ASSOCIATES IN INFECTIOUS DISEASES & TRAVEL MEDICINE, LLC

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. (Please Print) All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date__ /__ /__ Age___ ___	Marital Status Single ( ) Married [ ] Widowed [ ] Divorced [ ] Separated [ ]
Residence Address City State Zip E-Mail Address:		Home Phone: Cell Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birth Date / /	Responsible Party's Social Security#
Responsible Party's Drivers License # State: Number:		Occupation	How Long At Current Employer?
Name of Employer Address		Business Phone	Occupation
Name of Spouse/Parent	Birth Date	Social Security#	Business Phone
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship To Patient	Phone	

Race: Asian [ ] Black [ ] Hispanic [ ] White [ ]	Language: English [ ] Spanish [ ] Other [ ] (use line below)	Ethnicity: Latino [ ] Non Latino [ ]

Workers' Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] If Yes-put W/C or MVA carrier below	Date of Accident	Treatment authorized by	Claim#	W/C or MVA Insurance Phone#
Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy#		Group#
Secondary insurance name Address			Policy#	Group#

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Associates in Infectious Diseases & Travel Medicine, LLC for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.

Patient Signature _____ Date _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Associates in Infectious Diseases & Travel Medicine, LLC for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient, Parent or Guardian Signature (if child is under 18 years old) _____ Date _____

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Patient Medical History Sheet

Name: _____ Name of Referring Physician: _____

Medications name and dosage unless you already have a list written (pls give to receptionist)

1.	2.	3.
4.	5.	6.
7.	8.	9.

Allergies to any Medications

1.
2.
3.

Family History (Please list parents & sibling's names, ages & date of birth, living or deceased and any related health issues)

Mother:
Father:
Siblings:

Personal medical history (Hypertension, Diabetes, High Cholesterol, etc...)

1.
2.
3.

Please list all Surgical History (date, age etc when you had surgery)

1.
2.
3.

Please List local & Mail away Pharmacy

Please list Personal Email for future use of patient portal

ASSOCIATES IN INFECTIOUS DISEASES & TRAVEL MEDICINE, LLC

OFFICE FINANCIAL POLICY

Associates in Infectious Diseases & Travel Medicine, LLC's goal is to provide and maintain a good physician-patient relationship. Please read this carefully and if you have any questions, please feel free to ask any member of our staff.

1. Upon arrival, please sign in at the front desk and present your current insurance card(s) at every visit. If we are your Primary Care Physician, please make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your Primary Care Physicians as of this date, you may be financially responsible for the visit.
2. It is your responsibility to understand your benefit plan. It is also your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure and what services are covered.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances.
4. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
5. If you have no insurance, payment for an office visit is to be made at the time of the visit.
6. Co-pays are due at time of service. A $10 processing fee will be charged in addition to your co-pay if the copay is not paid at time of service or by the end of the next business day.
7. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 business days of the statement date.
8. If previous arrangements have not been made with our Finance Office, any account balance over 90 days will be turned over to a collection agency.
9. We require 24 hours' notice for canceling any appointments, or a $40 fee will be applied.
10. A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred
11. We charge $1 per page for Medical Record copying, as allowed by law. If you or your child has school forms, camp forms, sport forms etc. to be completed, there is a $1 charge per page. Payment is due when the forms are dropped off. We have a one-week turnaround time for those forms.
12. Advance notice is needed for all non-emergent referrals. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
13. Before making an annual physical appointment, check with your insurance company and inquire whether the visit will be covered as a well/healthy visit. Not all plans cover annual well/healthy physicals, it is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name: _____

Patient, Parent or Guardian _____ Date _____

Associates in Infectious Diseases & Travel Medicine, LLC

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE
AND
DESIGNATION OF DISCLOSURE

Acknowledgment of Privacy Practice Notice

I have received a copy of the Associates in Infectious Diseases & Travel Medicine, LLC's Notice of Privacy Practices.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient/Parent/Guardian Date

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Associates in Infectious Diseases & Travel Medicine, LLC may disclose my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Associates in Infectious Diseases & Travel Medicine, LLC will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Associates in Infectious Diseases & Travel Medicine, LLC making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this list in writing at any time.

_____ Date of Birth: _____
Print Name

_____ Date of Birth: _____
Print Name

_____ Date of Birth: _____
Print Name

_____ Date: _____
Signature of Patient/Parent/Guardian