NOT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT PAYMENT OR HEALTHCARE OPERATIONS

PRIVACY NOTICE
EFFECTIVE DATE APRIL 14, 2003

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.

1. Uses and Disclosures: Infectious Disease Associates LLC ("Clinic") is permitted by law to disclose the minimum necessary personal health information of each patient to carry our treatment, payment and healthcare operations of clinic. For treatment purpose, such disclosures may be made to physicians and other healthcare providers as necessary to officiate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payers for the purpose of obtaining payment for services provided. Clinic may also use personal health information to carry out clinic's day-to-day operations such as scheduling quality review and appointment reminders. A list of other examples of disclosures can be obtained from the privacy officer upon request.
2. Required Authorizations: Clinic will not disclose any patient's personal health information for any purpose aside from payment, treatment and healthcare operations, without patient's authorized consent to such disclosures. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosures of patient's personal health information.
3. Privacy Compliance: in accordance with the privacy regulations the Health Insurance Portability and Accountability Act 45 CFR Parts 160 and 164 ("the Privacy Regulations"). Clinic has adopted privacy policies regarding usage of patient's personal health information. Clinic is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patient's right to privacy.
4. Additional Information: For additional information regarding clinic's privacy policy or for a copy of this notice, please contact our Privacy Officer. Clinic reserves the right to change this notice and to make the revised and changed notice effective for medical information that clinic already has about you, as well as any information clinic receives in the future. We will post a copy of the current notice in clinic. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the privacy regulations. The following signature acknowledges that I received a copy.

Patient Signature_____ Date _____

INFECTIOUS DISEASE ASSOCIATES

A PROFESSIONAL MEDICAL CORPORATION

Frank J. Rabito Jr., M.D.
Board Certified
Infectious Disease

Diane M. Failla, M.D.
Board Certified
Infectious Disease

John Depaula, M.D.
Board Certified
Infectious Disease

April Ferguson, M.D.
Board Certified
Infectious Disease

PATIENT INFORMATION

Patient: _____

Mailing Adddress: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____

Social Security : _____

Sex: M or F

E-Mail: _____

Authorized Contact: _____

Phone: _____

Race:

- ☐ American Indian or Alaskan American
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian Pacific Islander
- ☐ White
- ☐ Other _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other _____

Insurance Info. if you are NOT the card holder please write the FULL name of the card holder & their date of birth

_____

Pharmacy: _____

Address: _____

Phone: _____

Referring Dr.First: _____ Last Name; _____ Ph# _____

I hereby authorize my insurance compaines to pay directly to Infectious Disease Associates. I will pay all charges in excess of whatever sums may be paid. I authorize Infectious Disease Associates to release information to the insurance company for my claims to be paid.

Is your illness work related ? Yes or No If so, please provide your Workers Comp Information

PATIENT SIGNATURE: _____ DATE: _____

Effective June1, 2012 our office will start charging patients a $50.00 fee for patients who do not show up for their doctor's appointments. We are asking all of our patients to please give us a 24 hr notice if they will not be able to make their appointment with us. We are sorry we have to take such drastic measure but, our practice has increased in volume so much that if you could please notify our practice in advance we will be able to triage and accommodate other patients who are in need of our service. Thank you, Management

PATIENT SIGNATURE: _____ Date; _____