

CONSULTANTS IN INFECTIOUS DISEASE

A Culture of Compassion

Steve Rademacher, MD
James Nora, MD
Daniel Smith, MD
Cindy Pieper, PA-C
Taylor Straube, APRN-NP
Claire Green, APRN-NP

PATIENT INFORMATION

Referring MD _____

Primary Care MD

Patient Last Name _____

Street Address _____

Patient First Name _____

MI _____

City _____

Social Security Number _____

State _____

Zip Code _____

_____/_____/_____

Date of Birth (MM/DD/YY)

Email _____

Male Female Transgender (circle one)

Patient Home Phone: _____

Do you have voicemail?

YES

NO

Single Married Divorced Separated Widowed (circle one)

Patient Cell Phone: _____

Do you have texting?

YES

NO

Employer: _____

Patient Work Phone: _____

Preferred Language: _____

Need Interpreter: _____

Race: _____

Ethnicity: _____

RESPONSIBLE PARTY INFORMATION

(Will be self unless patient under age of 19 years)

Last Name _____

First Name _____

Responsible Party Home Phone: _____

City _____

State _____

Zip Code _____

Responsible Party Cell Phone: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____

PHONE: _____

ADDRESS: _____

INSURANCE

Please present insurance card(s) and photo ID to be copied.
IF THE PATIENT IS NOT THE POLICY HOLDER * INFORMATION MUST BE FILLED OUT

PRIMARY Insurance _____

*Patient's relationship to be insured _____

*Policyholder's Name _____

*Policyholder's Employer _____

*Policyholder's Birth Date _____

SECONDARY Insurance _____

*Patient's relationship to insured _____

*Policyholder's Name _____

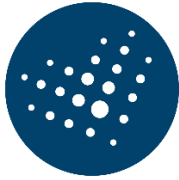
*Policyholder's Employer _____

*Policyholder's Birth Date _____

PHARMACY INFORMATION

Preferred Pharmacy is _____

Location _____



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Mail Order Pharmacy _____

ID# _____

Patient's Name: _____

ADVANCED DIRECTIVE

I have an advanced directive outlined: _____ NO _____ YES (please get us a copy of your directives for your file)

NOTICE OF PRACTICE SPECIALTY

Consultants in Infectious Disease physicians are Board Certified Board Eligible in Infectious Disease. Infectious Disease is a consultative practice dealing with the diagnosis, treatment, and prevention of infectious diseases. Due to some of our patient's diagnoses, their physician in this practice may be a frequent provider of their medical care, however, we are not to be considered a Primary Care provider. The majority of our physicians' time is required in the hospital setting which does not allow them to maintain daily office hours and staffing that are required of a primary care physician's practice.

APPOINTMENT NO SHOW, RESCHEDULE, AND CANCELLATION POLICY

Missed appointments, without notifying us at least 24 business hours in advance are considered a "No Show" appointment. In the event of a No Show, a \$25 fee will be assessed to your account that will need to be paid in full prior to scheduling any further appointments. After the first No Show you will receive a letter notifying you of the No Show and the missed appointment will be documented in your account ledger and records. After two No Shows, CIDLLC reserves the right to no longer provide patient care services in either the clinic or hospital inpatient outpatient settings, The patient will then be advised of discharge from CIDLLC via certified letter.

We track rescheduled and cancelled appointments. If you reschedule or cancel more than 3 times in a 12-month period, you may not be allowed to schedule further appointments.

LATE ARRIVAL

Late arrival for a scheduled appointment leads to inadequate time to see other patients on the schedule. If you are more than 10 minutes late, you may be asked to reschedule.

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to Consultants in Infectious Disease, LLC (hereinafter, "CIDLLC") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV").

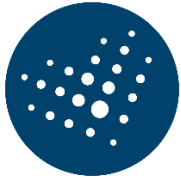
I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to CIDLLC. I understand that my COPAY is part of my insurance contract and is due at the time of my appointment. I further understand should my account become delinquent; I shall pay the attorney fees or collection expenses of CIDLLC, if any. If my account is past due and sent to a collection program a \$15 late fee may be applied to my balance due. If my account does go to full collection, I understand I will no longer be a patient in this practice as allowed by Nebraska law.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient Signature: _____ Date: _____

INSURANCE RELEASE OF INFORMATION

I request that payment of authorized insurance benefits be made to me or on my behalf to Consultants in Infectious Disease LLC for any service furnished to me by CIDLLC. I authorize CIDLLC to release any medical information to my insurance and its agents to determine these benefits or the benefits payable for related services.



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Patient Signature: _____ **Date:** _____

Patient's Name: _____

MEDICARE RELEASE OF INFORMATION

I request that payment of authorized Medicare benefits to be made either to me or on my behalf to Consultants to Infectious Disease, LLC for any service furnished to me by CIDLLC. I authorize release to the Center for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

I further request that payment of authorized MediGap benefits be made either to me or on my behalf to CIDLLC for services rendered. I authorize CIDLLC to release any medical information about me to my MediGap Insurer and its agents to determine these benefits or the benefits payable for related services.

Patient Signature: _____ **Date:** _____

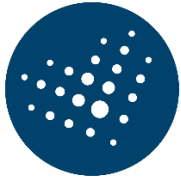
MEDICATION HISTORY RECONCILIATION

The physicians of Consultants in Infectious Disease, LLC believe that knowing your full medication history is essential in helping to decide your treatment plan. They need to know what medications and dosages you have taken in the past or might currently be taking to assist them in arriving at your care plan. Most medication history as well as ordering most medications can now take place electronically through our electronic medical record.

I agree that CIDLLC may request and use my prescription medication history that is now often available electronically. The access of this information is for treatment purposes and to strengthen continuity of care.

Patient Signature: _____ **Date:** _____

Patient's Name: _____



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ACKNOWLEDGEMENT OF THE RECEIPT OF CONSULTANTS IN INFECTIOUS DISEASE, LLC NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Consultants in Infectious Disease, LLC is furnishing you the opportunity to review the notice or have a copy of your own, which provides information about how CIDLLC and its physicians may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. By signing this form, you acknowledge that you have had a chance to review or have received a copy of CID's Notice of Health Information Practices.

Patient Signature: _____ **Date:** _____

Due to the HIPAA regulations, if you are wanting us to be able to talk to a friend or any family members (this includes spouse) regarding your care or any financial issues, we will need you to indicate whom these persons are below.

I authorize CIDLLC to speak with or release documents/information regarding my care to:

Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

Specific authorization for release of information protected by state or federal law.

I specifically authorize the release of data and information relating to: (check appropriate box below)

- | | | | |
|--|-----------|----------|-----------------|
| 1. Substance Abuse (alcohol/ drug abuse) | _____ YES | _____ NO | _____ NOT APPLY |
| 2. Mental Health | _____ YES | _____ NO | _____ NOT APPLY |
| 3. HIV/STD Related Info (AIDS related testing) | _____ YES | _____ NO | _____ NOT APPLY |

Patient Signature: _____ **Date:** _____