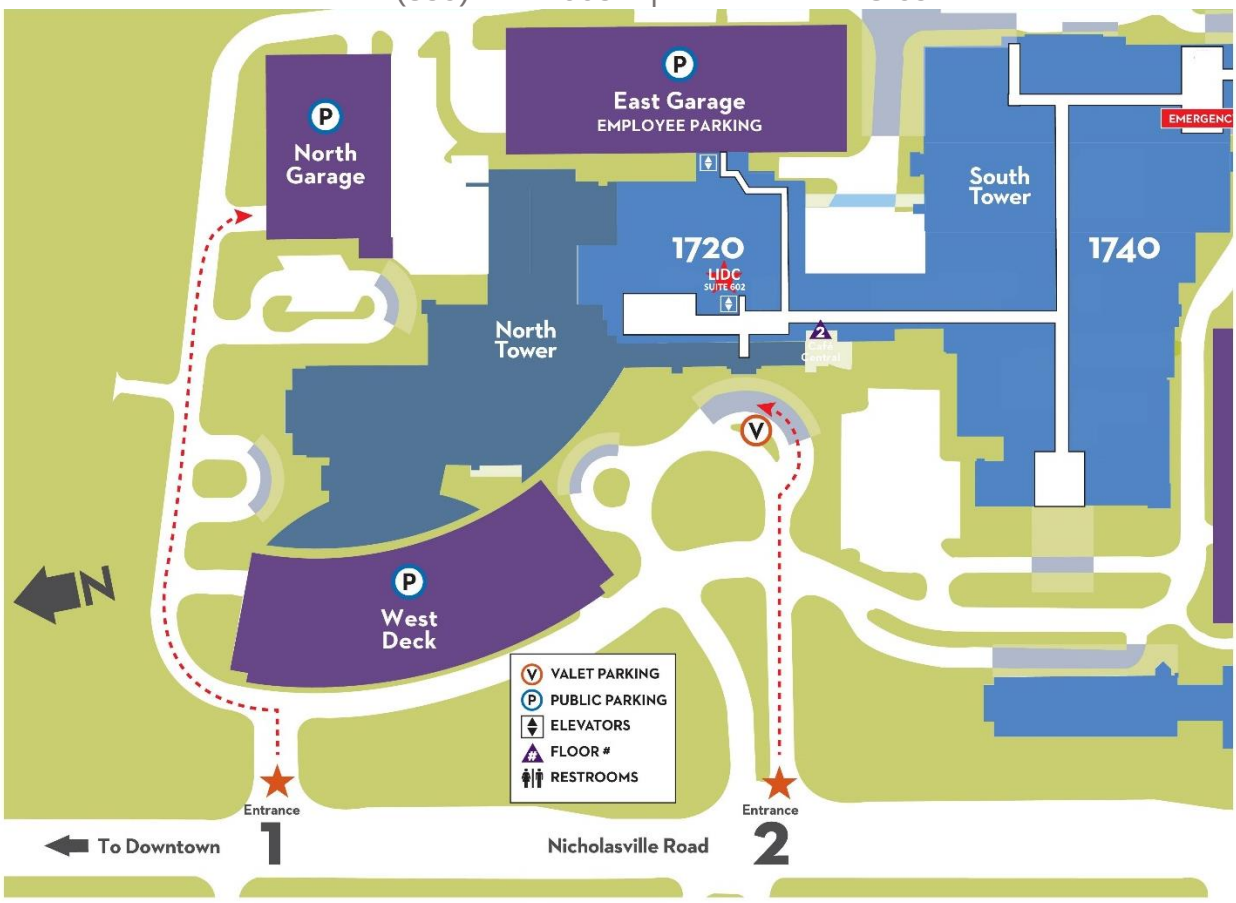
LEXINGTON INFECTIOUS DISEASE CONSULTANTS

1720 Nicholasville Road | Suite 602 | Lexington, KY 40503
(859) 277-4005 | www.LEXIDC.com



SELF PARKING

Use Entrance 1 (closest to Alumni Drive) and keep left toward the North Garage. After parking, enter the 1720 Building from the ground level, and take the elevator directly inside the double-doors to the first floor.

FREE VALET PARKING

Monday-Friday, 6:00 am to 6:00 pm

Use Entrance 2 Drive straight ahead toward the 1720 Building. Free Valet Parking is available under the awning *(keep right at the fork).*

GETTING TO BAPTIST HEALTH LEXINGTON

From Ashland

Take I-64 West to I-75 South to Man O' War - Exit 108. Right on Man O' War Blvd. to Alumni Drive. Right on Alumni Drive to Nicholasville Road. Left on Nicholasville Road. Baptist Health Lexington is ahead on the left.

From Louisville/Cincinnati

Take I-64 to Newtown Pike/Airport -Exit 115. Right onto New Circle Road - Circle 4. Left on Nicholasville Road - Exit 19. Continue on Nicholasville Road for approximately 2 miles. Baptist Health Lexington is ahead on the right.

From Knoxville

Take I-75 North to Man O' War- Exit 108. Left on Man O' War Blvd. to Alumni Drive. Right on Alumni Drive to Nicholasville Road. Left on Nicholasville Road. Baptist Health Lexington is ahead on the left.

From Danville/ Nicholasville (US-27)

Take US-27N/Nicholasville Road passing Fayette Mall and Southland Drive. Baptist Health Lexington is ahead on the right.

LEXINGTON INFECTIOUS DISEASE CONSULTANTS

For Office Use Only
Date: _____ MD: _____
Chart: _____ INT: _____

NEW PATIENT REGISTRATION

Last Name: _____ First: _____ Middle: _____

Address: _____

Street APT# City State Zip

Phone: home_____ cell: _____ work: _____

Date of Birth: _____ Social Security Number:_____ Race:_____

Marital Status: Married Single Divorced Widow Employer: _____

Your Primary Care Physician: _____phone:_____

Physician requesting this Consultation: _____ phone: _____

Email Address: _____

Do you have a living will?	YES	NO
You have a durable power of attorney?	YES	NO
Do you have a healthcare surrogate?	YES	NO
Is this visit related to an injury?	YES	NO

Emergency Contact: _____ relationship: _____ phone: _____

HIPAA Authorization

In addition to my emergency contact, I authorize Lexington Infectious Disease Consultants to use and disclose the protected health information to the following person/s. I understand they must provide my birth date and the last four of my social when inquiring. **(It is not necessary to include other physicians on this list)**

Name	Relationship
_____	_____
_____	_____

This authorization for release of information covers the period of healthcare until ___/___/___

or

☐ No Expiration, unless revoked or terminated by the patient or patient's personal representative

Past Medical

History: _____

_____

_____

Past Surgical

History: _____

_____

_____

Family History

Please circle all that apply

Mother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Father	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Sister	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Brother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Maternal Grandmother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Maternal Grandfather	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Paternal Grandmother	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type) _____		Other _____			
Paternal Grandfather	Arthritis	Asthma	Heart Disease	Depression	Diabetes	Hypertension	Hyperlipidemia	Stroke
	Renal Disease	Thyroid Problems	Cancer (type)		Other			

Social History:

Do you smoke? Y ___ N ___ How much?_____ How many years?_____

Do you drink Alcohol? Y ___ N ___

General	Eyes	Ears/Nose/Throat	Cardiovascular
__ *No symptoms*	__ *No Symptoms*	__ *No Symptoms*	__ *No Symptoms*
__ Fever	__ Blurred Vision	__ Earache	__ Chest Pains
__ Chills	__ Diplopia/Double Vision	__ Ear Discharge	__ Palpitations
__ Sweats	__ Irritation	__ Decreased Hearing	__ Syncope (fainting)
__ Night Sweats	__ Discharge	__ Watery Nasal Discharge	__ Shortness of Breath with Activity
__ Loss of Appetite	__ Vision Loss	__ Nosebleeds	__ Peripheral Edema
__ Fatigue	__ Eye Pain	__ Sinusitis	__ Artificial Valve
__ Weakness	__ Photophobia	__ Sinus Congestion	__ Vascular Graft
__ Malaise	__ Visual Changes	__ Sinus Drainage	__ Heart Murmur
__ Weight Loss	__ Visual Floaters	__ Sore Throat	__ Rheumatic Fever
__ Insomnia		__ Difficulty Swallowing	
__ Sleep Disorder		__ Hoarseness	
		__ Mouth Ulcers	
		__ Poor Teeth	

Respiratory	Gastrointestinal	Genitourinary	Muscles/Joints/Bones
__ *No Symptoms* __ Cough __ Cough with Deep Breath __ Shortness of Breath at rest __ Productive Sputum __ Blood In Sputum __ Respiratory Infections __ Recent Viral Infection	__ *No Symptoms* __ Vomiting __ Diarrhea __ Constipation __ Change in Bowel Habits __ Abdominal Pain __ Bright Red Blood in Stool __ Jaundice __ Gas/Bloating __ Rectal Pain/Burning __ Indigestion/Heartburn __ Difficulty Swallowing	__ *No Symptoms* __ Dysuria/Painful Urination __ Blood in Urine __ Discharge __ Urinary Frequency __ Urinary Hesitation __ Incontinence __ Flank Pain __ Testicular Pain __ Genital Sores __ Erectile Dysfunction __Prostate Problems __ History of Kidney Stones	__ *No Symptoms* __ Back Pain __ Joint Pain __ Joint Drainage __ Muscle Cramps __ Stiffness __ Sciatica __ Leg Pain at Night __ History of: __ Joint Trauma __ Joint Surgery __ Joint Injections __ Joint Surgery __ Gout

Skin	Neurologic	Mental Health	Endocrine
___ *No Symptoms* ___ Rash ___ Itching ___ Dryness ___ Suspicious Lesions ___ Cellulitis ___ Boils ___ Wound Drainage ___ Athlete's Foot ___ Psroiasis	___ *No Symptoms* ___ Stiff Neck ___ Paralysis ___ Decreased Sensation ___ Parasthesis ___ Numbness ___ Seizures ___ Loss of Consciousness ___ Tremors ___ Vertigo ___ Frequent Falls ___ Weakness ___ Transient Blindness ___ Frequent Headaches ___ Dizziness ___ Foot Tingling/Burning ___ Difficulty Walking ___ History of Head Trauma	___ *No Symptoms* ___ Depression ___ Anxiety ___ Memory Loss ___ Suicidal Ideation ___ Hallucinations ___ Paranoia ___ Phobia ___ Confusion ___ Nightmares ___ Troubling Dreams	___ *No Symptoms* ___ Diabetes ___ Thyroid ___ History of Steroid Use **Heme** ___ No Symptoms ___ Abnormal Bruising ___ Bleeding ___ Enlarged Lymph Nodes ___ History of Blood Clots

Travel/Exposure		
Exposure to: __ HIV __ EBV/Mono __ TB __ Sick Animals __ Sick People __ Small Children __ Caves __Bats __ Hunting/Wild Game __ Stagnant Water	Exposure to: __ Salt Water __ Marine Animals __ Animal Bites __ Tick Bites __ Cat Scratches __ Eating raw eggs __ Eating raw chicken __ Eating raw fish/shellfish	__ Blood Transfusion __ Needle Use/Puncture __ History of Antibiotic Use __ Recent Travel

PATIENT MEDICATION LIST

Patient Name: _____ DOB: _____

Pharmacy Name & Location: _____

Pharmacy Phone Number: _____

ALLERGIES: _____

Medication	*Dose*	*How Often?*	*Prescribing Doctor*

GENERAL CONSENT TO TREAT, PATIENT AUTHORIZATION, AND ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by Lexington Infectious Disease Consultants for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to medical treatment and diagnostic procedures provided by Lexington Infectious Disease Consultants and its associated physicians, clinicians, and other personnel. I consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis, and drug testing if deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. This can include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I further understand Lexington Infectious Disease Consultants share an Electronic Health Record network. I also agree to the release of medical or other information about me to government (federal or state) regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I guarantee payment of all charges made for or on account of the patient and I assign our rights in any insurance benefits or other funding to the physician and Lexington Infectious Disease Consultants. I understand that I am responsible for any charges not covered by insurance or other forms of benefits. I understand Lexington Infectious Disease Consultants can obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I shall pay all collection fees and costs, included reasonable attorney's fees. For Medicare beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that Kentucky's Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission.

I authorize Lexington Infectious Disease Consultants to provide copies of my medical records or to speak to duly authorize representatives of any of the above regarding my medical records, medical treatment, or condition.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

Please Sign Here

I understand that I will be responsible for all bills due to incorrect information on this form.

_____Date:_____

Signature of Patient

POA Signature: _____*Date:*_____

HIPAA Notice of Privacy Practices
Lexington Infectious Disease Consultants
Revised 07/15/2022

***Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received a copy of our Notice of Privacy Practices.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law,

- Public health issues as required by law, communicable diseases, health oversight, abuse or neglect,
- Food and drug administration requirements,
- Legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity,
- Military activity and national security, workers' compensation, inmates, and other required uses and disclosures.
- To outside companies that assist in operating our health services, including but not limited to, accounting, auditing and other services provided by these "business associates."
- Decedents: Allows a covered entity to disclose PHI to a family member, relative or other involved in your health care or payment thereof, unless you have objected, which you have the right to do, by signing a form.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request an electronic copy of PHI that is maintained electronically (EHR) in one or more designated record sets, if readily producible. If the PHI is not maintained in the requested form or format, the entity must provide the individual with the PHI in a readable electronic form and format agreed to by both parties, e.g., providing a disc with a PDF file, sending a secure email with a word file or providing access through a secure web-based portal. A hard copy may be provided if the requesting individual rejects all the offered electronic formats. (iii) if a medical record is in mixed media (e.g., some paper and some electronic), a Covered Entity is not required to scan the paper documents to provide a single electronic copy.

You have the right to have PHI transmitted to a Third Party-This must be done in writing and does not replace the authorization process for third party requests.

You have the right to be notified of a Breach in your HPI- In the event that we or one of our business associates discovers a breach of unsecured PHI involving your medical information; we will immediately conduct a risk assessment to determine the presumption of a reportable breach.

You have the right to request a restriction of your protected health information to a Health Plan – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full (if you pay out of pocket, you have the right to request that we not file to your insurance). 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 request an amendment to 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 – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

The current updates to the "privacy practice notice" included new limits on uses and disclosures of the sale of PHI, Fundraising, Research and Marketing, however, Lexington Infectious Disease Consultants does not participate in any of those events.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer, Stephanie Thompson of your complaint. We will not retaliate against you for filing a complaint.

Our Duties: We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Notice of Privacy Practices Acknowledgment

Lexington Infectious Disease Consultants, PSC
1720 Nicholasville Road, Suite 602, Lexington, Kentucky 40503
859 277-4005 Fax 278-2507

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name or Legal Guardian (print) Date

_____
Signature

Revised July 15, 2022

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____