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#: ________________
Emergency Contact Name: Phone: Relation:
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 charge 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:**_________________________

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:

______________________________ ______________________________

Patient's Signature **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:

☐ Emergency Department Report	☐ Hospital Consults	☐ Admission H & P
☐ Discharge Summary with Medication List	☐ Labs	☐ ED Report & Hospital Abstract
☐ Radiology/diagnostic Results	☐ Doctor's Office Evaluation	☐ ALL RECORDS

☐ **PLEASE FAX/MAIL MY RECORDS TO:** **Arizona Infectious Disease** **1951 Mesquite Ave, Suite I** **Lake Havasu City, AZ 86403** **Phone: 623-244-0050 Fax: 623-244-0100**	☐ Please send my records to: Provider/Facility: ____________________ Address: ____________________ ____________________

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): ____________