INFECTIOUS DISEASE
CARE CENTER

Imran Chowdhury, M.D.
Kody Modjtabai, M.D.
Imelda Russell, CRNP.

First name: Last name:

Birthday: / / Sex: ☐ Male ☐ Female

Contact

Home Number: Mobile Number:

Email:

Address

Address:

Address:

City: State: Zip Code:

Insurance

Primacy Care:

Physician Phone Number:

Referring Physician Phone Number:

Pharmacy Name:

Pharmacy Phone Number:

10816 Hickory Ridge Rd.
Columbia, MD 21044
Phone: 410-997-7677
Fax: 410-997-1636

6510 Kenilworth Ave.
Suite 2500
Riverdale, MD 20737
Phone: 240-770-6345
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ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITIES

I hereby assign any and all insurance benefits due and payable to me by any policy to pay Infectious Disease Care Center directly for services rendered. I further understand and agree that this assignment is non-revocable. I authorize any insurance company to pay benefits due directly to Infectious Disease Care Center and release to my insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier to process the payment.

I understand that I personally agree to be financially responsible to pay Infectious Disease Care Center for any and all charges not covered by this assignment and all fèes incurred by the practice in collection of all outstanding debt. Co-pays are due at the time of visit. As a guarantor, I fully accept the medical services provided to the above name of the patient as full consideration fòr my signing this document.

Statement of Finance Charges

To avoid additional finance charges on the balance of your account, pay the total amount due in full within ninety (90) days of the bill date. The rate of finance charges assessed is a monthly period rate of one and one-half percent (l .5%).

If you feel there is an error in this account. you must notify Infectious Disease Care Center in writing within sixty (60) days of the bill date. You must supply a description of the error and an explanation of why you believe it is an error; the dollar amount of the suspected error; and any information you believe may be helpful in resolving this matter. Infectious Disease Care Center must acknowledge all letters pointing out possible errors within thirty (30) days upon receipt of your written notice. Within ninety (90) days of receiving your letter, Infectious Disease Care Center will either correct any error or explain to you why we believe your bill is correct.

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I agree to pay anv finance charges incurred by failure to pay the balance due on any account in full within ninety (90) days of the bill date. I have read this document and I agree to execute it with full knowledge and understanding of its contents.

Signature of Guarantor	**Printed Name of Guarantor**	**Date**

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Health Questionnaire

Name: Date of Birth: / /

Age:

Chief Complaint / Symptoms

Have you ever had or been diagnosed with (check all that apply)

- ☐ Disease Diabetic Foot
- ☐ High Cholesterol
- ☐ Joint/Bone Disease
- ☐ Anemia
- ☐ Disease Diabetic Foot
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pre Diabetes
- ☐ Stroke
- ☐ Kidney

Depression

Cancer (Type):

STD (Please Specify) :

Other Medical Illness or Condition (Please Specify):

Surgery I Hospitalizations: (Please start with the most recent one)

Year: Surgery Reason:

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Medications: (List all medications you are taking regularly. Include over the counter, herbal remedies. Feel free to attach a copy or ask front desk to make a copy for you!)

Immunizations: (Please check and indicate year of last injection)

Influenza:	☐ Yes	☐ No	☐ Don't Know
Pneumonia:	☐ Yes	☐ No	☐ Don't Know

Allergies: Are you allergic to any drugs? ☐ Yes ☐ No

Family Medical History

Has any blood relative ever had? (Check if Yes and indicate relationship)

☐ Alzheimer'sHeart attack
☐ DiabetesHigh Blood Pressure
☐ TuberculosisStroke
☐ SeizuresCancer

Dental History

Date of last Dental cleaning: / /

Have you ever had any dental surgeries? ☐ Yes ☐ No

If yes, Reason:

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Travel History

Have you ever been out of the country? ☐ Yes ☐ No

If Yes, where!

Social History

☐ Married ☐ Single ☐ Divorce ☐ Widow

Occupation

If disabled, nature of disability:

Have you ever smoked? ☐ Yes ☐ No

Number of smoke: A day: Total year:

Caffeine

Do you drink Caffeine regularly? ☐ Yes ☐ No

Number of tea a day! Number of coffee a day:

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often!

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Do you currently or have you ever used marijuana, cocaine, heroin. And / or any other inhalants in the past? (Check) Yes Date quit?

Date quit? ☐ Yes ☐ No

Have you been tested for the following:

Low Density Lipoprotein (LDL) ☐ Yes ☐ No ☐ Don't know

If yes, what was the result?

Hemoglobin A lc (HbA I c) ☐ Yes ☐ No ☐ Don't know

If yes, what was the result?

HIV Exposure! ☐ Yes ☐ No

Do you have any concerns about possible exposure that you would like to discuss or be tested for?

Patient's Name:

Date of birth: / /

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Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of the following to Infectious Disease Care Center to be used for treatment purposes:

- Medical history • Laboratory reports • X - Rays
- MRI's / CT Scan's
- Other material regarding medical consultations and treatment.

_____ _____

Patient's Signature **Date**

Please forward this information to

Infectious Disease Care Center
10802 Hickory Ridge Rd
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Or

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices fòr Infectious Disease Care Center, detailing how my information may be used and disclosed as permitted under the federal and state law. I understand the contents of the notice. Further, I permit a copy of this authorization to be used in place of the original and request payment of my medical benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient's Signature **Date**

I acknowledge the following:

- Co-payment are due at the time of service
- A $35 cancellation fee will be charged for all appointments cancelled within forty eight (48) hours of the scheduled appointment.
- A $35 no show f-èe will be charged to patients who do not show up for their scheduled appointment.

Patient's Signature **Date**

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PATIENT HEALTH QUESTIONNAIR (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems

	Not All	Several	More than half	Nearly every day
1. Little interË or pleasure in doing things			2	2
2. Feeling down, depressed, or hopeless			2	3
3. Trouble falling or staying asleep, or sleeping too much			2	3
4. Feeling tired or having little energy		1	2	3
5. Poor appetite or overeating			2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down		1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television			2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a tot more than usual			2	3
9. Thoughts that you would be better off dead, or of hurting yourself		1	2	3

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