Infectious Disease Consultants, PA

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PATIENT INFORMATION:

Date of Visit:_____Soc.Sec #_____

Patient's Name:_____

Address:_____

City/State:_____ Zip code:_____

Age:_____ Birthdate:_____ Sex: M / F (Please circle) __ Transgender

Marital Status: S /M/ W/ Partner/ Legally Separated (Please Circle)

Home Phone:_____ Cell Phone:_____

Best Way to Contact You: Home:___ Cell:____ Work:_____ (Please Check One)

May We Leave Message at: Home__ Cell:__ Work:__ (Please Check One)

Email Address _____ (Optional - to join Patient Portal)

INSURANCE INFORMATION:
Primary Insurance Carrier Name:_____

Subscriber: Self / Spouse / Parent Subscriber Name:_____
Subscriber DOB:_____
Secondary Insurance carrier Name:_____

Subscriber: Self / Spouse / Parent Subscriber Name:_____
Subscriber DOB:_____

Emergency Contact/ Personal Representative (person(s) with authority to receive information about your health status and billing):

_____Realtionship:_____Phone:_____

_____Realtionship:_____Phone:_____

Referring Physician:_____

Primary Care Physicain_____

Pharmacy: _____ **Pharm Phone #**: _____

Authorization to release Medical Information:
I hereby authorize Infectious Disease Consultants, PA to release any information acquired in the course of my examination or treatment for the purposes of billing my insurance. I hereby authorize payment directly to Infectious Disease Consultants, PA of surgical and/or medical benefits. I also will be responsible for any deductibles, co-insurances or copayments that my insurance does not cover. **If 24 hours advanced notice of cancellation of any scheduled appointment is not given to Infectious Disease Consultants, PA, I agree to payment in full for the service scheduled.**

Referral Policy:
I understand that it is my responsibility as the patient to know if my insurance requires a referral or authorization(s). I understand that if I do not have the necessary insurance referral(s) at the time of my appointment(s), I will be personally responsible for the charge of the visit.

Collection Policy:
I understand that if my account is forwarded to a collection agency a 35% surcharge will be added to the balance which I am responsible for paying.

By signing and dating I am agreeing to all of the above policies.

Printed Name of Patient:

_____

Signature of Patient:

_____Date:_____

TO DECREASE BILLING COSTS, WE ASK THAT YOU PLEASE PAY AT THE TIME OF YOUR VISIT. THANK YOU.

Please provide the information requested in the fields below regarding diversity. This information is collected in conjunction with government and record-keeping requirements. It is completely optional for you to submit and will be used only for Equal Employment Opportunity reporting requirements

Race: __ White __ Other Race __ Other Pacific Islander __ Asian
__ American Indian or Alaska Native __ Native Hawaiian Other Pacific Islander
__ Black or African American __ Hispanic __ Decline to Report

Ethnicity: __ Hispanic or Lantino __ Not Hispanic or Not Latino __ Decline to Report