DATE: _____

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PHARMACY NAME AND ADDRESS:

_____

_____

_____

PRIMARY CARE PHYSICIAN: _____

INFECTIOUS DISEASES ASSOCIATES, P.C.
(770) 991-1500

PATIENT'S NAME: _____MALE___ FEMALE___
D.O.B.: _____ SOCIAL SECURITY#:_____
STREET ADDRESS:

_____
STATE: _____ ZIP CODE: _____ HOME PHONE: _____
WORK PHONE: _____ EXT._____ CELL PHONE: _____
PREFERRED CONTACT NUMBER (PLEASE CHECK ONE) CELL___ HOME ___ WORK ___

EMPLOYER'S NAME: _____
EMPLOYER'S ADDRESS: _____
SPOUSE'S NAME: _____ D.O.B.: _____
SOCIAL SECURITY #: _____ CONTACT NUMBER: _____

IN CASE OF AN EMERGENCY (OTHER THAN SPOUSE):
PLEASE CONTACT: _____ PHONE NUMBER: _____
RELATIONSHIP: _____

PRIMARY INSURANCE COMPANY: _____ PHONE #: _____
ID #: _____GROUP #: _____ SUBSCRIBER NAME: _____
POLICY HOLDER: _____ D.O.B: _____ SSN: _____
RELATION TO PATIENT: _____ ID #: _____

I authorize Infectious Diseases Associates, P.C. to release to my insurance company, any information required in the course of my examination or treatment. I also authorize any physician, hospital or clinic to provide details of my medical history to Infectious Diseases Associates. P.C.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Date

OFFICE POLICIES

REFERRALS:
Referrals are your responsibility. If you come to the practice with an outdated referral, we will be happy to reschedule your appointment or you can pay for the visit before seeing the doctor.

CONFIRMATION OF APPOINTMENTS:
We give a phone call to our patients 24 hours before your appointment. Please make sure we have correct phone numbers. **If you are a new patient and we cannot confirm your appointment, we will cancel the appointment.**

TIMELY APPOINTMENTS:
We strive to see patients at their scheduled appointment time. However, due to emergencies at the hospital, we sometimes run late. **No one arriving more than 15 minutes late will be seen.**

MEDICAL RECORDS:
We require a signed release for medical records. There is a $20.00 retrieval fee and 0.75 cents per page. We require a 48 hour advance notice. There is no charge if we are sending your records to another physician.

REGARDING CANCELLATION:
In an effort to better accommodate all patients, we require 48 hours notice for cancellation of a scheduled appointment.

RETURNED CHECK FEE:
There will be a $25.00 service charge for any returned check. If this office receives two (2) returned checks, we will no longer accept personal checks from that patient.

PAYMENT:
Payment is required at the time of service. We accept cash, check, Visa, MasterCard, Discover Card or your check/debit card. Should you choose to write a check, all checks will be processed through Telecheck. **Your insurance card must be presented at check-in in order for verification of coverage. We cannot bill co-payments**. Your insurance will not allow us to process your claim without posting your co-payment. Filing your insurance is not a means of payment and does not preclude you from paying your co-payment, deductible or coinsurance at the time of your appointment. Should your insurance company deem all or part of our charges for your care non-payable, you will be responsible for those charges. You are responsible for knowing your insurance coverage. To avoid misunderstandings, our insurance specialists are available to answer questions regarding fees or payments from insurance carriers before your visit. If you need assistance, we are glad to put you in touch with your carrier before being seen. You are responsible for the percentage of the charges that your insurance company will not cover at check out. We do not accept responsibility for negotiating claims with your insurance company or any other persons. You are responsible for payment of your medical care within a reasonable time, regardless of the status of your claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. If you prefer to file your insurance, fees are payable at the time services are rendered. Statements will be sent to everyone that has a balance due on their account. If you prefer a statement not come to your house, you need to provide us with a P.O.box, or you can pay at the time of service. After insurance has paid, the remaining balance is due within 90days or the account will be turned over to a collection agency. If you are experiencing personal circumstances that will make the payment of our charges difficult for you , please contact one of our Patient Account Representatives at 770-991-1500.

- Medicare Recipients: We are a participating Medicare practice and thus, will file supplemental plans. If you have supplemental coverage, we will also file ONE supplemental plan. **During the months of January, February and March, it is our policy to collect in full your $100 deductible and the 20% co-payment.**

By signing this document, I agree to and understand all of the above policies.

Signature: _____ Date:_____

Print Name: _____ Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Infectious Diseases Associates, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Infectious Diseases Associates, P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Infectious Diseases Associates, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtainedby forwarding a copy to Infectious Diseases Associates, P.C. Privacy Officer at 6285 Garden Walk Blvd, Suite A Riverdale, GA 30274.

With this consent, Infectious Diseases Associates, P.C. may call my preferred contact number as provided by the patient and leave a message on the voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. I also understand that it is my responsibility to notify the practice of changes related to my address, phone number, email address, insurance information or any other personal information required to contact or bill me.

With this consent Infectious Diseases Associates, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment change notifications and patient statements. I have the right to request that Infectious Diseases Associates, P.C. restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my personal requests, but if it does, it is bound by this agreement. With this consent, I understand that if I call to obtain lab results, or test results, I will be asked for my date of birth. In addition, I understand that I will be asked my date of birth before scheduling an appointment. These confirmations will serve to protect the identity of the patient. With this consent, I also authorize the following person(s) if any to inquire or be notified of my PHI should I be unable to inquire for myself. They will also be required to know my date of birth.

Name of alternate person(s) to release private health information to:

1:_____ 2:_____

By signing this form, I am consenting to Infectious Diseases Associates, P.C. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I have also read the Office Policy and the Notice of Privacy Practices has been made available to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Date

Patient consent for Use and Disclosure of Protected Health Information (Electronic)

I authorize Infectious Diseases Associates, P.C. to communicate my protected health information using my personal e-mail address as listed below. By providing the e-mail address, I authorize test results and lab results to be conveyed by e-mail and confirm that e-mail communication is a reliable means of contact.

Personal e-mail address: _____

By signing this form, I am consenting to Infectious Diseases Associates, P.C. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I have also read the "Office Policy and Mission Statement" of the practice.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Date

PATIENT RIGHTS AND RESPONSIBILITIES

The Staff and Physicians at Infectious Diseases Associates, P.C. respect the dignity and rights of each individual and take seriously our responsibility to provide the highest quality of medical care available.

YOU HAVE THE RIGHT TO:

 Receive respectful care regardless of age, race, sex, religion, sexual orientation or sources of payment for that care.

 Reasonable access to care.

 Considerate care that respects your personal and cultural values and belief systems.

 Informed participation in decisions regarding your care.

 Voice complaints, without recrimination, regarding the care received and to have those complaints reviewed by our Privacy Officer or designee, and, when possible, resolved.

 Request resolution of ethical issues by notifying the Privacy Officer of concerns.

 Be free from verbal or physical abuse or harassment.

 Have reasonable continuity of care and be informed of continuing health requirements.

 Receive an explanation of your office bill regardless of source of payment.

 Refuse treatment to the extent permitted by law.

 Access protective services. A resource list is available upon request. Request should be made to any caregiver.

 Be informed of any human experimentation or other research/education projects affecting your care.

 Personal privacy and confidentiality of information.

 Designate a representative decision maker in the event you are incapable of understanding a proposed treatment or procedure, or if you are unable to communicate your wishes regarding care.

 Appropriate assessment and management of pain.

Patient Rights and Responsibilities

YOU HAVE THE RESPONSILITY TO:

 Provide accurate and complete information about your present complaints, past illnesses, hospitalizations or other matters pertaining to your health.

 Provide accurate information concerning insurance and/or arrangement of payments to the hospital.

 Report unexpected changes in your condition to your physician.

 Provide feedback about service needs and expectations.

 Understand a possible course of care and what is expected of you; or let appropriate staff know if you need additional assistance.

 Follow office rules and regulations affecting patient care and conduct.

 Assure financial obligations for healthcare are fulfilled as promptly as possible.

 Be considerate of the rights of other patients and office personnel.

 Report to your doctor if you believe you cannot follow through with your treatment and/or discharge instructions.

To report any issue which cannot be resolved promptly by staff to our Privacy Officer by dialing 770-991-1500.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following category describes different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example: we may disclose medical information about you to people outside the practice who may be involved in your medical care such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example: we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment of your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of you personal information could include disclosure to, or for; coroners, medical examiners, and funeral directors; health oversight activities inmates; law enforcement; lawsuits; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risk; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you may submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information Is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Marianne Carden 770-991-1500. All complaints must be submitted in writing. **You will not be penalized for filling a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

October 2011

Patient Receipt of Privacy Practices & Release of Information Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of their home

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone
- ☐ OK to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone
- ☐ OK to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone
- ☐ OK to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/ office address
- ☐ OK to fax to this number: _____

☐ Other: _____

I have received a copy of the Infectious Diseases Associates, PC's privacy practices. This will also serve as authorization of the release of my PHI according to the indications above.

_____ Patient Signature

_____ Date

_____ Print Name

_____ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessity to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
NOTE:Uses and disclosures to TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	Disclosed by Whom	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Key: T=Treatment P=Payment O=Healthcare Operations A=Authorization on file D=Discretionary

(3) Enter how the disclosure was made: F=Fax P=Phone E=Email M=Mail O=Other

CONSENT FOR TREATMENT

PATIENT NAME: _____ **ACCOUNT:** _____

AUTHORIZATION & CONSENT FOR SERVICE

I authorize Infectious Diseases Associates (hereafter - Provider) to provide any and all medications, supplies, equipment and procedures as directed by my physician. I consent to the administration and procedure of any necessary treatment, procedures, and supplies.

Agreement to Pay

In consideration of Provider undertaking to supply the above patient with any products and services ordered by patient or on behalf of patient, the undersigned patient, spouse, guarantor and/or guardian agree that each of them is responsible for payment to Provider for all products and services provided to the patient.

Assignment of Benefits

The undersigned hereby authorized Provider to request on my/our behalf and to collect directly all public and private insurance coverage benefits due for products and services supplied by Provider. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Provider all checks for such benefits.

Release of Information

The undersigned authorizes our insurer(s) and any other third party payor who provides patient coverage to disclose to Provider any information regarding such coverage, including but no limited to A) Payments made such insurance(s) or third party payor(s) to any of us, for services rendered to patient by Provider and B) the scope and extent of coverage available.

Patient authorizes all medical personnel to provide information to Provider concerning his/her medical history, as it may relate to patient's medical condition and treatment. Patient authorizes Provider to provide information concerning his/her medical history and condition to his/her insurer(s) and any other third party payor who provides patient with coverage.

I acknowledge receipt of the ***"Patient Rights and Responsibilities"***.

_____

Patient/Spouse/Guarantor/Guardian Signature

_____

Date Signed

INFECTIOUS DISEASES ASSOCIATES
FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office.
2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit
3. It is your responsibility to contact your insurance carrier to confirm that the doctor you are seeing is a participant of your plan.
4. If your plan requires a referral number or prior authorization, it is your responsibility to obtain this prior to being seen by the doctor.
5. All co-payments are due at the time of service. A $20 service fee will be charged for failure to pay the co-payment at the time of service.
6. Failure to keep your scheduled appointment without 24 (twenty-four) hours notice will result in a $25.00 charge. This charge will not be filed to your insurance company and must be paid in full before another appointment is scheduled.
7. Medicare Recipients: We are a participating Medicare practice and thus, will file your Medicare claim. If you have supplemental coverage, we will also file ONE supplemental plan. During the months of January, February and March, it is our policy to collect in full your $100 deductible and the 20% co-payment. This holds true regardless of the availability of supplemental coverage or payment of your deductible to other physicians or providers.
8. If you are experiencing personal circumstances that will make the payment of our charges difficult for you, please contact one of our Patient Account Representatives at (770) 991-1500.
9. There will be $25.00 service charge for any returned check. If this office receives two (2) returned checks, we will no longer accept personal checks from that patient.

I acknowledge that I understand and accept this financial policy.

Signature Date Relationship to Patient

For your convenience, we accept cash, personal checks, VISA and MasterCard.

We look forward to being of service to you now and for years to come.
The Physicians and Staff of Infectious Diseases Associates

Insurance Waiver

Date _____

I, _____, attest that I am giving Infectious Diseases Associates, P.C. The correct insurance information for today's visit. I understand that if all information is not correct and my insurance denies payment due to incorrect information, I may be billed by Infectious Diseases Associates, P.C.

Signed _____

Tel: 770-991-1500
Fax: 770-991-9047

Infectious Diseases Associates, P.C.

6285 Garden Walk Blvd., Ste. A
Riverdale, GA 30274

Richard C. Prokesch, MD, FACP Lee A. Diamond, MD Zandractta Tims Cook, MD, MPH

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibility are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below, I give permission for Infectious Diseases Associates, P.C. to access my pharmacy benefits data electronically through RXHub. This consent will enable Infectious Diseases Associates, P.C. to:

- Determine the pharmacy benefits and drug co-pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patients' plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medication prescribed for a patient by any provider.

In summary, we are asking your permission to obtain formulary information and information about other prescriptions prescribed by other providers using RXHub.

☐ I give permission for IDA, P.C. to utilize RXHub to assist in ordering medications.

☐ I decline to give permission for IDA, P.C. to utilize RXHub in ordering medications.

Patient Name (Printed) _____ Date of Birth _____

Patient/Guardian Signature _____ Date _____