IDConsultants
Infectious Disease Consultants, PLC

11211 Waples Mill Road, Suite 200
Fairfax, Virginia 22030
Phone: 703-246-9560
Fax: 703-246-9564
Website: idcdoctors.com

Registration

Patient Information			
Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	
Fax:	Email:		
Date of Birth:	SSN:	Sex: ☐ M ☐ F	Marital Status:
Employer:	Occupation:	Employer Phone:	
Employer Address:			
Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander	☐ Asian ☐ White	☐ African American ☐ Other	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other			
Preferred Method of Contact:	Preferred Language:		
Emergency Contact Name:			
Emergency Contact Phone Number:	Relationship:		

Guarantor or Guardian Information			
Guarantor or Guardian Name:	Relationship:		
Address:			
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	SSN:	Sex: ☐ M ☐ F	
Employer:	Employer Phone:		
Employer Address:			

Insurance Information			
Primary Insurance Company:	Effective Date:		
Policy/ID #:	Group Name:	Group #:	
Insurance Address:			
Policyholder (i.e. employer, union, etc.):			
Subscriber Name:			
Address:			
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	SSN:		
Secondary Insurance Company (if applicable):	Effective Date:		
Policy/ID #:	Group Name:	Group #:	
Insurance Address:			
Policyholder (i.e. employer, union, etc.):			
Subscriber Name:			
Address:			
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	SSN:		

Authorization Release

I certify that the above information provided is correct, and I authorize the release of any necessary information to my insurance carrier(s) to process this or any related claim. I authorize Infectious Disease Consultants, PLC to apply for benefits on my behalf for rendered services, and I am financially responsible for any deductible, co-insurance, and co-pay as described in my health benefit policy. I agree to pay for any services not covered by my insurance plan(s). I further agree in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees, should this be required.

Signature of Patient or Representative: _____	Relationship to Patient:
Printed Name of Patient or Representative:	Date:

Release of Information and Payment Authorization

If you have MEDICARE, please sign and date below:

I request that payment of authorized Medicare benefits be made on my behalf to Infectious Disease Consultants, PLC for any services furnished to me by Infectious Disease Consultants, PLC. I authorize any holder of information, including medical information, about me to be released to the Social Security Administration and Health Care Financing Administration, and its agents, to determine benefits payable for related services.

Signature of Subscriber or Beneficiary:_____

Name of Subscriber or Beneficiary:_____

Date:_____

For ALL OTHER INSURANCE, please complete, sign and date below:

I authorize Infectious Disease Consultants, PLC to apply for any benefits on my behalf for covered services rendered by Infectious Disease Consultants, PLC, and request that payments from _____, be made directly to Infectious Disease Consultants, PLC.

(Insurance Company(ies))

I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information, including medical information, for this or any related claim to any representative party.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time, if the request is made in writing.

Signature of Subscriber or Beneficiary:_____

Name of Subscriber or Beneficiary:_____

Date:_____

Consent and Authorization for Treatment

I hereby authorize medical examination, testing, and treatment by the physicians, the clinical staff, and technical employees assigned to my care at Infectious Disease Consultants (IDC). I authorize my treating providers to order any services or treatments deemed necessary for my care and safety. I understand that I have the right to discuss my treatment plan with my physician or other healthcare provider, and to ask and have answered to my satisfaction any questions or concerns I may have.

As required by Virginia law, in the event that a health care worker is exposed to my blood or body fluids in connection with rendering me care, in a manner which may transmit Human Immunodeficiency virus (HIV), Hepatitis B, or the Hepatitis C virus, I consent to the testing of my blood or body fluids and authorize the reporting of the test results to the health care worker.

I understand IDC utilizes an electronic medical record system. I authorize the release of my prescription history between my IDC physician and any pharmacy or drug monitoring agency. I understand my IDC physician may utilize an electronic prescribing mechanism for the electronic transmission of my prescriptions to any local or mail order pharmacy I have designated.

I authorize IDC to release my medical and billing records to my insurance company(ies) and its agents to determine benefits payable for related services. I authorize Infectious Disease Consultants to apply for any benefits on my behalf for services rendered to me, and to request payment from my insurance company(ies) directly payable to Infectious Disease Consultants.

I understand this consent and authorization is indefinite and it continues until revoked in writing. By signing below, I acknowledge that I have read, understand, and agree with the above terms.

Signature of Patient or Representative: _____

Printed Name of Patient or Representative: _____

Relationship to Patient (if applicable): _____

Date: _____

Permission to Disclose Protected Health Information

_____I acknowledge and understand that in accordance to the Infectious Disease Consultants Notice of
(Initial)
Privacy Practices, my protected health information (PHI) may be disclosed to physicians and other health care providers who are in need of my health information to ensure coordinated and effective diagnosis and treatment.

Please list the name(s) of other individual(s), if any, to whom you would permit Infectious Disease Consultants to disclose your PHI.

Name and Relationship	**Allowed Disclosure(s) – ("ALL" or specify)**
_____	_____
_____	_____
_____	_____

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been made aware of Infectious Disease Consultants' Notice of Privacy Practices, that a copy is available on the practice website at idcdoctors.com, in the patient waiting room, and available to me upon request at the office.

I understand that this consent will remain in effect until revoked in writing.

Signature of Patient or Representative: _____

Printed Name of Patient or Representative: _____

Relationship to Patient (if applicable):_____

Date: _____

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Patient Telehealth/Virtual Visit Consent Form

I, _____, agree to participate in telehealth visits with Infectious Disease
(Printed Name of Patient or Representative)

Consultants (IDC) Physicians. I authorize the electronic transmission of my medical information and/or telehealth/virtual visit sessions through an interactive audio/video communication software, so that it can be viewed by my IDC physician. I understand that I have the right to withhold or remove this consent at any time without affecting my right to future care or treatment.

I attest, and understand that I have the following rights with respect to telehealth/virtual visits:

1. I attest that I am located in the state of Virginia and will be present in the sate of Virginia during all telehealth/ virtual visits with my IDC physician.

2. I understand that I will need to provide valid identifiction to confirm my identity during all telehealth/virtual visits with my IDC physician.

3. I understand that the same privacy practices that apply to an in-office visit, also apply to telehealth/virtual visits. (See Notice of Privacy Practices) The telehealth/virtual visit technology does not access, record, or store protected health information, and uses encryption to protect the video streams during transmission. I understand there are potential risks to using this technology, including interruptions, unauthorized access, technical difficulties, and call termination. My physician or I can discontinue the telehealth/virtual visit if it is felt the videoconferencing connection is not adequate, or a telehealth visit is not appropriate for the situation. In which case an in-office vist may be requested.

4. I understand my medical insurance(s) will be billed appropriately, and the same payment agreement terms that apply to in-office visits also apply to telehealth/virtual visits. (See Patient Financial and Payment Policy)

5. I understand there are alternatives to telehealth/virtual visits and that I may elect one or more of these at any time. I may ask my IDC physician any questions regarding the telehealth/virtual visits, including the risks, benefits, and alternatives.

6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that I have the right to access my medical records at any time.

8. I authorize the release of my medical information and records to other physicians who provide medical services to me, and to any insurance company or third party payer for the purpose of obtaining payment.

Patient Telehealth/Virtual Visit Consent Form

I have read and understand the information provided above regarding telehealth. I have discussed telehealth services with my physician and/or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care and authorize Infectious Disease Consultants physicians to use telehealth in the course of my diagnosis and treatment.

I permit a copy of this authorization to be used in lieu of the original.

Signature of Patient or Representative: _____

Printed Name of Patient or Representative: _____

Relationship to Patient (if applicable): _____

Date: _____

Infectious Disease Consultants Financial and Payment Policy

Infectious Disease Consultants, PLC strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. Please carefully read and familiarize yourself with our Financial and Payment Payment Policy. Note that certain items below may or may not apply to you.

Claim Filing: As a courtesy to its patients, Infectious Disease Consultants, PLC (IDC) is pleased to assist in the submission of medical insurance claims to insurance companies for payment. It is your responsibility to understand your insurance coverage and benefits, limitations and non-covered services, and to confirm that the provider you see at IDC is a participating provider under your policy. Further, your insurance company may not cover 100% of the charges for services provided, and you will be responsible for the payment of any remaining balance.

It is your responsibility to provide IDC with current insurance information at the time of service, and to notify IDC immediately upon any changes of your insurance coverage. In the event that you fail to provide all necessary and current information, your insurance company(ies) may deny payment of claims relating in services rendered to you, and you may be fully responsible for the entire balance.

Payment Method/Type: IDC accepts cash, check and debit, money order, flexible spending account, health savings account, and all major credit cards.

Co-Pay, Deductible, Coinsurance: If your insurance company(ies) require a co-pay, payment is required at the time of service. A $10 service charge may be added to any bill sent to collect a co-pay that was unpaid during your visit.

Referral and Authorizations: It is your responsibility to have obtained any and all necessary referrals and authorizations required for any services provided by IDC. If your insurance company(ies) require a referral and you do not have one at the time of service, you will be liable for the entire bill for the rendered services.

Self-Pay/Un-Insured Patients: If you don't have insurance, or don't provide insurance information at the time of service, IDC will collect $200.00 for your initial visit, and $150.00 for each follow-up visit. There may be additional charges for procedures performed, which will also be collected during your visit.

Medicare Patients: You are responsible to pay a yearly deductible, plus 20% of Medicare's allowable reimbursement for all rendered services, in accordance with federal laws.

Medicaid Patients: Infectious Disease Consultants only participates and files patient's claims for the states of Virginia and the District of Columbia. A $1.00 co-pay for each office visit, and/or $3.00 co-pay for each hospital visit is expected for all service rendered. If you have Medicaid coverage from another state, you will be responsible for full payment of all services rendered and will need to file your own claims for reimbursement from your state Medicaid.

Workers Compensation Patients: All worker's compensation information, such as a case worker contact name and case number, is required when you schedule your visit. If your claim is denied by worker's compensation, you will be responsible for payment in full for all services rendered by Infectious Disease Consultants.

Forms/Letters/Medical Record Fees: IDC charges $25 for forms or letters that a provider completes on your behalf. For printed records, IDC charges a copying fee of 0.50 cent per page for up to 50 pages and $0.25 per page thereafter, plus a $10.00 labor fee and any applicable postage fees. For electronic or faxed records, IDC charges a flat fee of $6.50 plus a $10 labor fee , and any applicable fees for external storage devices and postage. There is no charge for patient medical records sent to the IDC patient portal.

Cancellation Policy Fee: If you fail to provide a 24-hour cancellation notice prior to your scheduled appointment, you will be assessed a $50.00 fee. Additionally, you may be discharged by IDC if you "no show" or fail to provide a 24-hour cancellation notice for three or more appointments.

Returned Check Fee: In the event that your check is returned for insufficient funds, you agree to provide cash, money order, certified check, or a credit card payment for the full amount owed, in addition to a $50.00 returned check fee.

Patient Discharge, Collection Fees: In the event that you fail to pay for medical services rendered, you may be discharged by IDC until such time that your account is paid. You will be referred to a collections agency for non-payment of service charges 90 days past due. You may be responsible for collection fees, all agency and attorney fees, and any other costs associated with the collection process (such as court costs), which may be added to your account balance.

I have read, understand, received, and agree with the Infectious Disease Consultants, PLC Financial and Payment Policy. I accept full responsibility for payment of any charges not covered by my insurance company(ies), in addition to all applicable co-payment, coinsurance, and deductible. I acknowledge that IDC may change the above terms without notice to me.

I permit a copy of this authorization to be used in lieu of the original.

Signature of Patient or Representative: _____

Printed Name of Patient or Representative: _____

Relationship to Patient (if applicable): _____

Date: _____

INFECTIOUS DISEASE CONSULTANTS NEW PATIENT SUMMARY FORM

PATIENT NAME:_____DOB:_____

PAST MEDICAL HISTORY:

HEART DISEASE	YES ☐	NO ☐
HYPERTENSION	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐
LUNG DISEASE	YES ☐	NO ☐
EYE DISEASE	YES ☐	NO ☐
BOWEL DISEASE	YES ☐	NO ☐
LIVER DISEASE	YES ☐	NO ☐
KIDNEY DISEASE	YES ☐	NO ☐
ARTHRITIS	YES ☐	NO ☐
IMMUNE DISEASE	YES ☐	NO ☐
HIV/AIDS	YES ☐	NO ☐
NEUROLOGIC DISEASE	YES ☐	NO ☐
CANCER	YES ☐	NO ☐
FREQUENT INFECTION	YES ☐	NO ☐

_____
_____
_____

ALLERGIES/REACTION

_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY/ RELATIONSHIP

_____
_____
_____
_____
_____
_____
_____

MEDICATIONS:

LIST ALL CURRENT MEDS WITH DOSAGE

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

Do you Smoke ☐ No ☐ Yes _____

Drink Alcohol ☐ No ☐ Yes _____

_____

VACCINES:

Flu Shot Date: _____

Pneumonia Vaccine Date:_____

REFERRING DOCTOR:_____ PHONE: _____
(Full Name and Practice Name

PRIMARY DOCTOR: _____ PHONE: _____
(Full Name and Practice Name)

PHARMACY: _____ADDRESS:_____ PHONE:_____

Signature of Patient or Representative: _____
Printed Name of Patient or Representative: _____
Relationship to Patient (if applicable):_____
Date: _____

OFFICE USE ONLY: DATE: _____

Weight _____ Height _____ Temp _____ BP _____/_____ HR_____

Reason for Visit: _____