North Texas Infectious Diseases Consultants, PA

Demographic Information

Legal name: _____ Birthdate: _____

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

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

E-mail Address: _____

SS#: _____ Marital Status: _____ Race: _____ Ethnicity: Latin/Hispanic Other Prefer not to list

Gender:_____

Optional:

Name I preferred to be called:_____ Preferred pronouns:_____

Referring Provider_____ Phone: _____

Primary Care Provider_____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Insurance Please circle if appropriate: HMO / PPO

Insurance:_____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____

Group#: _____

Secondary Insurance Please circle if appropriate: HMO / PPO

Insurance:_____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____

Group#: _____

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 revise Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St. Suite 710, Dallas, TX 75246.

You may disclose and/or talk about protected health information (PHI) about me to the people listed below. (You must include full name.)

1._____ 2. _____ 3. _____

Acknowledgement of Receiving and Reading a Copy of,

"Notice of Privacy Practices" and "Patient Rights and Responsibilities"

I acknowledge receipt of NTIDC's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how NTIDC may use and disclose by confidential information. I understand that NTIDC reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Authorization to Release Medical Information

This is to serve as authorization to release medical information compiled during medical treatment at NTIDC to the undersigned patient. A copy of this will serve as an original.

Lab Test

This office uses LabCorp. If your insurance requires that you use a different lab you must let the office know. My insurance prefers: (circle one)

LapCorp Quest Unknown (If unknown you must call your insurance and check)

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

How did you hear about us? _____

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 make disclosures in reliance to prior consent.

_____ _____

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

_____ _____

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

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA

Consent for Treatment

I, as a patient/legal guardian, do consent for medical treatment in office or tele-medicine by North Texas Infectious Diseases Consultants' (NTIDC) physicians, physician assistants, and nurse practitioners this is inclusive of any treatment or procedure they deem medically necessary.

Physician Assistant and Nurse Practitioner Consent for Treatment

A physician assistant and nurse practitioner are not doctors. A physician assistant and nurse practitioner are a graduate of a certified training program and are licensed by the state board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" is overseeing the activities of and accepting responsibility for the medical services provided.

I have read the above, and hereby consent to the services of a physician assistant for my health care needs**. I understand that at any time I can refuse to see the physician assistant and request to see a physician.**

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive video conferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. I understand that I must be in the state of Texas when during telemedicine visits. The same standard of care applies to these visits. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.

Tardy and Late Cancellation Policy

To best serve all our patients, it may be necessary to reschedule your appointment if you are 15 minutes or more late. Failure to come in for your appointment **without giving our office at least 24 hours' notice may result in a $30.00 charge on your account.**

By signing this form, I attest that I have personally read this form or had it explained to me, and understood, and agree to its contents. I have had my questions answered to my satisfaction, and the risks, benefits and alternatives.

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

Dear Patient,
Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective, medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

Payment Guidelines:

- We must collect any co-payments, co-insurance, and /or deductibles at the time of service, unless other arrangements have been made in advance with our office.
- We accept **Cash, Checks, Money Orders, & Credit Cards** (Visa, MasterCard, Discover and American Express).
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If, by mistake, your insurance company remits this payment to you, please send it to us along with all paperwork sent to you. **Please do not send the payment back to the insurance company.**
- Any balance that your insurance company determines to be your financial responsibility will be billed to you. Payment is due in full upon receipt of your first statement.

When to Present Insurance Card?
Please present your insurance card at **EACH VISIT.** Specifically bring to our attention any changes (new card, new group #, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have a secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

Insurance Company Denies Payment?
Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

1. This is a pre-existing illness or condition that they do not cover.
2. You have not met your full calendar year deductible.
3. The type of medical service required is not covered.
4. The insurance was not in effect at the time of service.
5. You have other insurance which must be filed first.
6. You have exceeded your maximum dollar/visit amount.
7. You did not have a referral number for your visit/service.

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full at the time of billing.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at 214-276-5605.

I authorize NTIDC, its assignees, and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and any form of digital communications including, but not limited to, contact by manual calling methods, prerecorded or artificial voice messages, text messages, emails, and/or automatic telephone dialing systems. This consent includes any form of contact to a number for a cellular phone or other wireless device, regardless of whether I incur charges as a result. I hereby grant permission and consent to NTIDC, its assignees, and third-party collection agents to contact me on the numbers I have provided for any purpose related to my account, including debt collection, by a live person or automated dialing device. I understand that this consent may be revoked at any time, by informing NTIDC, its assignees, and/or third-party collection agents that I no longer consent to contact at the phone numbers I have provided, or by these forms of communication.

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. I assign the proceeds of such insurance claim to NTIDC. Both NTIDC and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my plan's guidelines. NTIDC may file a claim for services rendered by the physician, facility, and/or infusion center.

I understand that I will be fully responsible for payment in full at the time of billing of any and all medical services denied by my insurance company determined to be my portion of the billed charges. Balances that remain unpaid after 90 days from the date first billed may be referred to an outside collection agency for further collection efforts.

_____ _____

Printed Patient Name **Date of Birth**

_____ _____

Patient Signature Today's Date

North Texas Infectious Disease Consultants, PA

Medication List

Name: _____ DOB:_____

Allergies: _____

Preferred Pharmacy:_____Phone #:_____

Drug Name	Dose	Route	Frequency	Prescribing MD

Signature:_____ Date:_____

(Office Only) Reviewed by:_____Date:_____

Medical History

Name: _____ DOB: _____ Date: _____

Reason for today's visit:

Past Medical History
(please check all that apply)

- Blood Disorders ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Lung Disease ☐
- Diabetes ☐
- Peptic Ulcer Disease ☐
- Cancer ☐
- Liver Disease ☐
- Psychiatric Disorder ☐
- Other (please list below) ☐

Prior hospital Admissions:

	Dates

Previous Surgial History:

	Dates

Past Blood Transfusions:

	Dates

Social History:

Marital Status:	☐ Married	☐ Divorced	☐ Single
Tobacco Use:	☐ Yes	☐ No	How Much? _____
Alcohol Use:	☐ Yes	☐ No	How Much? _____
Drug Use:	☐ Yes	☐ No	How Much? _____

Occupation: _____

Patient Name:

Family History

Medical issues on your mother's side: _____

_____

_____

_____

Medical Issues on your father's side:_____

_____

_____

_____

Review of Systems (please circle all which are applicable) :

Constitutional: Weight loss Weight gain Fever Chills Sweats Fatigue Weakness

Eyes: Wear glasses Blurry vision Flashes of light Blindness

Ears, Nose, Mouth: Ear ache Poor hearing Sore throat

Cardiovascular: Chest Pain Palpitations Swelling of feet

Respiratory: Shortness of breath Cough Asthma

Gastrointestinal: Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool

Genitourinary: Painful urination Frequent urination Nighttime urination
Problems w/testicles
Abnormal periods Last menstrual period: _____ *DATE*

Musculoskeletal: Muscle pain Joint pain

Skin: Rash Sores on skin Skin cancer Boils

Neurological: Heme/ Headache Dizziness Seizures Numbness Tingling

Lymphatic: Swollen lymph glands Anemia

Do you have other symptoms? (please list) _____

_____

_____

_____

_____

_____

Do you have a Living Will? ☐ Yes ☐ No

If "Yes", what are the contents?

☐ No Resuscitation
☐ No Feeding Tubes
☐ No Medication Support
☐ No Mechanical Ventilation
☐ Unaware of Contents
☐ Other _____

Do you have a Durable Power of Attorney? ☐ Yes ☐ No **Name:** _____