



200 Banning Street, Suite 260 Dover, DE 19904

Phone: 302-674-4627 Fax: 302-674-4628

Robert Moyer, MD., FACP, Ramesh Vemulapalli, MD., Jinsong Zhang, MD., Nancy Lemoi, PA-C, Christopher Miller, RN, Cara J. Grove, MSN, APRN, FNP-BC
Specializing in Infusions, Infectious Diseases and Rheumatology

Patient's Name: _____
Last First MI

Address: _____
Street

City State Zip code

Home Phone: _____ Cell: _____ Work: _____

Sex: M F Date of Birth: ____/____/____ Social Security: ____-____-____

Marital Status: Single Married Widowed Divorced Legally Separated Partner

Race: Black or African American White American Indian or Alaska Native Asian
 Native Hawaiian Hispanic Choose not to disclose Other: _____

Ethnicity: Hispanic Non-Hispanic Choose not to disclose

Primary Language: English Spanish Indian (Hindi & Tamil) Other: _____

Referring Physician: _____ Primary Physician: _____

Employer: _____ Occupation: _____

Current Pharmacy: _____ Location: _____

Phone Number: ____-____-____

Mail-In Pharmacy: _____ ID#: _____

I do not have a Mail-In pharmacy

Insurance

If the primary insurance holder is someone other than you please fill out section below.

_____/_____/_____
Policy Holder's Name Date of Birth Social Security Number

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number: ____-____-____



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Notice of Privacy Practices

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply to.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided by this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

E-Mail/Portal Consent

To better accommodate our patients, we are now able to reach patients by secure E-mail. If you agree to receive E-mails from our office (in reference to any non-urgent labs, X-ray, MRIs etc. results) please place your E-mail address and name on the line below.

I do not have an E-mail/ do not wish to give my E-mail

I _____ give Infusion Solutions of Delaware, LLC permission to contact me via E-mail for non-urgent lab results, X-ray results, etc. The E-mail address I would like to have sent to is:

_____@_____.net/com/edu/org

If you would NOT like to have transmissions to your E-mail or if you do NOT have a working E-mail please print your name below.

Medical History

1. Briefly describe your problem and where your pain is if applicable:

2. How long have you had this problem?

3. List any previous treatment for this problem.

4. Have you ever had any significant medical problems such as:

Diabetes	High Blood Pressure	Stroke
Heart Attack	Cancer: _____	Tuberculosis
Bleeding Disorder	Liver Problems	Kidney Problems
Lung Disease	Arthritis	Oral Ulcer
GI (stomach) Bleed	Acid Reflux	Weight Loss
Rash	Sleep Disturbance	Nail Abnormalities
Neuropathy (loss of sensation/tingling)	Dry Eyes	Dry Mouth
Pregnancy Loss	Hepatitis	Stomach Ulcer
Prolonged Fever	Raynauds	Eye Inflammation
Abnormal Chest X-Ray	+ PPD Skin Test	
Myalgia (joint pain) if so, where:		
Joint Swelling if so, where:		
Morning joint stiffness if yes, how long:		
Other significant medical problems:		

5. Do/did you smoke (ever)? No Yes, see below:

Smoker: Light smoker (1-9 a day), moderate smoker (10-19 a day), Heavy smoker (20-39 a day) Ready to quit, thinking about quitting, not ready to quit

Previous smoker: EX-Light smoker (1-9 a day), EX-moderate smoker (10-19 a day) EX-Heavy smoker (20-39 a day) How long ago did you quit: _____

6. **Alcohol:** Did you have a drink containing alcohol in the past year? Yes No

If yes, how often Monthly or less, Two to four times a month, two to three times per week, four or more times a week

If yes, how many drinks did you have on a typical day when you were drinking? 1-2, 3-4, 5-6, 7-9, 10 or more

If yes, how often did you have 6 or more drinks on one occasion in the past year? Never, less than monthly, monthly, weekly, daily or almost daily

7. Are you currently working? •No •Yes

If no, how long and why have you been out of work? _____

8. Have you ever seen another rheumatologist or infectious disease specialist, and if so whom and when? _____

PHONE MESSAGE CONSENT

Infusion Solutions of Delaware may need to contact you to discuss medical and or financial information. If you are not available we may wish to leave a voice message or give the message to a spouse etc.

Please fill out only ONE of the following sections below to make your preference known.

A. I DO CONSENT TO LEAVE DETAILED MESSAGES:

I, _____ DOB _____, give permission to Infusion Solutions of Delaware LLC and their staff to leave phone messages regarding my medical care and/or financial status with the following:

Initial for each

____ My home phone answering machine Phone # _____

____ My cell phone voice mail Phone # _____

I also give my consent to Infusion Solutions of Delaware, LLC to disclose my health/billing information to the following: Initial for each

____ NAME: _____ Relationship: _____ Phone Number: _____

____ NAME: _____ Relationship: _____ Phone Number: _____

Signature: _____ Date: _____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____ DOB _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care and/or financial be left on an answering machine, voice mail or with others, with the exception of appointment reminders.

Signature: _____ Date: _____

Patient/ Authorized Person's Signature

- I authorize release of any medical information necessary to process this claim, and request payment of insurance benefits be paid directly to Infusion Solutions of Delaware, LLC.
- I also authorize release of my medical information necessary to process disability, loss of income, or any other form requested by myself or my insurance company on my behalf.
- I further authorize the release of above requested information via FAX transmission.
- I agree to provide the necessary information for billing this claim.
- I understand that there is a no-show fee of \$25 for follow up appointments and \$100 for first time consults for appointments not canceled within 24 hours
- If co-pay assistance is available, I give permission to infusion solutions of Delaware, LLC to submit co-pay assistance program applications on my behalf.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE
- In the event that any account is placed with a third party for collection, I agree to pay the collection fee of 35-50% of the balance owed on the account.

Signed _____ Date: _____

Witness _____ Date: _____



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RELEASE OF RECORDS

I AUTHORIZE AND CONSENT FOR MY RECORDS TO BE SENT TO THE OFFICE OF **INFUSION SOLUTIONS OF DELAWARE, LLC** TO OBTAIN THE FOLLOWING RECORDS:

LAST **OFFICE NOTES** (PAST ONE OR TWO VISITS)

MOST RECENT **XRAYs**

MOST RECENT **LABs**

OTHER _____

PLEASE SEND THE ABOVE RECORDS TO *INFUSION SOLUTIONS OF DELAWARE, LLC* VIA FAX TRANSMISSION (FAX: 302-674-4628) OR BY MAIL TO 200 BANNING STREET, SUITE 260 DOVER, DE 19904

Signature: Patient or Legal Guardian

Date

Print Name

Date of Birth