COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS
18370 Burbank Blvd suite 412
Tarzana, Ca 91356
818-506-3384 fax 818-774-2298

PATIENT INFORMATION

Last:	First:	Date of Birth:	Age:
Preferred Language:	Marital Status:	M/F	
Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Email:	Responsible Party:		
Referring Physician:	Phone:		
Emergency Contact:	Phone:	Relationship:	

EMPLOYMENT INFORMATION

Employer Name:	Work Phone:	
Employer Address:		
City:	State:	Zip:

AUTHORIZATION TO DISCLOSE/DISCUSS PATIENT HISTORY TO INDIVIDUAL LISTED

Financial History:	Y/N	Medical History	Y/N
Name:	Phone:		
Relationship to patient:			

Patient Health Intake Form - Infectious Disease

Patient Information: Full Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Medical History:

1. Have you been diagnosed with any infectious diseases? (Yes/No)
   - If yes, please specify: _____
2. Are you currently experiencing any of the following symptoms? (Check all that apply)
   - Fever ☐
   - Chills ☐
   - Cough ☐
   - Shortness of breath ☐
   - Fatigue ☐
   - Body aches ☐
   - Sore throat ☐
   - Loss of taste or smell ☐
   - Diarrhea ☐
   - Nausea/Vomiting ☐
   - Rash ☐
   - Other (please specify): _____
3. When did your symptoms begin? _____
4. Have you traveled recently? (Yes/No)
   - If yes, list locations and dates: _____
5. Have you had contact with anyone diagnosed with an infectious disease? (Yes/No)
   - If yes, specify disease and date of contact: _____
6. Do you have any chronic conditions (e.g., diabetes, heart disease, lung disease)? (Yes/No)
   - If yes, please specify: _____
7. Are you currently taking any medications? (Yes/No)
   - If yes, list medications: _____
8. Have you been vaccinated for any of the following? (Check all that apply)
   - Influenza ☐ Date: _____
   - COVID-19 ☐ Date: _____
   - Hepatitis A/B ☐ Date: _____
   - Other: _____

Exposure and Risk Factors:

1. Have you been hospitalized in the past 6 months? (Yes/No)_____
2. Do you work in a healthcare setting or with high-risk populations? (Yes/No)_____
3. Have you consumed unpasteurized dairy products or raw meats? (Yes/No)_____
4. Have you been bitten by an animal or insect recently? (Yes/No)_____

Consent and Signature: I acknowledge that the information provided is accurate to the best of my knowledge. I consent to the collection and use of this information for medical evaluation and treatment.

Patient Signature: _____ Date: _____

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GENERAL OFFICE POLICY:

Subject: Important Notice: Updates to Fees for Medical Records, After-Hour Calls for Prescription Refills, and Non-Emergency Phone Calls

Effective **January 1st 2024**, the following changes to fees will be implemented:

Medical Records:

Standard Medical Records Request: $35.- Please allow 3-5 business days for processing.

Expedited Medical Records Request (within 24-48 hours): $75.

Please note that fees for medical records may vary depending on the extent of the records requested. If you have any questions about the cost of obtaining your medical records, our staff will be happy to provide you with a detailed estimate.

After-Hour Calls for Prescription Refills:

After-Hour Prescription Refill Requests (4:30 PM - 8:00 AM) including weekends: $75.

Please allow up to 48-72 hours for regular refill prescription request

We understand that sometimes you may need prescription refills outside of our regular office hours. To cover the additional cost of providing this service, there will be a fee associated with after-hour prescription refill requests.

Non-Emergency Phone Calls:

Non-Emergency Phone Consultation (e.g., medical advice, questions, follow-up) will require a telehealth or in-office visit and will be billed to your insurance.

Non-emergency phone calls that require the time and attention of our medical staff will also be subject to a nominal fee of $75.

These changes are necessary to help us maintain the quality of care you expect from us. We want to emphasize that we remain committed to delivering exceptional healthcare services, and these fees will help support the availability and responsiveness of our team even during non-standard hours.

If you have any concerns or questions about these new fees or how they may apply to your specific situation, please feel free to reach out to our office at 818-506-3384. We value your trust and are here to address any inquiries you may have.

Thank you for choosing CIDC for your healthcare needs. We appreciate your understanding and look forward to continuing to provide you with excellent medical care.

Signature of patient/responsible party:_____ Date:_____

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INSURANCE INFORMATION

Primary Insurance:		Policy ID:
Group ID:	Insured's Name:	Relationship:
Secondary Insurance:		Policy ID:
Group ID:	Insured's Name:	Relationship:

I hereby authorize Comprehensive Infectious Disease Consultants and Physicians above to furnish my insurance company with all the information requested concerning my claim. I authorize my insurance Co. to pay the provider of services directly and hereby assign to said provider all the money to which I am entitled for medical services rendered, not to exceed my indebtedness. I accept full financial responsibility to the physician for all the charges not covered by this assignment and agree to pay any balance not paid by my insurance. All 30 days past due accounts are subject to charges of 1.50% per month.

Signature of patient/responsible party: Date:

LIST ALL MEDICATIONS:

Name of Drug	Dose	How often	Dated started	Prescribing MD

Allergies & Reactions:

_____

_____

Signature of patient/responsible party: _____ Date:_____

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

Antimicrobial Stewardship * HIV Medicine * Infection Prevention * Telemedicine & Information Technology
18370 Burbank Blvd Suite 412 Tarzana, CA 91356-2843
Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send accurate, error free, and understandable prescription directly to pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program. These include:

- √ **Formulary and benefit transactions:** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- √ **Medication history transactions:** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- √ **Fill status notifications:** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **Comprehensive Infectious Disease Consultants** may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **Comprehensive Infectious Disease Consultants** to enroll me in the ePrescribe program. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient Date of Birth

_____ _____

Signature of Patient or Representative Date

_____

(If Representative, Print Name and Relationship to Patient)

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24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

Our goal is to provide you, our patient, with quality services in a timely manner. With that being said, we have implemented an appointment cancellation policy, including "no show" policy, which will enable us to provide you with quality care and the highest standards of medical care in a cost-effective manner.

All appointments require a minimum 24-hour cancellation notice to avoid a cancellation fee. **For a missed appointment or cancellation with less than 24-hour notice** for an appointment scheduled, we reserve the right to charge a fee of

$75.00 for all missed appointments ("no shows"). If you are more than fifteen (15) minutes late for any appointment, you may be required to re-schedule and may be subject to the "no show" policy. **Please arrive at least 15 minutes prior to your scheduled appointment.**

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

How to Cancel Your Appointment. To cancel your appointments, please call the office that you are scheduled to be seen at the respective telephone numbers listed above.

Violation or Abuse of Cancellation Policy. If you forget to cancel or do not arrive (a "no show") for your appointment on three occasions and have not paid all outstanding cancellation fees, we reserve the right of discharging you from the practice with a 30-day notice and referral to other practitioners in the area.

ACKNOWLEDGEMENT OF RECEIPT OF CANCELLATION POLICY

I, the undersigned, acknowledge receipt of Comprehensive Infectious Disease Consultants cancellation policy as outlined above. If I or the patient cancel the appointment with less than 24 hour notice, I understand that I may be billed for the amount indicated above for each appointment that I fail to cancel or show up.

_____ _____
Patient's or Patient's Representative's Signature Date

_____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrate:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claims, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to the Code of Civil Procedure Section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient's Representative's Signature Date

By: _____ _____ _____
Physician's or Authorized Representative's Signature Date Print Patient's Name

Comprehensive Infectious Disease Consultants _____
Print or Stamp Name of Physician/Medical Group Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to given to the Patient. Original is to be filled in Patient's medical records.

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ACKNOWLEDGEMENT OF NOTICE OF PROVIDER/PATIENT PRIVACY PRACTICES

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

☐ I have received the Notice of Privacy Practices (effective date May 1, 2015).

_____ _____

Patient's (or Legal Representative's) Signature Date

_____

Patient Name (Last, First, Middle)

_____

Relationship of Legal Representative

COMPREHENSIVE INFECTIOUS DISEASE CONSULTANTS

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Telephone: (818) 506-3384 Fax: (818) 774-2298 (818) 699-1278

TELEHEALTH CONSENT FORM

Patient Name: _____

Date of Birth: _____

Date: _____

Provider: _____

Consent for Telehealth Services

I understand that my healthcare services may be provided through telehealth using telephone and/or video technology instead of an in-person office visit.

I understand and agree that:

- Telehealth allows me to communicate with my healthcare provider by phone or video.
- Telehealth has limitations, and my provider may recommend an in-person visit if necessary.
- There may be technical issues that could interrupt the visit.
- My medical information will be kept confidential in accordance with applicable privacy laws.
- Telehealth is not intended for medical emergencies. If I am experiencing a medical emergency, I should call 911 or go to the nearest emergency room.
- I am responsible for any copayments, deductibles, or charges not covered by my insurance.
- I may withdraw my consent for telehealth services at any time.

By signing below, I acknowledge that I have read and understand this consent form and agree to receive medical care through telehealth services via phone and/or video.

Patient Signature: _____

Date: _____

If signed by a representative:

Representative Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____