HOUSTON CENTER FOR INFECTIOUS DISEASES

Patient Information

Last Name:	First Name:	Middle Initial:
Address:	City:	State/Zip:
Home Phone:	Work Phone:	Mobile Phone:
Birth date:	Soc Sec #:	(Circle) Male Female
Driver's License:	Other ID:	(Circle) Married Single Divorced

Employer Name:	Emergency Contact:
Employer Phone:	Relationship: Phone:
Patient Email Address:	Primary Care Physician:

Insurance Information

	Primary	Secondary
Insurance Company:		
Subscriber Name:		
Relation to Patient (Circle)	Parent Child Self Spouse Other	Parent Child Self Spouse Other
Subscriber Birth Date:		
Subscriber Social Security Number:		
Policy Number:		
Group Number:		
Insurance Address:		
Insurance Phone Number:		

Work Related Injury Summary

What Body Part Hurts? (Circle) Right Left Both	Date of injury?	What would you like to have done today?
How often do you have pain?	How long does the pain last?	
Have you injured this area before?	Have you had it evaluated before?	
If yes, when?	If yes, what did they tell you was wrong?	
Circle your Symptoms: Swelling Grinding Numbness Chills Tingling Fever Instability Catching Locking Weakness Redness	**Circle Your Treatments:** Ibuprofen (Advil, Motrin) Tylenol Ice Heat Surgery injection(s) Physical Therapy Other: _____	
Employer Name	Adjuster Name	
Employer Phone #	Adjuster Phone #	
Work Injury Claim #		

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

I hereby consent to the Notice of Privacy Practices currently in force by HCID. I certify by my signature that I have read and understand the information disclosed in the above reverenced notices.
I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes. A copy of the current Notice of Privacy Practices will be available for inspection at the reception desk at all times, and copies of the current notice can be obtained at no charge, upon request.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

I, the undersigned, have insurance coverage as stated above and directly assign all medical benefits to HCID for services rendered by the physicians or other medical providers under their supervision. I also understand that I am financially responsible for all charges. I hereby authorize HCID to release all information necessary to obtain payment of insurance benefits. I authorize the use of this signature on all insurance claims submitted on my behalf. I consent for care and treatment as required by the physician. I understand that there is a charge of $40.00 for all returned checks.

DME & SUPPLIES UNDERSTANDING

I understand that I will be responsible for all supplies and other medically necessary equipment, prescribed and/or distributed by my physician that my insurance plan does not cover.

_____ _____

Signature of Patient/Insured/Guarantor Date MM/DD/YYYY

PATIENT HISTORY

Revised __/__/__

HOUSTON CENTER FOR INFECTIOUS DISEASES

Patient Name:	Date of Birth:	Circle One: M / F

Medical History (Please check all that apply)

Brain/Seizure Activity [ ]
Cancer [ ]
COPD/Asthma [ ]
Diabetes [ ]
Heart Attack/Disease [ ]
High Blood Pressure [ ]
HIV / AIDS [ ]
Kidney Disease [ ]
Panic Attacks/Anxiety [ ]
Prostate [ ]
Tuberculosis [ ]
Allergies [ ]

Past Surgical History

Procedure Date

_____

_____

_____

_____

_____

_____

Any Known Drug Allergies? If so list below:

_____
_____
_____
_____

Latex Allergy? Yes [ ] No [ ]

What Pharmacy Do You Use?

Name: _____
Address: _____
_____
Phone Number: _____

Current medications: (please include over the counter, herbal remedies and vitamins)

Name of Medication	Dosage (e.g. 100 mg)	How often?

Immunizations: (Please check if you have had any of the following and list the date of your most recent)

Name:	Received?	When?
FLU		
HEPATITIS A & B		
MENINGITIS		
PNEUMONIA		
TETANUS		

Who May we Thank for the referral (circle)?

Friend Advertisement School Healthcare Facility Walk-In
Insurance Provider Internet Physician Other _____

Signature of Patient/Insured/Guarantor Date (mm/dd/yyyy)

Revised __/__/__

HOUSTON CENTER FOR INFECTIOUS DISEASES

Contract of Agreement
For Payment of Services Rendered

(Please initial the areas that pertain to you)

Name of Patient: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship: _____

I, _____, understand that I am responsible for all services performed, for the above-named patient or myself, at _____.

_____ **I have insurance coverage**: I will provide complete and correct information to _____ to assist in ensuring that my insurance pays for all services rendered. If any conflicts arise regarding payment on services, I agree to contact my insurance company to resolve the conflict upon notification.

_____ **I have a work related injury/illness**: I will provide complete and correct information to ensure the Worker's Comp. Insurance pays for my services. I understand that unless authorization for treatment has been obtained from my employer, I am responsible for payment of all services rendered at _____. If any conflicts arise regarding payment on my claims, I agree to contact my employer and their insurance provider to resolve the conflict upon notification.

_____ **I have no insurance**: I am presenting for services without any insurance coverage and I understand that payment for services is due upon the completion of my visit today unless prior arrangements have been agreed upon by _____ Management and myself in writing.

_____ **Third party billing**: I am presenting for services that are to be paid by someone other than myself or an insurance company. I understand that _____ does not bill Third Parties without written consent and a verbal confirmation. I understand that I am responsible for all services rendered at _____ and if any conflict arises regarding payment, I agree to contact the payor to resolve the conflict upon notification. I understand that I am ultimately responsible for the payment of all services.

Durable Medical Equipment (DME) / Supplies: I understand that some insurance companies or specific plans do not cover all DME or supplies that are distributed from a physician office and that I am responsible for ensuring that these items are covered by my insurance plan or by myself.

NOTICE: Photo identification is required to ensure the identity of our patients and to protect them from fraud. I understand that _____ requires a copy of my photo identification or drivers license to be kept in my chart for identification purposes only. If I refuse to allow them to copy my identification, I will provide the identification card number and present the card for verification as requested.

_____ _____

Signature of Patient/Insured/Guarantor Date MM/DD/YYYY

Revised __/__/__