Infusion Solutions
OF DELAWARE, LLC
1100 Forrest Avenue, Dover, DE 19904
Phone: 302-674-4627 Fax: 302-674-4628
Robert Moyer, MD., FACP, Jinsong Zhang, MD, Nancy Lemoi, PA-C, Christopher Miller, RN;
Specializing in Rheumatology and Medical Infusions

New Patient Packet

LAST NAME | FIRST NAME | MI

STREET ADDRESS

CITY | STATE | ZIP

HOME PHONE | CELL PHONE | WORK PHONE

☐ MALE ☐ FEMALE | SEX

/ / | DATE OF BIRTH

- - | SOCIAL SECURITY

Marital Status ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER

Race ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ AMERICAN INDIAN ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ HISPANIC ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER: _____

Ethnicity ☐ HISPANIC ☐ NON-HISPANIC ☐ CHOOSE NOT TO DISCLOSE

Primary Language ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

REFERRING PHYSICIAN | PRIMARY PHYSICIAN

EMPLOYER | OCCUPATION

CURRENT PHARMACY | LOCATION | PHONE NUMBER

☐ I DO NOT HAVE A MAIL-IN PHARMACY

MAIL-IN PHARMACY | ID NUMBER NO. | OTHER

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

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:

E-MAIL ADDRESS

Infusion Solutions
OF DELAWARE, LLC

Name _____

Medication Allergies	
Drug Name	**Reaction if known**

Include vitamins, herbals, supplements, and over-the-counter drugs

Medication Name	Strength	Frequency

Broken Bones or Fractures	Site	Date

Surgery (ex. Total knee replacement)	Details (ex. Left/Right)	Date

Doctors Name	Specialty	Phone Number

Family History
Father
☐ Alive ☐Deceased ☐ DM ☐HTN ☐ Heart Disease ☐Stroke ☐Mental Health ☐Cancer: ☐ Other:
Mother
☐ Alive ☐Deceased ☐ DM ☐HTN ☐ Heart Disease ☐Stroke ☐Mental Health ☐Cancer: ☐ Other:
Siblings # of brothers: # of sisters:
☐ Alive ☐Deceased ☐ DM ☐HTN ☐ Heart Disease ☐Stroke ☐Mental Health ☐Cancer: ☐ Other:
Children # of sons: # of daughters:
☐ Alive ☐Deceased ☐ DM ☐HTN ☐ Heart Disease ☐Stroke ☐Mental Health ☐Cancer: ☐ Other:

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 <u>ONE</u> 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 Infusion Solutions of Delaware, LLC permission to submit benefit investigation forms and copay 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 record(s) INFUSION SOLUTIONS OF DELAWARE, LLC via fax transmission (FAX: 302-674-4628) or by mail to 1100 Forrest Avenue, Dover, DE 19904.

SIGNATURE: PATIENT OR LEGAL GUARDIAN DATE

PRINT NAME DATE OF BIRTH