Med Center Health.
Infectious Disease &
Travel Medicine Specialists

We are pleased to welcome you to our practice! Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

- Please bring your driver's license or government-issued photo identification card, insurance card, and all your prescription and over-the-counter medications or medication list with you to each visit.
- Our office will collect co-pays and any owed amounts at the time of each visit.
- If you are new to our practice, or if you have only been seen in the hospital and this is your first visit to our outpatient office, please arrive at least 15 minutes before your appointment time to complete new patient paperwork.
- Please arrive on time for your visit. If you arrive late, you may be asked to reschedule your appointment.
- We strive to notify our patients of their testing results within one week. If you have not heard from our office in that timeframe, please contact us.
- If you cannot attend your appointment, please notify us as soon as possible. We monitor all "no show" appointments. After three (3) "no-shows", you may be discharged from our practice.

On behalf of our entire staff, we look forward to seeing you! Please call us at 270-780-2760 should you have any questions or concerns before your appointment.

Sincerely,

Medical Center Infectious Disease Staff

Commonwealth Medical Plaza • 720 Second Avenue, Suite 307 • Bowling Green, KY 42101
270-780-2760 • Fax: 270-780-2761 • MedCenterHealth.org

INFECTIOUS DISEASE AND TRAVEL MEDICINE SPECIALISTS
PATIENT INFORMATION
Please Complete in Full, Sign and Date

Last Name: _____ First _____ Middle _____ Sex: _____
Marital Status: _____ Spouse's Name: _____
Social Security Number: _____ Date of Birth: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Message/Other Phone: _____
E-Mail Address: _____
Employer: _____ Occupation: _____
Employer's Mailing Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Employed (please check): ❑ Full Time ❑ Part Time ❑ Student

Ethnic Origin: W B H I Other _____ Patient declines to answer: _____
Are you allergic to any medications? _____ If so, list: _____
_____

Emergency contact *(a person that does **not** live in the same household!)*
Name: _____
Phone: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____

********Please give the receptionist your current insurance card so a copy can be placed in your file***
Insurance Name: _____ Insured's Name: _____
Insurance Address: _____ Insured's DOB: _____

INSURED SPOUSE OR PARENT INFORMATION

Name: _____ Relationship to patient: _____
Social Security No: _____ Birthdate: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Employer's Mailing Address: _____
City: _____ State: _____ Zip: _____

Signature: _____ **Date**: _____ Time: _____

Please check one:

- ❑ I **have** executed an advanced directive (Living Will)
- ❑ I **have not** executed an advanced directive (Living Will)
- ❑ I **would** like information on advanced directives

HEALTH HISTORY QUESTIONNAIRE FOR INFECTIOUS DISEASE

Name: _____ **DOB**: _____

Primary Care Physician: _____**Pharmacy**:_____

Who referred you? _____

List any allergies to medications: _____

_____

List any medical problems: _____

_____

List any surgeries: _____

_____

Current Medications: _____

_____

Have you had the Influenza vaccine? **NO__ YES__ Approx Date: _____**

Have you had the Pneumonia Vaccine? **NO__ YES__ Approx Date: _____**

Have you had a Pneumovax 23? NO__ YES__ Approx Date: _____

Have you had a Previnar 13 vaccine? NO__ YES__ Approx Date: _____

Have you had a Covid Vaccine? YES NO

Which manufacturer (Circle): Pfizer Moderna Johnson & Johnson

DATES: Dose 1: _____ Dose 2: _____ Additional/Boosters:_____ _____ _____

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Med Center Health Infectious Disease & Travel Medicine Specialists

COVID SCREENING

*Are you Currently covid+ & under home isolation?	YES OR NO
*Fever of 100.00 or higher or chills?	YES OR NO
*Dry or persistent cough?	YES OR NO
*Shortness of Breath?	YES OR NO
*Loss of taste or smell?	YES OR NO

Last 14 days, close contact (within 6 feet for 15 min or longer) with:

*Anyone covid positive?	YES OR NO
*Or anyone who has symptoms of covid?	YES OR NO

MED CENTER HEALTH | Infectious Disease & Travel Medicine Specialists

Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a Infectious Disease and Travel Medicine Specialists, their assistants and designees, and other employees of Infectious Disease and Travel Medicine Specialists as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Infectious Disease and Travel Medicine Specialists and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed byInfectious Disease and Travel Medicine Specialists as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Infectious Disease and Travel Medicine Specialists in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by Infectious Disease and Travel Medicine Specialists, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree Infectious Disease and Travel Medicine Specialists, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in Infectious Disease and Travel Medicine Specialists' corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize Infectious Disease and Travel Medicine Specialists and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Infectious Disease and Travel Medicine Specialists to make collection of any unpaid charges. I further authorize my employer to release to Infectious Disease and Travel Medicine Specialists or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.
(initial)

_____ This authorization is valid until revoked in writing.
(initial)

_____ My medical/financial information may also be released to the following persons.
(initial)

_____

_____

Primary Care Physician: _____

If you were sent to us by another physician, please list the physician: _____

Print patient name: _____

_____	_____	_____	_____
Signature	*Date*	*Time*	*Relationship (if not patient)*

_____
Witness

MED CENTER HEALTH | Infectious Disease & Travel Medicine Specialists

Treatment with Controlled Substances

Patient Name:_____ DOB:_____

I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate.

_____ _____

Witness | Patient Signature or Person Authorized to Consent for Patient

_____ _____ _____

Date | Time | Relationship to Patient