Houston Center for Infectious Diseases, P.A.
1111 Medical Plaza Drive, Suite 170
The Woodlands, Texas 77380
(281) 444-1303 phone / (281) 444-5161 fax

PATIENT INFORMATION FORM

Thank you for choosing our Clinic. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to update your information from time to time to make sure it stays up to date.

Patient Name	Patient Gender
Social Security Number	Address: (street, city, state, zip)
Date of Birth	
Race (Please Circle) Asian African American Caucasian	Hispanic Other_____
Home Phone	Cell Phone
Work Phone and Extension	Email Address [ ] Check if you would like to sign-up for our newsletter
Employer and Occupation	Emergency Contact Name/Phone No./Relationship
Spouse Name	Spouse Social Security Number
Spouse Date of Birth	Spouse Work Phone
Spouse Cell Phone	Referring Doctor Name and Phone No.
Primary Care Physician and Phone No.	Today's Date

RESPONSIBLE PARTY: Please fill out the following information for insurance and financial purposes.

Insured/Responsible Party name	Relationship to Patient
Insured/Responsible Party SS Number	Date of Birth
Address (street, city, state, zip)	Home Phone
Work Phone	Cell Phone
Email address	Employer and Occupation

Please be prepared to provide proof of insurance if applicable and photo identification upon submission of form

Houston Center for Infectious Diseases

Patient Name _____ DOB _____ M__F__ Date _____
Date of Birth Sex

Medical History (Please check all that apply)

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

Past Surgical History

Reason for surgery *Dates*

_____
_____
_____
_____
_____
_____

Allergies [ ] **None**

Medication *Reaction*

_____
_____
_____

Please list your Pharmacy

Name _____
Address _____
_____
Phone _____

Latex Allergy [ ] **Yes** [ ] **No**

Current Medications (include over the counter meds, herbal remedies, and vitamins)

Name	Dose (Ex. XXX mg)	How many times per day?

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

Date

Flu [ ] _____
Hepatitis A & B [ ] _____
Meningitis [ ] _____
Pneumonia [ ] _____
Tetanus [ ] _____

Signature of Patient/Legal Guardian _____

Patient Consent for Use and Disclosure of Protected Health Information

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed, and I hereby give my consent for H.C.I.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I understand that I am entitled to receive a copy of this document from Dr. Palau upon request. If I do not sign this consent, or later revoke it, H.C.I.D. may decline to provide treatment to me.

Signature of Patient or Legal Guardian | Print Patient's Name or Legal Guardian | Date

Financial Responsibility

We are committed to provide you with the best possible care and pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

1. Payment is due at time services are rendered unless other arrangements have been made in advance. Please call our billing department at (281) 444-1303 for any questions. Accepted methods of payment are Visa, MasterCard, Discover, Amex, and cash.

2. My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to H.C.I.D. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits or if payments are made directly to me or my representative, I will endorse such payments to Dr. Palau.

3. I understand that I am responsible for charges not covered or reimbursed by the above agents. I understand that payment from my insurance company can never be guaranteed as the insurance companies never guarantee payment to my provider. I understand that H.C.I.D. will file my claim to my insurance company on my behalf as a courtesy to me but ultimately I am always financially responsible for any services received from H.C.I.D. I also understand that I am responsible for ensuring my claims are paid in a timely manner and that any services not covered by my insurance, for any reason, I am financially responsible for. It is my responsibility to provide the office with current insurance information and to pay for any due co-pays, co-insurance, deductibles, or past due amounts even in the event I am not asked by the office. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).

   Patient Initials

4. Due to the nature of a busy medical practice, if you are more than 30 minutes late you may be asked to reschedule. Should you need to cancel your appointment, please give 24 hour notice in consideration to other patients who may need your appointment time. Failure of notification will result in a $25.00 fee.

   Patient Initials

5. This office utilizes Quest Diagnostics for laboratory orders. If your insurance company utilized a preferred lab other than Quest, such as LabCorp, please notify the nurse in advance so your order can be submitted on the appropriate Lab requisition. Failure to do so may result in a lower level of benefits paid on your lab claims.

   Patient Initials

6. Disability and FMLA forms cannot be filled out during patient appointments. We charge $25.00 for each form and payment is due before the paperwork is completed. If there is a section for you to complete, please do this before sending us the forms.

I have read the above statements and accept the terms.

Patient or Responsible Party Signature | Date