PATIENT REGISTRATION FORM

HUDSON INFECTIOUS DISEASES ASSOCIATES

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Patient's Name:_____ Birth Date:_____ Patient Sex: M F

Address:_____ City:_____ State:_____

Zip:_____ Social Security #:_____ Marital Status: _____

Home Phone: _____ Work:_____ Cell:_____

Referring Physician: _____ Phone: _____

Insurance Information

Primary Insurance

Insurance Company:_____ ID#:_____

Name of Insured:_____ Insured Birth Date:_____

Insured Social Security#:_____ Co-Pay:_____

Secondary Insurance:

Insurance Company:_____ ID#: _____

Name of Insured:_____ Insured Birth Date: _____

Consent for Use and Disclosure of Protection Health Information:

I hereby give my consent for Hudson Infectious Diseases Associates, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. With this consent, Hudson Infectious Diseases Associates, P.C. may call my home or other alternative location and leave a message on an answering machine or voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to the patient's treatment. With this consent the office may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient billing statement. By signing this form, I am consenting to this office 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 upon my prior consent. If I do not sign this consent, or later revoke it, the office may decline to provide treatment.

Signature_____ Date_____

Medicare Beneficiary Signature:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Hudson Infectious Diseases Associates, P.C. for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Adm. and its agents.

Signature_____ Date_____