DFW Infectious Disease Patient Information

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Name: _____ Date: _____
Date of Birth: _____ SS#:_____ Marital Status: M S D W
Address:_____ City : _____State:_____Zip:_____
Home Phone:_____ Cell/Pager:_____
Emergency Contact:
Name: _____ Phone: _____ Relationship:_____
Referring Physician: _____ Phone: _____
Primary Physician: _____ Phone: _____
E-mail_____
Pharmacy Name & Number _____

Employment Information of Insured

Job Title : _____ Full Time_____ Part Time _____
Employer Name:_____
Employer Address:_____ City:_____ State: _____ Zip:_____
Employer Phone _____ Is your condition job related? Yes / no

Primary Insurance Information

Insurance:_____ HMO / PPO / POS / EPO / WC / Indemnity / Cobra
Address:_____ City: _____ State:_____ Zip: _____ Phone:_____
ID#:_____Group: _____
Relationship to Insured – (circle one) Self Spouse Child Other
Policy Holder Name: _____DOB:_____SS#::_____
Address: _____ City: _____State: _____Zip: _____

Secondary Insurance

Insurance:_____ HMO / PPO / POS / EPO / WC / Indemnity / Cobra
Address:_____ City: _____ State:_____ Zip: _____ Phone:_____
ID#:_____Group: _____
Relationship to Insured – (circle one) Self Spouse Child Other
Policy Holder Name: _____DOB:_____SS#::_____
Address: _____ City: _____State: _____Zip: _____

Please circle Perffered Lab: labcop Quest

Authorization for Release of Information and Assignment of Benefits:

I authorize the use of this signature on all insurance submissions and release of any and all medical records and/or financial information necessary to collect payment for medical services. I understand that my medical/financial information may be transmitted electronically via facsimile and/or Internet. I also authorize and assign payment of medical or government benefits directly to Infectious DFW Infectious Disease and/or physician on file, for the services provided to me. I understand that I am financially responsible for the charges not covered by my insurance policy.

Signature: _____ Date: _____

Patient's Name: _____ Age: _____ Date: _____

Weight: _____ Height: _____

What **Health Problem** brought you here today?

_____

Do you have a history of.....?

Seizures	No	Yes	Liver Disease/Hepatitis/Cirrhosis	No	Yes
Lung Disease	No	Yes	Kidney/Bladder Disease	No	Yes
Heart Problems	No	Yes	Stomach Disease	No	Yes
Chest Pain	No	Yes	Bowel Disease	No	Yes
Cancer	No	Yes	Sexually Transmitted Diseases	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes

Other _____

Are you pregnant, how far along? (female pts) _____

Do you.....

Smoke?	No	Yes	How much? _____
Drink Alcohol?	No	Yes	How much? _____
Use illegal drugs?	No	Yes	What / How much? _____

Experiencing any problems with.....? (Please circle)

Urination	Diarrhea	Constipation	Swallowing	Breathing
Fevers	Night Sweats	Skin Rashes	Hearing	Vision

Immunizations

Tetanus in last 10 years?	No	Yes
Pneumonia vaccine in last 5 years?	No	Yes
Flu Shot in the past year?	No	Yes

List Major Surgeries

_____

_____

_____

Drug Allergies

_____

_____

Medication List (use back of form if needed)

_____

_____

_____

Family History (please list any major illnesses in siblings, parents or grandparents)

_____

_____

_____

I believe that all the above information is true and correct.

_____ _____ _____

Patient Name *(Print Please)* Patient Signature Date

CONSENT FOR TREATMENT

I, as a patient/legal guardian, do consent for medical treatment by DFW Infectious Disease, physicians and nursing staff. This is inclusive of any treatment or procedure they deem medically necessary.

_____ _____

Patient Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

_____ _____

Patient Signature Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

DFW Infectious Disease may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to DFW Infectious Disease Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. DFW Infectious Disease reserves the right to revise at any time.

I acknowledge and agree that I have read DFW Infectious Disease notice of privacy practices. I also understand that I will be given a copy of the notice if I ask for one.

_____ _____

Patient Signature Date

You may disclose protected health information about me to the people listed below:

_____ _____

_____ _____

PATIENT RESPONSIBILITY AND ASSIGNMENT AGREEMENT / FINANCIAL POLICY

DFW Infectious Disease

Patient Name: _____ Insured's Name: _____

PATIENT'S RESPONSIBILITIES

Patient is Responsible:

1. For providing accurate and complete information regarding his/her medical history.
2. For agreeing to a schedule of services and reporting any cancellation of scheduled appointments.
3. For participating in the development and updating of a plan of care.
4. For following the plan of care and clinical condition. For communicating whether he/she clearly understands the course of treatment and plan of care. For accepting responsibility for his/her actions if refusing treatment.
5. For timely reporting problems, changes in physical condition, re-hospitalizations, concerns or complaints.
6. Any replacement cost of lost/misused/damaged drugs/pumps or supplies will be responsibility of the patient and reimbursement that the patient seeks will be between the patient and his/her insurance company.
7. For fulfilling financial obligations for service.
8. For being responsible for picking up drugs and supplies from office during office hours.

FINANCIAL POLICY

1. Our physicians participate in a number of HMO and PPO networks. It is the patient's responsibility to verify that the doctor is in or out of network.
2. If your insurance company requires a referral from your PCP, please have it sent to our office before your visit. We must have a referral on file before seeing you.
3. Payments are due at time of service & informing the office of any insurance changes in a timely manner. There will be a $25 charge for all returned checks.
4. We accept Medicare assignment and will bill Medicare for you. If you have any supplemental insurance, please bring this information with you to your appointment. You may be responsible for a portion of your charges if your secondary/supplement does not pay.
5. If you are being treated for a work-related injury (Worker's Comp), we must have written approval from your adjustor prior to your appointment.
6. If treatment is sought due to a motor vehicle accident or other personal injury, you will be responsible for your bill, including office visits, radiology and labs.

We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the billing department promptly for assistance in the management of your account.

LIFETIME BENEFICIARY AUTHORIZATION FOR PERIOD OF THERAPY

I request that payment under any medical insurance program be made to DFW Infectious Disease on any bills for services, supplies, equipment and/or medications furnished by DFW Infectious Disease

AGREEMENT TO PAY

I take responsibility and agree that I am responsible for payment for all supplies, medications, pumps, poles and services provided to me by DFW Infectious Disease

ASSIGNMENT OF BENEFITS

I hereby authorized DFW Infectious Disease to request on my/our behalf and to collect directly all public and private insurance coverage benefits due for supplies, equipment, medications and services by DFW Infectious Disease. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to DFW Infectious Disease all checks for such payment.

RELEASE OF INFORMATION

The undersigned hereby authorize our insurer(s) and any other third party payer who provides patient with coverage to disclose to DFW Infectious Disease any information that enables them to collect payment. Patient authorizes all medical personnel to provide information to DFW Infectious Disease concerning patient/client medical history, as it may relate to patient/client therapy. I allow the use of electronic transmission of medical/financial information including facsimile and email. The undersigned consents to the review of patient/client records including medical records by and Federal, State, or Accrediting Body or Agency as required by the Regulatory, Licensing or Accrediting body.

The undersigned certifies that he/she has read the foregoing and received a copy. The undersigned also certifies that he/she is the patient, or is duly authorized by the patient as patient's general agent to execute and accept its items.

_____ _____

Patient Signature Date

DFW INFECTIOUS DISEASES
4461 COIT RD FRISCO, TX 75035
PHONE 214-396-8877 FAX 214-983-0983

1. Authorization: I hereby authorize _____ (healthcare provider or hospital) to release the protected health information described below or on a separate request form to my healthcare provider at DFW INFECTIOUS DISEASES.

2. Effective Period: This authorization for release of information covers the period of healthcare from: *(please choose one)*
A. ☐ **Only** dates of service between _____ to _____.
B. ☐ **All** past periods and all future periods of healthcare from the date of signature until this authorization expires.

3. Extent of Authorization: *(please choose one)*
A. ☐ I authorize the release of my **complete health record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
B. ☐ I authorize the release of my complete health record **with the exception of the following** information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization for release of health information shall be in force and effect for one year after date of signature or until _____ (specify date or event, if necessary), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the Insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for Benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by Federal or state law.

_____
Signature of patient or personal representative (if representative, please include printed name and relationship)

_____
Printed name of patient and date of birth

_____
Date of signature

Notice of Privacy Practices for DFW Infectious Disease

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.

This practices uses and disclosed health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the Office Manager.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment.

Payment
We are permitted to use or disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or used already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery systems and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcements
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is related pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has dies under circumstance that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation
We may disclose your medical information as required by the Texas Worker's Compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized government functions such as separation or discharge from military services, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations
The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information of both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspections of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstance may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designed record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosure that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests

within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits
We may contact you by telephone, mail or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulations to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.