Meridian Infectious Disease Consultants, PLLC
New Patient Forms

Patient Name: _____
Last Name First Name Middle Name Suffix

Date of Birth:_____ Gender: (encircle) M / F

Home Address: _____

_____

Phone number: _____ Email address: _____

Emergency Contact:
Name: _____

Relationship: _____

Phone:_____

Pharmacy:
Name:_____

Address:_____

Phone:_____

Insurance Information

Primary:_____ Secondary _____
(Name of Insurance) (Name of Insurance)

Name of Insured:_____ Name of Insured:_____

ID#_____ ID#_____

Group #_____ Group #_____

I hereby authorize Dr. Ceres Tiu/Meridian Infectious Disease Consultants, PLLC to release any medical information to my insurance company, primary care/family physician, or referring doctor. I understand that I am responsible for all charges and full payment is due at the time of service, including my Co-pay. If my insurance plan requires a referral authorization and no authorization is provided, I understand that I am responsible for all charges. I will notify the office of any changes that occur, such as address, phone number, primary care/family doctor, and insurance plans. I understand that when my insurance changes from one HMO to another, that my previous referral is void. I must contact my primary care/family physician to get another referral under my new plan. I understand that if I fail to notify the office of changes, I will be held accountable for those charges. I authorize Dr. Ceres Tiu/Meridian Infectious Disease Consultant PLLC office to file with my insurance on my behalf. In the event that my insurance company does not pay for any of the services provided, I understand that I am responsible for the charges.

_____

Signature Date

Meridian Infectious Disease Consultants, PLLC
Ceres Tlu M.D.

Authorization and Consent Form

Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Officer for Meridian Infectious Disease Consultants, PLLC.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are required to agree to this restriction but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. Your information will be disclosed to your insurance company, and physicians for billing purposes, and to required federal and state reporting agencies. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your consent.

In the event that a family member or caregiver attends my office visit and remains in the exam room at the time of my evaluation and /or treatment, I give Ceres Tlu, M.D. or her staff/ employees, permission to freely discuss my condition, treatment, or diagnosis.

Any and all medical information can be released to the following:

1. _____Relationship:_____

Phone#:_____

2._____Relationship:_____

Phone #:_____

Patient Name:_____

Patient Signature:_____

Date:_____

Meridian Infectious Disease Consultants, PLLC

Patient History

Name: _____ Date of Birth: _____ Gender: _____

Referring Physician: _____

Briefly State the reason for Visit: _____

PAST MEDICAL HISTORY:

Diabetes	Yes	No
Hypertension	Yes	No
High cholesterol	Yes	No
COPD	Yes	No
Asthma	Yes	No
Heart Disease	Yes	No
If yes: specify _____		
Heart Rhythm Disorder	Yes	No
If yes: specify_____		
Depression or Anxiety	Yes	No
STD	Yes	No
If yes: specify_____		

Other medical history:

_____

_____

PAST SURGICAL PROCEDURES AND YEAR IT WAS PERFORMED:

_____

_____

_____

ALLERGIES TO MEDICATIONS AND SPECIFY REACTION:

_____

_____

CURRENT MEDICATIONS

_____

_____

_____

_____

SOCIAL HISTORY:

Marital Status: _____

Number of children:_____

Work Status, encircle one:

Employed Unemployed Retired On Disability

Do you drink Alcohol? _____
If yes: what type _____ Number of drinks per week: _____

Smoking history, please encircle one:

Current smoker Never smoker Former smoker

If a Current smoker:
How many packs per day? _____ How many years? _____

If Former Smoker:
When did you quit smoking? _____
How many packs per day were you smoking?_____
How many years did you smoke? _____

FAMILY HISTORY:

Relation Health problem

_____

_____

_____

_____

Meridian Infectious Disease Consultants, PLLC

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare, Medicaid, patient assistance programs, or other third-party payer benefits for medical or health care services otherwise payable to me to Meridian Infectious Disease Consultants, PLLC. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company, patient assistance programs, or other third-party payer, up to the total amount of my medical and health care charges, to Meridian Infectious Disease Consultants, PLLC.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by Meridian Infectious Disease Consultants, PLLC. Co-payments are due at time of service. However, I understand I may be responsible for additional coinsurance and/or deductibles as determined by my insurance company once they have paid my claim. I understand that if I am not able to pay my balance in full, I am responsible for contacting Meridian Infectious Disease Consultants, PLLC's billing office and/or financial counselors to discuss a payment schedule. If I fail to make payments as agreed upon, my account may be referred to a professional collection agency and/or attorney. I understand I will be responsible for all costs incurred, including attorney's fees and court costs if applicable.

In the event I submit payment by check and the bank returns the check unpaid for any reason, Meridian Infectious Disease Consultants, PLLC will add $25 to my original balance.

By signing below, I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct and that it is my responsibility to notify The Center of changes to my address, telephone number, primary care physician, or insurance carrier.

_____	_____	_____
Patient Name in Print	**Signature**	**Date**

Meridian Infectious Disease Consultants, PLLC

Financial Policy

All patients must read and sign this form prior to receiving services.
It is your responsibility to provide us with the most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim.
If the claim is denied, you will be financially responsible for services rendered.
We must emphasize that, as a medical provider, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
You are financially responsible for services not covered by your Insurance company.
Co-Payments, coinsurance and / or deductibles are due at the time of services.
It is your responsibility to provide us with your most current billing information.
You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with updated information.
We will send a statement (to the address you provided) notifying you of any balances you may owe. If you have any questions, or dispute the validity of this balance, it is your responsibility to contact our billing staff within 30 days after receipt of the initial statement. You can call 870-729-1020 for Billing Information.
PAYMENT IN FULL IS DUE UPON RECEIPT OF THE STATEMENT. Patient balances not paid in full within 30 days are deemed past due.
If you are unable to pay the balance in full, you must contact our billing staff to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and / or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs fi applicable.
In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas Law.
We may charge you a "NO SHOW fee" if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- Failure to keep your account balance current may require us to cancel or reschedule your appointment.

_____ _____

Signature of Responsible Party Date

Meridian Infectious Disease Consultants, PLLC

Telehealth Consent Form

Introduction

Telehealth involves the use of electronic communications to enable health care providers to provide patient care through the means of live two-way audio and/or video. The purpose of this form is to obtain your consent to participate in a Telehealth consultation for various medical conditions/illnesses. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, Medical images, Live two-way audio and/or video and Output data from medical devices and sound and video files.

Confidentiality

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth consultation.

Nature of Telehealth Consent

During the Telehealth consultation: Details of your medical history, examinations and tests will be discussed using interactive video and/or audio, A virtual examination may take place, Other medical professionals such as Medical Assistants and/or Scribes may be present during the visit to assist the provider and Photographs may be taken of you during the service. In an emergency, it is the responsibility of the Telehealth provider to direct the patient to emergency medical services, such as an emergency room. The Telehealth provider may also discuss and advise with the patients local provider (if applicable). The Telehealth providers responsibility will end upon the termination of the Telehealth connection.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. The session may be discontinued by the patient and/or the provider if the video conference connection is not adequate for the situation.

Your Rights

You may withhold or withdraw consent to the Telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.

Billing and Payment

This practice participates with many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. It is also your responsibility to provide accurate insurance information prior to the service. If you do not have your up to date insurance information, we will reschedule your appointment or classify your appointment as self-pay. Telehealth services may not be covered by all insurance plans. If your insurance does not cover the Telehealth visit, you will be considered self-pay and our published self-pay fee will apply. Non-covered Telehealth visits will be the patients responsibility.

I Consent to Telehealth.

_____

Signature

_____

Name in Print

_____

Date

Meridian Infectious Disease Consultants, PLLC

Consent to Receive Communication via Email or Text

By signing below, I agree to receive communication via email or text, and I understand that communication via email or text is unsecured. Meridian Infectious Disease Consultants, PLLC cannot guarantee the privacy or confidentiality of information transmitted via email or text. This extends to any attachments sent via email. Additionally, while Meridian Infectious Disease Consultants, PLLC and staff may use email or text to assist with scheduling and billing related issues, I understand that email or text **is not to be used for emergencies, urgent contact or when a timely reply is required**. Email or text communication cannot take the place of clinical appointments and will not be used for extended clinical discussions.

_____ _____

Patient Signature Patient Name in Print

_____

Date

_____ _____

Patient's Representative, if applicable Representative's Name in Print

"NO SHOW" POLICY CONSENT FORM

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. I understand that Meridian Infectious Disease Consultants, PLLC reserves the right to charge a "No Show" fee for any appointment that the patient does not keep without giving 24 hours notice; this No Show fee is currently $25.00 and subject to change without notice.

Thank you for your understanding and cooperation, as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you understand that the "No Show" fee is not covered by insurance and must be paid in full prior to the next appointment.

_____

Patient Name

_____

Signature

_____

Date