**NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A.**

**Circle Provider:**

☐ **Masri** ☐ **Berhe** ☐ **Bettacchi** ☐ **Duhaime** ☐ **Haley** ☐ **Sloan** ☐ **Wada**

If you are a member of an HMO/PPO, and they require prior authorization numbers, you must provide the number prior to service. **If the necessary numbers are not provided, you will be financially responsible for unauthorized services.**

Your Name: _____ Birthdate: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex ☐ M ☐ F Race: _____ Ethnicity: ☐ Latin/Hispanic, ☐ Other, ☐ Not Reported

Marital Status: _____ SS# _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax: _____ Best way to reach you: ☐ Home ☐ Cell ☐ Work

*Circle One*

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician _____ Phone: _____

Spouse: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ ☐ hm ☐ cell ☐ wk

*Circle One*

*EmergencyContact _____ Relation: _____ Phone: _____ ☐ hm ☐ cell ☐ wk

*may put same if spouse* *Circle One*

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

**PRIMARY INSURANCE** Please circle if appropriate: ☐ HMO ☐ PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

**SECONDARY INSURANCE** Please circle if appropriate: ☐ HMO ☐ PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

**PLEASE COMPLETE THE BACK OF THIS FORM.**

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA

**Patient Consent for Use and Disclosure of Protected Health Information**

North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St, Suite 710, Dallas, Texas, 75246.

You may disclose protected health information (PHI) about me to the **friends and family LISTED**

1._____ 2._____ 3._____

4._____ 5._____ 6._____ **N/A _____**

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**Email Address:**_____**N/A_____**

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to prior consent.

_____ _____

Print Patient's Name Date of Birth Patient's Signature Date

_____ _____

Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian

***With my consent, NTIDC may contact me regarding a possible research study.*** ***Initials_____***

How were you referred to our office?___Personal Physician____Internet___Friend/Family

__Newspaper____Seen in the hospital___other

**PLEASE COMPLETE THE BACK OF THIS FORM**

**NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A.**

**AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION**

I, (patient name) _____, authorize **North Texas Infectious Diseases Consultants:**

**Check ONE box**

☐ to **GET** records from: _____

Address and/or Phone number: _____

☐ to **SEND** records to:_____

Address and/or Phone number: _____

For the following purpose: ☐ patient's request, ☐ continued medical care, ☐ insurance, or ☐ other

I specifically authorize the use or disclosure of the following health information, if such information exists:

☐ Send my entire medical record
☐ Immunization Information
☐ Lab/Radiology Results
☐ Billing Records
☐ Office Notes
☐ Other_____

**I understand that the specified information to be release may include, but is not limited to: history, diagnoses, treatment of HIV, AIDS, communicable diseases, mental illness and drug or alcohol abuse.**

**Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to** North Texas Infectious Diseases Consultants, P.A. **(a form will be supplied to you upon request at the reception area).**

**Unless revoked earlier, this authorization will expire 180 days from the date of signing. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.**

**I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.**

| _____ | _____ | _____ |
|---|---|---|
| **Patient Signature** | **Date of Birth** | **Date** |

## Return to fax number: 214-824-8679 or mail to:

**Medical records**
**North Texas Infectious Diseases Consultants, PA**
**3409 Worth St. Suite 710**
**Dallas, TX 75246**