Herbal)

Name of Medication	Dosage

Preferred Pharmacy:_____ Location:_____

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Patient History Form (continued)

MEDICAL HISTORY (Check appropriate Box… Obtained from ☐ Patient ☐ Other _____)

Neurologic: ☐ Stroke ☐ Headache ☐ Head Injury ☐ Seizures	**Musculoskeletal:** ☐ MS ☐ Amputee ☐ Arthritis
Respiratory: ☐ COPD ☐ TB ☐ Asthma ☐ Home O2	**GI:** ☐ Hepatitis ☐ Ostomy ☐ Ulcers
Immune: ☐ HIV ☐ Chemo ☐ Radiation ☐ Transplant (please list)_____	**Pain:** ☐ Sleep ☐ Appetite ☐ ADL Location: _____
Circulatory: ☐ CHF ☐ CABG ☐ MI ☐ Pacemaker ☐ HBP	**Psychiatric:** ☐ Depression ☐ Anxiety
GU: ☐ Renal Failure ☐ Kidney Stones ☐ Catheter	**Endocrine:** ☐ Diabetes ☐ Insulin ☐ Thyroid ☐ Hypoglycemia
Reproductive: ☐ Pregnant ☐ BPH ☐ STD Date of last menstrual period: _____	**Other:** _____ _____
☐ Immunizations Up to Date	Last Tetanus: _____ Last Flu: _____ Last Pneu: _____

SURGICAL HISTORY

☐ Hysterectomy ☐ Gallbladder ☐ Appendectomy ☐ Stomach (list procedure) _____

☐ Tubal Ligation ☐ Vasectomy ☐ Bowel (list procedure)_____

Hip Fracture - ☐ Right or ☐ Left Hip Replacement - ☐ Right or ☐ Left Knee Replacement - ☐ Right or ☐ Left

☐ Arthroscopy (list procedure)_____ ☐ Carotid ☐ Vascular

☐ PE Tubes ☐ Tonsillectomy ☐ Removal Skin Lesions/Cancers (location of lesion) _____

☐ Other _____

_____

_____ _____

Signature of Patient or Guardian Date

INFECTIOUS DISEASES ASSOCIATES, PLLC

Dr. Anita Fleenor, MD Dr. Carl LeBuhn, MD

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EFFECTIVE MAY 1, 2009

To our Patients:

All physician offices must now confirm patient's demographic information and verify patient's identityat each visit under the Federal Government's Identity Theft Red Flags and Address Discrepancies Rule.

A photograph will be taken of you at the front desk. You must also provide us with a photo ID, such as a driver's license that shows your current address. If this ID does not show your current address, we must verify it with an addressed correspondence to you, such as a utility bill. In the case of a minor, we will collect the information on the legal guardian who brings the patient in as well.

The photo identification will be used at all future visits to confirm your identity and to identify potential red flags for both financial and medical identity theft.

INFECTIOUS DISEASES is committed to protect our patient's information and prohibit illegal misrepresentation. Thank youfor cooperating with us to keep you and your information safe!

ADVANCE CARE PLAN: I currently have an advanced care directive. (Living Will)

☑ Yes ☐ No

_____ I appoint the person listed below to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided bythe decisions I have made in the parts of the form that follow. (Place your initials in blank provided.)

I understand that Infectious Diseases Associates, PLLC may leave medical/financial information by the following methods: home telephone, home answering machine, cell phone, page, work telephone, work voice mail. I consent to Infectious Diseases Associates, PLLC (the "Practice") using or disclosing my protected health information (PHI) for the purpose of providing treatment to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my (PHI) for treatment activities provided by another health care provider, and well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my PHI in order for assessment and reviewing the competence of health care professionals.
The following people are also authorized to receive a copy of my PHI.

SPOUSE/SIGNIFICANT OTHER: _____ PHONE: (_____)_____

OTHER: _____ PHONE: (_____)_____

OTHER: _____ PHONE: (_____)_____

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Signature of Witness Date