



**ARIZONA INFECTIOUS DISEASE PLLC  
NEW PATIENT FORMS**

**Today's Date:** \_\_\_\_\_  
**Name Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_  
**Address:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_  
**Phone: Cell** \_\_\_\_\_ **Home** \_\_\_\_\_ **Work:** \_\_\_\_\_  
**Preferred Phone to call:** \_\_\_\_\_ **Leave message on phone: YES/ NO**  
**Email:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Primary Care Provider:** \_\_\_\_\_

**Insurance:** Attach a copy OR provide details  
**Primary Insurance Company:** \_\_\_\_\_  
**Policy Holder's Name:** \_\_\_\_\_  
**Policy ID:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_  
**Secondary Insurance Company:** \_\_\_\_\_  
**Policy Holder's Name:** \_\_\_\_\_  
**Policy ID:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_  
**Mail Order Pharmacy:** \_\_\_\_\_

**CIRCLE ONE: Gender:** Male Female  
**Marital Status:** Married Single Divorced Separated Widowed  
**Race:** African American White Asian Hispanic Other: Declined  
**Ethnicity:** Hispanic/Latino Not Hispanic/Latino Declined  
**Living Will/Advanced Directives:** No Yes (Please provide a copy)

**Allergies:** \_\_\_\_\_

**Medications:** (Attach a list or provide details)

Name	Dose	How Often

**Medical Problems:**

High Blood Pressure	High Cholesterol	Heart Problem	Blood Clots
Asthma	Pneumonia	Sleep Apnea	Seasonal allergies
Reflux/Heartburn	Cancer	Anxiety	Kidney Problems
Alcohol Abuse	Substance Abuse	Tobacco Abuse	Gout
Underactive Thyroid	COPD	Stroke	Valley Fever
Headache	Urine Infection	Anxiety	Depression

**Surgeries:**

Month/Year	Type of Surgery

**Hospitalizations:**

Month/Year	Reason

**Family History:**

	Alive	Deceased	Medical Problems
Father			
Mother			
Siblings			
Children			

**Social History:**

Work	Employed/ Unemployed/ Retired
Alcohol	Drink (How much & how often):
	Non-drinker/ Quiet (When):
Tobacco	Smoke (How much): /Never Smoked/Quiet (When):
Drugs	NO/ Yes:
Caffeine	NO / Yes (How many cups a day):

# Arizona Infectious Disease PLLC

## Patient Financial Responsibility Statement

- I will present proof of Insurance coverage at every visit.
- You are ultimately responsible for ALL payment obligations arising out of your treatment and care, you will also guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts, and/or any other patient responsibility indicated by your insurance carrier or our Financial Policies, which are otherwise covered by supplemental insurance.
- I understand it is my responsibility to be educated about the benefits and limitations of my Insurance policy.
- I understand my insurance policy is a contract between me and my insurance company. In the event they do not pay for services rendered to me which may include vaccinations, injections, and durable medical goods, I am financially responsible for payment for those services.
- I understand that my account may be sent to a professional collection agency if payment is not rendered within 90 days from the billing date and in that event my relationship with Arizona Infectious Disease may be terminated.
- You will be required to follow all registration procedures, which include, but not limited to, updating personal information like your address, presenting verification of current insurance, and paying co-pay at time of visit. If we do not have your insurance card on file and/or unable to verify your eligibility for benefits, you will be considered a self-pay patient and payment is due at time of service. **Returned mail will be automatically sent to collections.**
- I understand that if I disagree with any charges, I must contact the billing office in writing and/or telephone within 30 days of the billing date. You will be mailed a billing statement that contains the total cost of your services, procedures, and/or injections you have received during your visit.
- I understand that it is my responsibility to provide ARIZONA INFECTIOUS DISEASE with any information necessary to be paid for services rendered to me or anyone covered under my insurance policy or I will be responsible and will pay the balance in full.

We accept payment by Check, Cash, Money order, Debit card, and Credit card.

**Payment by check-** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of \$35.00 and/or up to the applicable state maximum legal limits, in addition to any costs assessed or charged by any depository institution.

**If you do not cancel your appointment before 24 hours and/or no show for your scheduled appointment, you will be charged a fee of \$25.00.**

**Managed Care (HMO, PPO, Etc.):**

All managed care co-payments and/or co-insurance amounts are due at time of visit.

**Medicare:**

Arizona Infectious Disease is a participating provider with Medicare programs and accepts as payment the Medicare allowable, patient deductible and/or co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatments are covered before proceeding. You understand that you will be responsible for your annual deductible, co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all the necessary policy information. Medicare patients will be required to sign an ABN form for possible non covered services.

**\*\*We do charge the patient for medical records request at 10 cents a page and/or up to \$25.00. This fee will be due at time of pick up\*\***

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Arizona Infectious Disease to apply for benefits on my behalf for covered services rendered by my physician, or by his/her order. I request that payment from my insurance company be made directly to Arizona Infectious Disease (or to the party who accepts assignment).

I certify that the information I have reported about my insurance coverage is correct. I agree and accept the terms of the Arizona Infectious Disease Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient's **PRINTED NAME** \_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient (parent, spouse) \_\_\_\_\_

## New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand as part of my health care, **ARIZONA INFECTIOUS DISEASE**, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payor can verify that services billed were provided, and

I understand that I have the following rights and privileges as:

- The right to review the notice prior to signing this consent.

I understand that ARIZONA INFECTIOUS DISEASE is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ARIZONA INFECTIOUS DISEASE reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept/decline** the terms of this consent.

I have been presented with and understand ARIZONA INFECTIOUS DISEASE Notice of Privacy Policy as:

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**Patient's Signature**

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**Date**

Patient's **PRINTED NAME** \_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient (parent, spouse) \_\_\_\_\_

**FOR OFFICE STAFF ONLY**

( ) Consent received by \_\_\_\_\_ on \_\_\_\_\_

( ) Consent refused by patient, and treatment refused as permitted

## Patient Portal Account

PRINT Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

E-mail Address: \_\_\_\_\_

By signing this form, I authorize Arizona Infectious Disease (AZID) to communicate via personal, secured-access Patient Portal with me for my medical care and treatment. AZID will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers of Arizona Infectious Disease because of the communications:

1. My personal health information.
2. Electronic displays of Radiological images (x-rays)
3. Laboratory Test results
4. Pathology reports
5. Other diagnostic tests results

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all the following issues before signing this Authorization.

1. Portal communication is a convenience and **not appropriate for emergencies or time sensitive issues.**
2. Portal messages received at Arizona Infectious Disease may be accessible to office staff in the course of their duties supporting the providers.
3. We advise caution when communicating extremely sensitive or personal information via Portal messages (i.e.: HIV status, mental illness, chemical dependency, and workers compensation issues.)
4. Clinically relevant messages and responses will be documented in the medical record
5. AZID will not be liable for information lost or misdirected due to technical errors or failures
6. AZID does not own or have any interest in the Portal website. E-Clinical Portal is a secure conduit in which communication with our database is managed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to Arizona Infectious Disease. I understand that if I revoke this authorization, it will not apply to any information already released because of this authorization.

I understand that I may refuse to sign this authorization. I also understand that Arizona Infectious Disease cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this Authorization.

I have read and understand the information in this authorization form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA Authorization for Use or Disclosure of Protected Health Information

I understand as part of my health care, ARIZONA INFECTIOUS DISEASE, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care/treatment. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or eligibility for benefits unless allowed by law. I understand that I have the right to revoke this authorization, except to the extent that the organization has already acted in reliance thereon. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information, including disclosure by fax, and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This authorization is valid for one year from the date of signature. I wish to have the following restrictions to the use/disclosure of my health information:

- Please send my entire medical record or  Please send my medical record but exclude the following
- HIV / AIDS testing, diagnoses, and treatment
  - Sexually Transmitted Disease testing, diagnoses, and treatment
  - Mental Illness diagnoses and treatment
  - Psychotherapy notes
  - Drug or Alcohol Addiction diagnoses and treatment
  - Genetic testing, results, and genetic information about me
  - Other: \_\_\_\_\_

I hereby authorize the release of my medical records concerning my care and treatment. These include but are not limited to the records indicated below:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Emergency Department Report            | <input type="checkbox"/> Hospital Consults          | <input type="checkbox"/> Admission H & P               |
| <input type="checkbox"/> Discharge Summary with Medication List | <input type="checkbox"/> Labs                       | <input type="checkbox"/> ED Report & Hospital Abstract |
| <input type="checkbox"/> Radiology/diagnostic Results           | <input type="checkbox"/> Doctor's Office Evaluation | <input type="checkbox"/> ALL RECORDS                   |
| <input type="checkbox"/>  | <input type="checkbox"/>                            | <input type="checkbox"/>                               |

<p><b>PLEASE FAX/MAIL MY RECORDS TO:</b></p> <p><input type="checkbox"/> <b>Arizona Infectious Disease</b>  <b>1951 Mesquite Ave, Suite I</b>  <b>Lake Havasu City, AZ 86403</b></p> <p><b>Phone: 623-244-0050 Fax: 623-244-0100</b></p>	<p>Please send my records to:</p> <p><input type="checkbox"/></p> <p>Provider/Facility: _____</p> <p>Address: _____</p> <p>_____</p>
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PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient (parent, spouse): \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**  
**Arizona Infectious Disease PLLC**  
**Effective Date: January 01, 2020**  
**SUMMARY**

**WHAT IS THIS NOTICE FOR?** This Notice of Privacy Practices (Notice) describes how Arizona Infectious Disease (We or Us) may use and disclose your medical information that we maintain and how you can get access to this information.

**WHO ARE WE?** Arizona Infectious Disease is an Infectious Disease Specialist which consists of all employed doctors, nurses, medical assistants, administrative staff, and other healthcare professionals. This Notice applies to these individuals as well as all services that are provided to you at any of our facilities.

**WHY DO YOU NEED THIS NOTICE?** The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, places certain obligations upon us regarding how we may use and disclose your *personal health information* (PHI). Your PHI includes medical information about you such as your medical record and the care and services you have received. We are committed to **maintaining the privacy** of your PHI. When we need to use or disclose it, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the **minimum** amount of data **necessary** to respond to the need or request unless otherwise permitted by law.

**WHEN CAN WE USE/DISCLOSE YOUR PHI?** There are certain uses and disclosures of your PHI that we may undertake **without your written or other authorization**. These uses and disclosures may be for purposes such as to provide you with treatment, obtain payment for services we have provided, and other health care operations (such as administration, quality improvement, cost studies and other activities designed to improve the care we provide to all our patients). Some other examples include: PHI made known to your relatives, close friends, or caregivers, public health activities and officials, reporting of abuse or neglect as may be required by law, health oversight activities, judicial and administrative proceedings, law enforcement officials, workers' compensation, and other individuals and activities as set forth in this Notice. Individuals who may have access to your information **without your written or other authorization** may include doctors, nurses, health care students, and other hospital staff.

**WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION FOR ANY USE OR DISCLOSURE NOT SET**

**FORTH IN THIS NOTICE.** You may revoke this authorization AT ANY TIME. In addition to obtaining your written authorization for uses or disclosures not described in this Notice, we generally will also need to seek your written authorization or approval prior to disclosing the following information:

- HIV/AIDS related information
- Sexually transmitted disease information
- Tuberculosis
- Psychotherapy notes
- Mental health information
- Drug & alcohol information
- Genetic information
  
- Any information where you, if a minor, sought emancipated treatment (e.g., care related to your pregnancy or child, sexually transmitted diseases, etc.)

We will also seek your **written authorization** for any "marketing" activities we may conduct or where we would receive money for providing a third party with your PHI.

**WHAT RIGHTS DO YOU HAVE FOR YOUR PHI?** You have the right to ask us to limit certain uses and disclosures of your PHI. We will consider ALL requests but may not be *required* to agree to your requested limitations. You also have the right to inspect and receive copies of your PHI, the right to request a change or amendment be made to your PHI, the right to an accounting (a list) of certain disclosures of your PHI, and the right to revoke any authorization you may have made to the extent we have not yet relied upon it. You also have the right to receive a paper copy of this Notice at anytime.

**CAN WE CHANGE THIS NOTICE?** We may change this Notice **at any time**. The revised Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised Notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice on our web site [www.AZinfection.com](http://www.AZinfection.com). You may obtain the new Notice in hard copy as well from our Privacy Office.

**ADDITIONAL INFORMATION/COMPLAINTS.** You may contact our Privacy Office if you wish any additional information or have questions concerning this Notice or your PHI. If you feel that your privacy rights have been violated, you may also contact our Privacy Office OR file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. **We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.**

**THE ABOVE IS ONLY A SUMMARY OF THE RIGHTS AND OBLIGATIONS WITHIN THIS NOTICE.**

**PLEASE READ CAREFULLY THE ENTIRE NOTICE THAT FOLLOWS. WE WELCOME ANY QUESTIONS YOU MAY HAVE.**