Name: _____ Date: ___/___/____

Princeton Infectious Diseases Associates, LLC

Arunima Mamidi, MD

We will make our best effort to reach you personally. If we are not able to reach you, we will leave a message asking you to give us a call back during business hours. Please check all items that are approved for us to leave as a message.

We can leave messages on (**please check all that apply** and verify we have this number on file):

____ Cellphone ____ Home phone ____ Work Phone

____ Do not leave any messages

Please check all that apply. If any specific instruction, please write them underneath.

____ If we get an answering machine/voicemail, we can leave a general message.

____ We can leave a message regarding appointment reminders.

____ We can leave a message regarding specific test results.

____ We can discuss test results with a family member.

If so, which family member? _____ (print name/s).

____ If we get a family member, we can leave a general message with them regarding appointment reminders, needing a callback, etc.

(BACK)

Name: _____ Date: ___/___/____

Patient Responsibility Agreement/Referral

I, _____, understand that obtaining a referral from my primary care physician, before my visit, is my responsibility *if* my insurance requires it. I also understand that if I do not obtain the required referral, I will be responsible for payment of charges and will be billed directly. The HMO will not be responsible for any charges connected with this unauthorized visit.

Signature of Patient: _____ Date: _____
(Please sign even if you do not require a referral)

Pharmacy Information:

Name: _____

Address: _____

Phone: _____

Fax: _____