HUDSON INFECTIOUS DISEASES ASSOCIATES

HUDSON TRAVEL MEDICINE, PC

PATIENT REGISTRATION FORM

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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: _____

Statement

I understand that I am responsible for payment at time of visit and may request receipts for me to submit to my insurance.

Signature_____

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 _____