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.

For Office Use Only	
Date: ________	MD: _________
Chart: _______	INT: __________

LEXINGTON
INFECTIOUS DISEASE
CONSULTANTS

DEMOGRAPHIC UPDATE / HOSPITAL FOLLOW-UP 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

PATIENT MEDICATION LIST

Patient Name: ________________________________ DOB: _________________________

Pharmacy Name & Location: ____

Pharmacy Phone Number: ____

ALLERGIES: ____

Medication	*Dose*	*How Often?*	*Prescribing Doctor*
___________________________	_________	_________	________________________
___________________________	_________	_________	________________________
___________________________	_________	_________	________________________
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___________________________	_________	_________	________________________

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:*___________________