Alka Rebentish, MD
Chukwudum Uche, MD

Infectious Disease Associates

NEW PATIENT
REGISTRATION FORM

TODAY'S DATE / /

PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST	MI	ADDRESS		
SUITE OR APARTMENT #	CITY		STATE	ZIP CODE	SEX
EMPLOYED YES NO	EMPLOYER		HOME PHONE ( )	CELL or ALTERNATE PHONE ( )	
DATE OF BIRTH / /	SOCIAL SECURITY #		MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER		

Preferred Method of Contact : ☐ Phone ☐ Text ☐ Email Address

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION #		GROUP #
ADDRESS	CITY	STATE ZIP CODE	PHONE ( )
SUBSCRIBER NAME (INSURED)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH / /
EMPLOYER	ADDRESS		PHONE # ( )

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION #		GROUP #
ADDRESS	CITY	STATE ZIP CODE	PHONE ( )
SUBSCRIBER NAME (INSURED)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH / /
EMPLOYER	ADDRESS		PHONE # ( )

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP CODE
CONTACT PHONE ( )	CONTACT PHONE ( )		

HOW WERE YOU REFERRED TO OUR OFFICE?

Assignment and Release: I hereby AUTHORIZE my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required to process my insurance claims. I hereby consent to examination and treatment by attending physician.

Patient Signature:

(Parent or Guardian if patient is a minor) X Date

updated 1/02/17

Infectious Disease Associates
Financial Policy

We would like to welcome you to our office. The following information is provided to avoid any misunderstanding concerning payment for services. Please take a moment to read this information sheet concerning our financial policy.

- All co-pays and deductibles are due at the time of check in. Payment for services for cash patients are due "In full" at the time of check in. For your convenience, we accept Cash, Checks, MasterCard, Visa and American Express.

- I fully understand that Infectious Disease Associates will bill my provided insurance as a courtesy. In the event of non-payment by your insurance carrier I fully understand that I am financially responsible for the payment of my treatment. If my account becomes delinquent I fully understand that I am hereby responsible for any subsequent collection and or legal fees related to repaying the amounts owed Infectious Disease Associates."

- If your insurance company changes, you must notify us immediately so that we can obtain a copy of your new card and submit claims to the correct insurance. If you do not you will be responsible for all denied charges.

- Your insurance policy is an agreement between you and your insurance company. It is your responsibility to know what is covered and what is not covered. Fees for non-covered services are due at the time service is rendered.

- If your insurance is through an Exchange you will be required to show proof of payment before services are provided.

- Please help us to better serve you by keeping all scheduled appointments. We require at least 24 hours advance notice for all appointment cancellations. If you miss your appointment or fail to cancel it with 24 hours advance notice our policy is to charge a **No Show Fee of $50.00.**

- Returned checks will be subject to a **$30.00** fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I herein authorize payment of medical benefits to Infectious Disease Associates when an assigned claim is filed. My signature authorizes Infectious Disease Associates to release any medical information necessary to process my insurance claims. My signature below indicates that I understand and accept these policies.

Print Name :_____ DATE:_____

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

UPDATED 07/21/2016

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Infectious Disease Associates *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient Name:

_____ Date: _____

(Signature)

If not signed by patient, please indicate relationship to patient (i.e. spouse)

Relationship: _____ Witnesses by: _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this Acknowledgement.
Date: _____
Time: _____
Employee Name: _____

Infectious Disease Associates

www.IDAssociateslv.com

Alka Rebentish, M.D., FACP
Board Certified in Infectious Diseases
Chukwudum Uche, M.D., FIDSA, FACP,AAHIVS
Board Certified in Infectious Diseases

Main Office:
6088 S. Durango Drive, # D-100
Las Vegas, NV 89113
Tel: (702) 380-4242
Fax: (702) 380-4141

Corporate / Billing Office:
1450 W. Horizon Ridge Pkwy. B304 #668
Henderson, NV 89012
Tel: (702) 868-8387
Fax: (702) 314-9134

Medical Records Release

I hereby request that Infectious Disease Associates, Alka Rebentish MD, Chukwudum Uche MD. release my medical records, laboratory data, x-ray reports and other related information and materials to:

_____ Myself (a charge of .60 cents per page will apply. Payment is due when the records are picked up. If you want records mailed, an additional cost for postage will be added).

_____ Physician

_____ Other

_____
Physician Name or Person receiving records

_____
Address

_____
Telephone number and fax number

_____
Patient Name DOB Social Security#

_____
Address City State Zip Code

_____
Telephone Number Date Patient Signature

Updated 7/21/2016

Infectious Disease Associates

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Alka Rebentish, M.D., MRCP, FACP
Board Certified in Infectious Diseases
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CONSENT TO DISCUSS PATIENT INFORMATION

Patient: _____ Chart # _____

Nevada State Law prevents this office from discussing patient information without express written consent from the patient. If you would like someone other than yourself to be allowed to discuss your care, please list the names of the individuals below. Please keep in mind that you can change this list at any time. Any person on the list must be able to verify your date of birth as an added security.

NAME OF PERSON	RELATIONSHIP TO PATIENT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Patient Signature: _____ Date: _____

Date of Birth: _____

Infectious Disease Associates

Alka Rebentish M.D., Joseph Poliquin APRN, Chukwudum Uche M.D.
6088 S. Durango Dr. Suite 100
Las Vegas, NV 89113
Tel: (702) 380-4242 Fax: (702) 380-4141 & (702) 314-9134

AUTHORIZATION TO RELEASE MEDICAL RECORDS

( ) Centennial Hills Hospital
Ph: (702) 835-9700 Fax: (702) 629-1645

( ) Desert Springs Hospital
Ph: (702) 733-8800 Fax: (702) 369-7556

( ) Mountain View Hospital
Ph: (702) 255-5000 Fax: (702) 255-5007

( ) North Vista Hospital
Ph: (702) 649-7711 Fax: (702) 649-1523

( ) St. Rose Delima Hospital
Ph: (702) 564-2622 Fax: (702) 616-4644

( ) St. Rose San Martin Hospital
Ph: (702) 492-8000 Fax: (702) 492-8165

( ) St. Rose Siena Hospital
Ph: (702) 616-5000 Fax: (702) 616-5235

( ) Southern Hills Hospital
Ph: (702) 880-2100 Fax: (856) 743-4266

( ) Spring Valley Hospital
Ph: (702) 853-3000 Fax: (702) 853-3144

( ) Summerlin Hospital
Ph: (702) 233-7000 Fax: (702) 233-7916

( ) Sunrise Hospital
Ph: (702) 731-8000 Fax: (702) 892-3686

( ) University Medical Center
Ph: (702) 383-2000 Fax: (702) 383-2012/383-6275

( ) Valley Hospital
Ph: (702) 388-4000 Fax: (702) 383-4585

( ) Dr:_____
Ph: _____
Fax: _____

Patient Name: _____ Date of Birth:_____

Patient's Signature:_____

( ) Recent Progress Note
( ) Recent Lab Report
( ) Radiology Report
( ) Medication List
( ) Other Test Report
( ) All Medical Record(s)

Comments:

_____

_____

Please Fax Requested Records to (702) 380-4141 or (702) 314-9134

We will use your health information for regular health operations.
We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to run our practice and support the core functions.

For example:
Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce health care costs.

- Appointment Reminders
  We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

- Decedents
  Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

- Workers Compensation
  We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

- Public Health
  As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- Research
  We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal.

- Organ Procurement Organizations
  Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of donation and transplant.

- As Required By Law
  We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulations and civil rights laws.

- Specialized Government Functions
  We may disclose health information for military and veterans affairs or national security and intelligence activities.

- Business Associates
  There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

- Practice Marketing
  We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example, to notify you of any new tests or services we may be offering).

- Food And Drug Administration (FDA)
  We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

- Personal Representative
  We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

- To Avert A Serious Threat To Health/Safety
  We may disclose your information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

- Communication With Family
  Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

- Disaster Relief
  Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all *non-routine* operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

Infectious Disease Associates

Notice Of Privacy Practices

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise To You,
Our Patients

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of Infectious Disease Associates, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Infectious Disease Associates, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of information for public health officials charged to improve the health of the state and nation,
- Source of data for our planning and marketing, and
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Infectious Disease Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request,
- Inspect and obtain a copy your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law),
- Amend your health record as provided by 45 CFR 164.526,
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528,
- Request confidential communications of your health information as provided by 45 CFR 164.522(b), and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a) (however, we are not required by law to agree to a requested restriction).

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer, Anni Drury, at 702-860-9890.

If you believe your privacy rights have been violated, you can either file a complaint with Anni Drury, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Nevada is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza – Room 322
San Francisco, CA 94102

Examples Of Disclosures For Treatment, Payment, And Health Operations

We will use your health information for treatment.
We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:
Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.
We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:
If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.