Infectious Disease Physicians, P.A

Diplomates, American Boards of Internal Medicine and Infectious Disease

H. Barry Baker, MD, FACP
Nathan A. Jacobson, MD
Richard L. Levine, MD
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Snapper Creek Professional Center
7800 S.W. 87th Ave, Suite B260
Miami, FL. 33173
Phone: (305) 595-4590
Fax: (305) 279-2278

Date: ______________________

Last/First Name_________________________________ Date of Birth_____________ Sex: ___ Age:___

Street Address____

City_______________________________ State____________________________ Zip Code__________

Employer: ____

Business Address ____

Home Phone____________________ Work Phone_________________ Cell Phone___________________

Email Address________________________________ SS#______________________________________

Marital Status____

Ethnicity _______________________ Preferred Language____________________

American Indian or Alaskan Native ____ Asian ____ Black____ Caucasian____ Other____ Declined____

Primary Care Doctor__________________________ Referring Doctor_____________________________

Nearest Relative (if no spouse)_______________________________ Relationship____________________

Address____ Phone__________________________

Spouse____ Spouse's Employer________________________

Spouse work phone or contact number____

Primary Insurance (including Medicare, Medicaid, Commercial, etc.):

Name of Insurance Company_______________________________________ PPO/HMO/IND (circle one)

ID#_________________________ Group#___________________ Subscriber Name__________________

Secondary Insurance (including Medicare, Medicaid, Commercial, etc.):

Name of Insurance Company ____PPO/HMO/IND (circle one)

ID#_________________________ Group#___________________ Subscriber Name _________________

Consent for Treatment: I voluntarily consent to the rendering of care and treatment. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician. ______Initial

Guarantee of Account: I understand that I am fully responsible for all charges made to my account. I herby authorize **Infectious Disease Physicians, P.A.** to release any medical information necessary to process claims or any information requested from my records. I hereby assign payment of medical benefits to **Infectious Disease Physicians, P.A.** for services rendered as described. **___Initial**

Medicare Lifetime Assignment: I request that payment of authorized Medicare benefits be made on my behalf to **Infectious Disease Physicians, P.A.** for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. **___Initial**

Medicare and Medicaid Patient Certification: Patient Certification Authorization to Release Information and Payment Request I certify that the information given to me in applying for payment under Title XVIII and/or Title XIX, of Social Security ACT, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician (s) services. I understand that I am responsible for my health insurance deductibles and co insurance. **___Initial**

HMO Disclaimer (Medicare Patient's Only): I certify that I am not presently enrolled in any (HMO). Subsequent rejection of a claim due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part. **___Initial**

Signature: ____________________________________ Date:___________________________________

Electronic Medical Records Storage: To improve patient care, **Infectious Disease Physicians, P.A.** transmits patients' office visit dictations to a transcription company known as E-Scribe. This method of transmitting office notes enables our physicians to continually improve the medical care provided to you and the other patients.
I authorize **Infectious Disease Physicians, P.A.** to transmit portions of my medical records to E-Scribe. I understand that this information will be accessible by my physicians or, my physicians authorized staff, and authorized for E-Scribe employees only. E-Scribe will secure my records from unauthorized access, and will not distribute patient-identifiable information to anyone except authorized individuals.

Signature: _____________________________________ Date:__________________________________

Notice to all HMO and PPO patients:

Your "HMO" or "PPO" health insurance plan has specific rules you must follow in order for you to avoid liability for full payment of services rendered. We participate with many HMO and PPO plans. It is your responsibility as a patient to provide us with an updated referral/authorization on the day of your scheduled appointment. Our office cannot be held responsible for obtaining referrals/authorizations. In order to keep as close to our schedule as possible, if you do not have an authorization/referral our appointment schedulers will reschedule you for a later date. To avoid this problem, we suggest you contact you primary care physician in advance. This will allow sufficient time to provide an authorization.

We strongly urge you to learn in exact terms:

1. What your insurance plan covers and does not cover.
2. If you must present a referral/authorization for each visit.
3. What your patient responsibility is for each visit (co-payment and/or deductible).
4. Which hospitals have a contract with your plan

You are responsible for co-payments and deductibles on the day that services are rendered. Our office accepts cash, checks, Visa, MasterCard, and American Express for your convenience.

Finally, this is you insurance plan. Please familiarize yourself with every rule of the health plan you are enrolled in, it can save you a substantial amount of money! Your insurance company will mail you a summary of charges, payments, denials, or request for further information. Please review all insurance correspondence.

Please sign and return to the front desk after reading. If you have any questions, feel free to speak to one of our office personnel.

I have read and understand the above information.

Patient Name (print):____

Signature: ____ Date: ____________________________

MEDICAL HISTORY

Reason for Visit (Present Illness)

____

____

____

____

Past Medical History: If you answered yes below when diagnosed?

High Blood Pressure Yes _____ No _____ ____

Diabetes Yes _____ No _____ ____

Asthma Yes _____ No _____ ____

Tuberculosis Yes _____ No _____ ____

Lung Disease Yes _____ No _____ ____

Heart Disease Yes _____ No _____ ____

Heart Murmur Yes _____ No _____ ____

Increased Lipids Yes _____ No _____ ____

Kidney Disease Yes _____ No _____ ____

Arthritis Yes _____ No _____ ____

Seizures Yes _____ No _____ ____

Stroke Yes _____ No _____ ____

Infectious Diseases Yes _____ No _____ ____

Crohns Disease Yes _____ No _____ ____

Ulcerative Colitis Yes _____ No _____ ____

Cancer Yes _____ No _____ Type___________________________________

Blood disorder Yes _____ No _____ Type___________________________________

Thyroid Disease Yes______ No_____ ____

Venereal Diseases Yes _____ No _____ Type__________________________________

Hepatitis A, B or C ____

Depression Yes_______ No________

Other ____

Past Surgical History

1. ____
2. ____
3. ____
4. ____
5. ____

Past Hospitalizations

1. ____
2. ____
3. ____
4. ____

Social History

Smoking _____ Packs per day _____

Drinking _____ Amount ingested _____

Drug use Yes or No If yes, drug of choice _________________

Pets' _____ Type ______________________

Traveled in the past 6 months Yes _____ No _____ Where? ____________________________________

Do you eat raw meat or fish? Yes _____ No ______

Single _____ Married _____ Divorced _____ Widowed _____

Sexual Preference: Heterosexual _____ Gay _____ Lesbian _____ Bisexual _____

Medication List	Dosage	Frequency
____________________________________	________	______________
____________________________________	________	______________
____________________________________	________	______________
____________________________________	________	______________
____________________________________	________	______________

Preferred Pharmacy Name ____________________________ Phone #_________________

Zip Code: ________________

Allergies

1. ____

2.____

3. ____

4. ____

CONTIUATION OF PATIENT MEDICAL HISTORY

Review of Systems: If you answered yes to any of the questions below please explain.

Fever Yes_____ No_____ _____________Degrees

Chills Yes_____ No_____ ____

Night Sweats Yes_____ No_____ ____

Weight loss or gain Yes_____ No_____ (Cirle) Up or down and if so How Much? ______________

Fatigue Yes_____ No_____ ____

Headaches Yes_____ No_____ ____

Seizures or convulsions Yes_____ No_____ ____

Fainting or loss of Consciousness Yes_____ No_____ ____

Dizziness Yes_____ No_____ ____

Double Vision Yes_____ No_____ ____

Sore throat Yes _____ No_____ ____

Swollen Glands Yes _____ No _____ ____

Runny Nose Yes _____ No _____ ____

Nose Bleed Yes _____ No _____ ____

Sinus Drainage Yes _____ No _____ ____

Ear Ache Yes _____ No _____ ____

Cough Yes _____ No _____ ____

Sputum Production Yes _____ No _____ ____

Coughing up Blood Yes _____ No _____ ____

Cough on Swallowing Yes _____ No _____ ____

Shortness of Breath Yes _____ No _____ ____

Chest Pain Yes _____ No _____ ____

Palpitations Yes _____ No _____ ____

Abdominal pain Yes _____ No _____ ____

Nausea Yes _____ No _____ ____

Vomiting Yes _____ No _____ ____

Vomiting Blood Yes _____ No _____ ____

Reflux Yes _____ No _____ ____

Constipation Yes _____ No _____ ____

Diarrhea Yes _____ No _____ ____

Blood in Stool Yes _____ No _____ ____

Frequency of Urination Yes _____ No _____ ____

Burning on Urination Yes _____ No _____ ____

Blood in Urine Yes _____ No _____ ____

Urethral Discharge Yes _____ No______ Type ___________________________________

Menstrual abnormalities yes _____ No ______ ____

Presently pregnant Yes _____ No ______ ____

Menopause Yes _____ No______ ____

Joint Pain Yes _____ No _____ ____

Joint Swelling Yes _____ No _____ ____

Muscle Pain Yes _____ No _____ ____

Muscle Weakness Yes _____ No _____ ____

Decreased Sensation feet/hands Yes _____ No _____ _____________________________________

Pain Yes _____ No _____ Location ______________________________

Rash Yes _____ No ______ Location ______________________________

Flu Vaccine Yes_____ No______ If yes, when? ___________________________

Pneumonia Vaccine Yes_____ No______ If yes, when? ___________________________

Date and location of last colonoscopy ____

Names of other Physicians

____

____

Family History

Please check off if Parents are alive or deceased? Same goes for Siblings and Children.

Parents:

Mother: Alive_____ Deceased_____ if so what was the cause? ___________________________________

____

____

Father: Alive_____ Deceased_____ if so what was the cause? ___________________________________

____

____

Sibling's How Many: (Please Circle)

Female: 1 2 3 4 or etc __ Alive__ Deceased__ if so what was the cause? _______________________

____

____

Male: 1 2 3 4 or etc __ Alive ___Deceased__ if so what was the cause? _________________________

____

____

Children- How Many: (Please Circle)

Female: 1 2 3 4 or etc __ Alive__ Deceased__ if so what was the cause?

____

____

Male: 1 2 3 4 or etc __ Alive ___Deceased__ if so what was the cause? _________________________

____

____

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THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the practice for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the office receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to public health organizations or federal organizations in the event of a communicable disease or to report a defective device or unknown event of a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the office to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- Your have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to know who has accessed you confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form on an electronic transmission or on paper.
- The office is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- Our office will abide by the terms of this notice. The office reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare

information. Patients will receive a mailed copy of any changes to this notice within 60 days of making any changes.

- You have the right to complain to the office if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the office:

- All complaints will be investigated. No personal issue will be raised for filing a complaint with the office.

For further information about this Privacy Notice, please contact

- Office Manager (305)595-4590
- This notice is effective as of 02/13/09

It is our desire for our staff to use your name, address and or telephone number for contacting you to remind you about scheduled appointment, reevaluations, messages to call our office, or other appointment related issues.
The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from the Infectious Disease Physicians, P.A., or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Patient Signature: ____

This authorization may be revoked by you at any time. Revocation may be accomplished by advising in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

I wish to be contacted in the following manner:
1. Home telephone number: ________________________________
  - O.K. to leave a message with detailed information
  - Leave a message with a call-back number only

2. Work telephone number: ________________________________
  - O.K. to leave a message with detailed information
  - Leave a message with a call-back number

3. O.K. to fax to this number: ________________________________
4. O.K. to mail to my home address: __________________________

List Names of People Authorized to speak on your behalf:

Name:____________________________**Phone:**____

____

____

____

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RECORD REQUEST FORM

Infectious Disease Physicians is Requesting ____
Patient Name

_____/_____/_____ and _____-_____-_____ to provide to consent to release confidential healthcare
D.O.B
Information to Infectious Disease Physicians for the purpose of Medical Records

_____ Doctors Notes

_____ Diagnostic Testing

_____ Laboratory Results

_____ All HIV Records

_____ All Patient Information

CONDITIONS:

- The patient has the right to revoke this consent at any time. Revoking of this consent must be made in writing, signed and dated.
- This consent is between Infectious Disease Physicians, P.A. and the patient named above. No other individuals/organizations have permission to obtain the patient's confidential healthcare information under this consent.
- This consent form will be stored in the patient's office chart, or warehouse location for a period of seven (7) years.

Patient Signature: ________________________________ Date: ______________________

Office Representative: _____________________________ Date: ______________________