Infectious Disease Specialists, P.C.
Allergies and Medications List

Patient's Name: _____ **DOB:** _____ **Phone:** _____

Pharmacy Name and Location: _____

Allergies with reactions: ☐ Check box if no known allergies or list all allergies

_____

_____

_____

Instructions: Please list all prescriptions, over-the-counter medications, herbals, and vitamin/mineral/dietary (nutritional) supplements you are currently taking: Subsequent visits only require an update of the original listing.

Date: _____

			How Taken (mark one)				
Medication Name	Dose (g, mg, etc.)	How Often	Oral	Injection	IV	Sub Q	Other (please list)
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	

Infectious Disease Specialists, P.C.

First Name: _____ **Middle**: _____ **Last Name**: _____

Nickname/Preferred Name: _____ **Maiden Name**: _____

Date of Birth: _____ **Sex**: ☐ Female ☐ Male **Social Security #**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone #: **Hom**e: _____ **Work**: _____ **Cell**: _____

Referring Physician: _____ **PCP/PG**: _____ **Phone**: _____

Race (choose one below):

☐ American Indian/Alaska Native Asian
☐ Black/African American White/Caucasian
☐ Native Hawaiian/Pacific Islander Other Race
☐ Declined

Ethnicity (choose one below):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined

***Note: Government regulations require both questions be answered or declined.**

Primary Language: _____ **Driver's License #**: _____

Marital Status (choose one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other_____

Do you currently stay at a skilled nursing facility? ☐ Yes ☐ No

Preferred Communication - Automated Appointment Reminder Service (choose one): ☐ Cell ☐ Home ☐ Work

<u>Employer Information:</u>

Employer: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Employer Phone: _____

Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed **Occupation**: _____

Electronic Health Information Exchange - Our office participates in CORHIO, an electronic, secure and confidential Health Information Exchange for health care providers participating in your care to efficiently share and access your clinical medical records. You may choose to opt-out of participation or cancel an original opt-out decision, at any time.

CORHIO- (Health Information Exchange (HIE) ☐ **Opt-In** ☐ **Opt-Out**

Emergency Contact: Please indicate a relative or friend we could contact if we are unable to reach you for any reason.

Name: _____ **Phone**: _____

Relationship: _____ May we speak to alternate contact regarding billing or patient care? ☐ Yes ☐ No

Insurance Information:

Primary Insurance Plan: _____ **Policy ID #:** _____

Group # (if applicable): _____ **Policy Holder:** _____

Policy Holder's Relationships to Patient: _____ **Policy Holder's Date of Birth:** _____

Secondary Insurance Plan: _____ **Policy ID #:** _____ **Group # (if applicable):** _____

Policy Holder: _____ **Policy Holder's Relationships to Patient:** _____

Policy Holder's Date of Birth: _____

If secondary insurance is Medicare, please mark applicable status:

- ☐ Patient is still employed - working age benefits
- ☐ Disabled (under age 65)
- ☐ Public Health Service or other Federal Agency
- ☐ No fault insurance including auto
- ☐ Black Lung
- ☐ Spouse is still employed - employer name: _____
- ☐ End-stage renal disease
- ☐ Workers compensation
- ☐ Other liability insurance
- ☐ Other reason: _____

I attest that all information above is true and current. I hereby authorize the release of all medical care information for any illness and treatment to my insurance carriers for billing, utilization review, and quality assurance purposes. For those insurances under contract, I authorize assignment to the physician of all payments for medical services rendered to me and I understand I am responsible for any amount not covered by the insurance carrier, for whatever reason. I understand all other insurance coverages will be filed as a courtesy and payment is expected at the time of service.

I acknowledge that I have been given the opportunity to review the **Notice of Privacy Practices** of Infectious Disease Specialists. This notice describes how this practice may use and disclose my protected health information, certain restrictions on its use and disclosure, and the rights I may have regarding it. A copy of this notice has been offered to me. Any questions I have regarding this notice have been answered to my satisfaction.

The Medicare Modernization Act (MMA) of2003 listed standards in an e-prescribe program which include formulary, benefit, and medication history transactions. By signing this consent form, you are agreeing that Infectious Disease Specialists can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Any questions I have regarding this consent have been answered to my satisfaction.

Patient's Signature: _____ **Date:** _____

Infectious Disease Specialists, P.C.

HIPAA Privacy Authorization Form

** Authorization for Use of Disclosure of Protected Health Information
(Required by the HealthInsurance Portability And Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization

I authorize Infectious Disease Specialists to use and disclose the protected health information described below to my spouse, family member, care advocate or Power of Attorney (PO):

1. _____

2. _____

3. _____

Effective Period

This authorization for release of information covers the period of healthcare from:

Dates: _____ to _____

☐ All past, present and future dates of service

Extent of Authorization

☐ I authorize the verbal release of my complete health record including communicable diseases, HIV or AIDS, mental health, treatment of drug or alcohol abuse. I will sign a Medical Release of Information Form ifI authorize the above individuals to obtain copies of my medical records.

Other specific medical records (please specify): _____

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization in writing at any time.

☐ I do not wish to give authorization for release of medical information.

Printed Name of Patient _____

Signature of Patient _____ Date: _____

INFECTIOUS DISEASE SPECIALISTS, P.C.
POLICIES AND PROCEDURES

The following is a statement of the Office Policy and Procedures for doctors Thomas A. Hackenberg, M.D., Peter R. Brookmeyer, M.D., Elizabeth A. Kleiner, M.D., C. Allen Bernas, M.D., Matthew A. Hevey, M.D., and Cathy J. Cichon, M.D. doing business as Infectious Disease Specialists, P.C. We require that you sign this statement acknowledging understanding and compliance prior to the rendering of professional services. We feel these policies will assist you in understanding how this office operates. Your assistance in following these policies will be greatly appreciated. If you have any questions that might help you better understand how your medical care, records, and insurance billing will be handled, please feel free to ask our staff and we will be happy to assist you.

APPOINTMENTS

We will do everything within our power to honor your appointment time. We realize that your time is valuable, too. Please understand that occasionally there are emergencies beyond our control which may cause unforeseen delays in your appointment time. If this occurs, please be considerate of our efforts and if the delay causes a burden on your time, our staff will be more than happy to reschedule your appointment.

Our office hours are Monday through Friday 8:00 A.M. to 4:30 P.M.

If you cannot keep an appointment, please notify us as soon as possible. This courtesy allows us to give your appointment time to another patient.

RELEASE OF MEDICAL RECORDS

If you need a copy of your medical records for another physician, insurance company, attorney, authorized individual(s) or yourself, you will need to fill out a Release of Medical Records Form. There may be a charge for copying your records. Contact our office in advance to determine if this charge applies to your request.

COLORADO BOARD OF HEALTH

In compliance with Colorado law, we are required to submit to the Colorado Board of Health a list of those patients who we have diagnosed with certain communicable diseases. For those patients to whom this legislation applies, their name, address, phone number, race, date of birth, sex, and diagnosis will be forwarded to the El Paso County Department of Health and Environment. Please consult your physician to determine if this mandate applies to your specific condition.

AUTO ACCIDENTS/ WORKMAN'S COMPENSATION

If you are being treated for an automobile accident or an on-the-job injury, there will be additional information required prior to being treated. You will be personally responsible for all charges until requisite information is provided to us for billing purposes. It will also be your responsibility to make sure the injuries are reported to your insurance company and/or employer so that all paperwork can be submitted to the proper authorities.

INSURANCE COPAYMENTS

Copayments are applied for each office visit and payment is required prior to treatment. In addition, daily copay may be applied for IV therapy, if so indicated and assessed by your insurance company. Occasionally, you may be subject to a co -insurance as dictated by your insurance company. You will be billed for this additional patient liability as well as for any non-covered services your insurance company disallows.

INSURANCE FORMS AND THIRD PARTY PAYMENTS

We will file insurance claims for patients provided we receive complete and accurate information. The amount that your insurance does not cover will be due upon receipt of your monthly statement.

You are responsible for knowing your insurance plan and providing us with any new information or changes with regard to your insurance coverage. If there are any stipulations regarding limits on visits, referrals, copayments, etc., you are responsible for those constraints and you must provide our office with the necessary information. If, after six weeks, your insurance company has not made payment, it is your responsibility to submit payment in full to this office.
The patient (or legal guardian, if patient is a minor) is responsible for all fees charged by this office regardless of insurance coverage. The contract you have with your insurance company is between you and your insurance company. You are totally responsible to us for payment even though we have filed a claim to your insurance company on your behalf. We cannot accept responsibility for negotiating insurance claims should there be a dispute between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

REFERRALS

It is your responsibility to know if your insurance company requires a written referral to see a specialist in this office on an outpatient basis. Should your insurance company require a written referral, it is your responsibility to secure that referral from your primary care physician prior to your visit in our office. In the event that you arrive in our office without are feral, you have two options:

1) You may reschedule your appointment to a later date to allow you time to secure your referral.
2) You may keep your appointment and sign a waiver stating that you will be responsible for the charges if you are unable to obtain a retroactive referral.

Should you choose to reschedule and have health concerns that require immediate attention, you should not delay seeking treatment from your primary care physician or an Emergency Room.

Please understand that the referral process can be tedious and inconvenient to our patients and our physicians, we are obligated by our contracts with your insurance companies to follow through with their rules and regulations.

PAYMENT POLICIES

Payments can be made by cash, check, or credit card (Visa, Mastercard, or Discover, Amex).
All returned checks are subject to a $40.00 non-sufficient funds fee.

Full payment at the time of service will be expected for those patients who do not have insurance coverage. Necessary payment arrangements must be made with the office prior to treatment.

If an account is over 90 days old without any payment activity, we may be forced to turn your account over to a collection agency or an attorney. If this occurs, the patient will be responsible for any and all collection costs.

ACKNOWLEDGEMENT

I have read and understood the Policies and Procedures outlined above and agree to these policies.

_____
Patient Name (printed)

_____ _____
Patient Signature (or legal guardian if minor patient) Date

Infectious Disease Specialists, P.C.
Patient Portal

Benefits:

- It allows some questions and issues to be handled without a phone call or visit.
- The Patient Portal can be accessed on computers, laptops, tablets and your smartphone.
- E-mail our office with non-urgent medical questions, request medical records, change demographic and insurance information.
- Request medication refills.
- View visit summaries, labs, progress notes and future appointments.

Non-essential uses: We will only use your email address or home phone number for important communications related to our practice. We will not give your email address or phone number to anyone who is not authorized.

Changes: If your email address or phone number changes, please let us know. All electronic messages become part of your medical record.

Mistakes: Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. Delete any messages that are not intended for you.

Would you like to become part of our patient portal? ☐ **Yes** ☐ **No**

Acknowledgement and Agreement

I acknowledge that I have read this form. I agree to use reasonable judgment with regard to any messages I send or receive.

Patient (or legal representative name): _____

Email address to be used: _____