## RURAL INFECTIOUS DISEASE SPECIALIST

# REGISTRATION AND HEALTH FORM

(Please Print)

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: (optional) | Home phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

## INSURANCE INFORMATION

(Please send a copy of your insurance card front and back with this form to 585-625-3855 or email it to anarine@ruralid.org)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

❑ Other

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rural Infectious Disease Specialist or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

**Your Preferred Pharmacy:**
Name :_____
Phone No.:_____

**Allergies:**
Do you have any Allergies to medications, testing dye or latex( as in gloves)?
Circle one Yes No

| Medication | Reaction eg. Hives, swollen tongue, diarrhea etc |
|---|---|
| | |
| | |
| | |
| | |

**Family History:**

| Relative | Alive | Deceased | Medical Problems |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sister (s) | | | |
| Brother(s) | | | |

List all Medical Conditions that you are being treated for / or have been treated for in the past:
_____
_____
_____
_____
_____
_____
_____
_____

List all Surgeries or Operations that you have EVER had in your lifetime and the YEAR:
_____
_____
_____
_____
_____
_____
_____
_____

Do you have anything implanted in you that you were not born with? Eg, rods, screws, pacemaker? Circle one: Yes No
_____
_____
_____

List all your current medications and doses including over the counter drugs or herbal meds:

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

Social History: Please Circle Yes or No :-
Are You Married: Yes No
Do you have children? Yes No If so , how many?_____
Where were you Born? _____
Have you EVER left the US in your Lifetime? Yes No
If so what countries have you visited in your lifetime:-
_____
_____
_____

Do you Smoke? Yes No If you ever smoked, when did you quit?
Do you Drink Alcohol? Yes No If so, how often and What do you drink?

Have you ever tried any illicit drugs? Yes No If so, which ones?

Have you ever used IV drugs? Yes No If so, when was the last time?

Have you ever lived in a shelter? Yes No If so, how much time did you spend there?
Have you ever been incarcerated? Yes No If so, how much time did you spend there?

What was/is your occupation?_____

Do you have any pets? Yes No If so what ?

Any bird, fish or reptile contact? Yes No

What are your hobbies?
_____
_____
_____
_____
_____

| Constitutional | no | yes | If yes when did it start | Musculoskeletal | no | yes | If yes when did it start |
|---|---|---|---|---|---|---|---|
| Weight loss | | | | Joint Pain | | | |
| Fevers | | | | Muscle Pain | | | |
| Chills | | | | Muscle Weakness | | | |
| Night sweats | | | | Joint swelling | | | |
| Fatigue | | | | Aspirin, ibuprophen use? | | | |
| Eyes | no | yes | | Skin | no | Yes | |
| Blurry vision | | | | rash | | | |
| Eye pain | | | | itching | | | |
| Discharge from eye | | | | sores | | | |
| Dry eyes | | | | Nail change | | | |
| Decreased vision | | | | Skin thickening | | | |
| ENT | no | yes | | Neurological | no | yes | |
| Sore throat | | | | Migraines | | | |
| Ringing in Ear | | | | Numbness | | | |
| Bloody nose | | | | Falling | | | |
| Hearing loss | | | | Tremors | | | |
| Sinusitis | | | | Dizziness | | | |
| Respiratory | no | yes | | Endocrine | no | yes | |
| Shortness of breath | | | | Excess thirst | | | |
| Cough | | | | Frequent urinating | | | |
| Coughing up blood | | | | Cold intolerance | | | |
| Wheezing | | | | Heat intolerance | | | |
| Chest pain with deep breaths | | | | Swelling in neck | | | |
| CVS | no | yes | | Psychiatric | no | yes | |
| Chest pain | | | | Anxiety | | | |
| Shortness of breath when laying back | | | | depression | | | |
| Swelling in legs | | | | Abuse | | | |
| Orthopnea | | | | Ever tried to hurt yourself | | | |
| Passing out | | | | Insomnia | | | |
| palpitations | | | | Anti-depressants | | | |
| GI | no | yes | | Hem/Lymphatic | no | yes | |
| Nausea | | | | Easy bruising | | | |
| Vomiting | | | | Bleeding | | | |
| Diarrhea | | | | Blood clots | | | |
| Vomiting blood | | | | Swollen glands | | | |
| Black tarry stool | | | | | | | |
| GU | no | yes | | Allergic/Immun | no | Yes | |
| Blood in Urine | | | | Allergic rhinitis | | | |
| Burning with Urination | | | | Hay fever | | | |
| Accidentally urinating on yourself | | | | Asthma | | | |
| Urinary tract infections | | | | Positive TB test | | | |
| Stopping urinating in the middle of a stream | | | | Hives | | | |

# Rural Infectious Disease Specialist
# Authorization for Release of Information Form

Patient Name_____ Date of Birth_____

Many of our patients allow friends or family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members or friends you must sign this form.

Signing this form will only give information to family members indicated below.

I authorize Rural Infectious Disease Specialist to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

4._____ Relation to Patient:_____

5._____ Relation to Patient:_____

Please circle ALL communication method(s) you are in agreement with for us to contact you:

1. Call/leave message on home phone
2. Call/leave message on cell phone
3. Contact you through mail
4. Call/ leave message on work phone

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipients is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature:_____Date:_____

**RURAL INFECTIOUS DISEASE SPECIALIST PLLC**
**CONSENT AND UNDERSTANDING**

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

**Consent Related to Privacy Notice:**
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

**Consent for Care:**
I, with my signature, authorize (Rural Infectious Disease Specialist), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian or power of attorney. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

**Consent for Release of Information and Assignment of Benefits:**
I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

**Financial Policy:**
We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.
_ I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
_ I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
_ I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group.

**Rural Infectious Disease Specialist PLLC** is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

**Rural Infectious Disease Specialist PLLC is a physician owned and operated facility.**

Returned Checks will incur a $30 service charge. Stop Payments constitute a breach of payment and are subject to the $30 service fee and collections action.
Collection Fees: In the event that my account is placed in collections a $15 administrative fee will be added to my outstanding balance.
Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.
I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

_____ _____
Patient/Responsible Party Date

_____ _____
Patient name if different from Responsible Party Date

# Rural Infectious Disease Specialist
## Patient Rights and Responsibilities

Patient Rights

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure.
4. You have the right, at your own expense, to consult with another physician or specialist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment that is free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.
11. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you.
12. You have the right to request an itemized statement of all services provided to you through this practice.
13. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
14. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You will be responsible for participating in the development of your plan of care.

3. You will be responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.
4. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice.
5. You are responsible for following practice rules and regulations.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your stay treatment and care in our practice. Please inform any staff member or visit our website, on the 'contact us' page.

Response to a concern/complaint will take place within 24-48 hours. Concerns/complaints will be monitored and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

_____ _____

Date Care Giver signature

_____

Patient Name Patient/ Caregiver name