PATIENT INFORMATION

Please Print

Primary Care Physician & Phone Number: ______________________________

Referred by & Phone Number: ______________________________

Patient Name: ______________________________

Address: ____________________ City: ______________ State: _____ Zip: __________

Social Security Number: _____-_____-_____ Age: _____ Date Of Birth: ____/____/____

Race: ______________ Marital Status: ______________ Sex: Male Female

Home Phone: (_____)_______-_______ Cell Phone: (_____)_______-_______

Work Phone: (_____)_______-_______ Other: (_____)_______-_______

Employed By/Occupation: ______________________________

INSURANCE INFORMATION

Primary Insurance: ______________________ Phone (____) _____-_____

Subscriber #: ______________________ Group: ______________________

Name Of Insured: ______________________ Relationship To You: ______________

Co-Pay Amount: __________ Is A Referral Needed? (HMO) __________

Secondary Insurance: ______________________ Phone (____) _____-_____

Subscriber #: ______________________ Group: ______________________

Name Of Insured: ______________________ Relationship To You: ______________

Co-Pay Amount: __________ Is A Referral Needed? (HMO) __________

EMERGENCY CONTACT

Nearest Relative (**Not Living With You/Relationship**) ______________________

Address ______________________ Phone (_____)_______-_______

LOCAL PHARMACY

Name ______________________ Phone Number (_____)_______-_______

City/Address ______________________________

MAIL-ORDER PHARMACY (IF NEEDED)

Name ______________________ Phone Number (_____)_______-_______

Address ______________________________

LAB COMPANY YOU LIKE TO USE

LabCorp _____ Quest _____ Other _______

MEDICAL HISTORY

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION

Reason for today's visit: ____

____

____

MEDICATIONS: List (**PRINT**) **ALL** medication you are **Currently** taking. List those that are prescribed and not prescribed, include over the counter and birth control pills OR attach a list with your paperwork.

NAME OF MEDICATION	STRENGTH (mg)	HOW IS THIS TAKEN (1 tab once a day)	HOW LONG

MEDICAL HISTORY: ____

____

____

____

ALLERGIES TO MEDICATION OR FOOD: **NONE** **YES**, Please List: ______________________

____

____

HOSPITALIZATIONS: ____

____

SURGERIES: Please check all that apply and indicate the approximate date in the blank space, **If "other", please be specific:** if you have Never had any surgeries mark **"N/A"**

□ Appendix ________	□ Hernia ________	□ C-Section _______	□ Cataracts _________
□ Hysterectomy _______	□ Prostate _______	□ Ovaries ________	□ Other _____________
□ Tonsils _________	□ Gallbladder ________	□ Tubal Ligation ____	□ Other _____________
□ Breast (Type)________	□ Heart(Type) _________	□ Vasectomy ________	□ Other _____________

Have you received the Pneumovax vaccine? YES NO Approximate Date: ________________

Have you received the Flu vaccine? YES NO Approximate Date: ________________

Have you received the Prevnar-13 vaccine? YES NO Approximate Date: ________________

FAMILY MEDICAL HISTORY: Use initial code after the disease to specify who had the disease.

M-Mother **F**-Father **GP**-Grandparent **S**-Sibling

Alcoholism	**Arthritis**	**Anemia**	**Aneurysm**	**Asthma**
Dementia/Alzheimer's	**Heart Disease**	**Cancer (Type)**	**Diabetes**	**Epilepsy**
Glaucoma	**Gout**	**Hay Fever**	**Heart Attack**	**Hypertension**
Kidney Disease	**Mental Illness (type)**	**Migraine**	**Osteoporosis**	**Osteoarthritis**
Stroke	**Thyroid Disease**	**Other:**	**Other:**	**Other:**

Father Living: YES NO Age ________ (Now Or At Death)
Mother Living: YES NO Age ________ (Now Or At Death)

SOCIAL HISTORY:

Have you ever been diagnosed with a sexually transmitted disease: **No** **Yes**, and if so what were you diagnosed with: ____

Have you had **Sex** in the last **12 months** (example: vaginal, anal, oral) : **Yes** **No**

If Yes: Do you have sex with: Men Women Both
Do you use protection: No **Yes, and if so what type**: ____________________
How often is protection used: **All** of the time **Most** of the time **Half** of the time **Some** of the time

Do you **Smoke** Now or in the Past: **Never** **Now** **Past - Quit date** ________________

If Currently: How many cigarettes do you smoke per day: __________________
How soon after you wake up do you have your first cigarette: ______________
Are you interested in quitting? Ready to quit Not ready to quit Thinking about quitting

Have you had a drink of **Alcohol** in the last **12 months**: **Yes** **No**

If Yes, How often did you have a drink containing alcohol in the last 12 months:
Monthly or less 2-3 times a month
2-4 times a month 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the last 12 months:
1-2 3-4 5-6 7-9 10 or more
How often did you have 6 or more drinks on one occasion in the last 12 months:
Never Less than monthly Monthly Weekly Daily

Any **Recreational Drugs** used: **Never** **Now** **Past - Quit date** ___________________

If you used drugs now or in the past what drugs did you use, please list: _________________________

____

Have you ever used IV Drugs: Never Now Past - Quit date ________________

Authorization for Use and/or Disclosure of Protected Health Information

Please Print:

Patient Name: ______________________________

Social Security Number: ________-________-________ DOB: ______/______/______

Daytime Phone #: (_____) ________-________ Evening Phone #: (_____) ________-________

Address: ______________________________

City: ____________________ State: ____________ Zip Code: ____________

I hereby authorize TCIDA to use and/or disclose my protected health information as indicated below to the following doctor(s) first and last name:

Doctor's name: ____________________ Doctor's name: ____________________

Doctor's name: ____________________ Doctor's name: ____________________

Doctor's name: ____________________ Doctor's name: ____________________

Information to be released:

From & To Dates: ______________________________

____ Copy of complete records

____ Information related to HIV testing and results

____ History & Physical, Consultation/Operative Reports

____ Labs, Cultures, X-Rays/Imaging, Echo, Angio

____ Other: ____________________

I understand that this health information may include HIV-related information and/or information relating to diagnosis and/or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

___ HIV related information, including AIDS related testing
___ Mental Health
___ Substance Abuse, including alcohol/drug abuse
___ Psychotherapy Notes

____________________ ____________
Signature of Patient or Legal Guardian Date

Purpose of Disclosure:

____ Changing Physician
____ Second Opinion
____ My/Patient request
____ School
____ Continuing of care
____ Insurance
Other: ____________________
____ Legal
____ Worker's Compensation

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Pam Dunaj Privacy Officer at the address indicated below in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

   Texas Centers for Infectious Disease Associates
   1025 College Avenue
   Fort Worth Texas, 76104
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

____________________ ____________________ ____________
Signature of Patient or representative Relationship Date

______________________________ ____________
Witness Date

Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

Health information **Texas Centers for Infectious Disease Associates** collects or receives about you may be disclosed to the following persons:

____
Name of person and relationship to patient

____
Name of person and relationship to patient

____
Name of person and relationship to patient

____
Name of person and relationship to patient

Use and Disclosure of Information:

_____ I **authorize** the person(s) listed above to receive **all health information** about appointments, treatment, and/or other information pertinent to my health care and/or payment for my healthcare provided at **Texas Centers for Infectious Disease Associates**

_____ I **do not authorize** the above information to be disclosed to any other parties except to me as the patient.

Expiration Date of Authorization:

This authorization is effective through ___/___/___, unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Texas Centers for Infectious Disease Associates** You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure:

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

______________________________ ____________________
Patient Signature Date

____
Printed Name

REFERRAL WAIVER

It is the patient's responsibility to inform us of their current insurance plan and provide copies of all insurance cards. **It is the responsibility of the patient to obtain a REFERRAL /PRE-AUTHORIZATION for office visits. If a referral is not on file, and the insurance company denies payment, the patient will be responsible for full payment.**

Patient Signature ____________________ Date ____________________

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to **Texas Centers for Infectious Disease Associates** unless revoked by my orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to

the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situation: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to the **Texas Centers for Infectious Disease Associates** protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you me be tested if any of these situations occur during you treatment period.

Patient Signature ____________________ Date ____________________

ASSIGNMENT OF BENEFITS

I, the undersigned, have health insurance with ______________________________ and assign directly to **Texas Centers for Infectious Disease Associates** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Texas Centers for Infectious Disease** Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Medical Authorization

I request that payment of authorized Medicare benefits be made on my behalf, to **Texas Centers for** Infectious Disease Associates for any services rendered to me by one of their physicians. I authorize any holder of information about me be released to **Texas Centers for Infectious Disease** Associates. I understand that my signature enables payment to be made and authorized the release of medical information necessary to pay the claim. If "other health insurance" is indicted in item 9 of the HDFA-1500 form, or elsewhere on other approved claims or electronically submitted claims, my signature authorizes releasing of information to the insurer of the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. The Medicare carrier bases coinsurance and the deductible upon the charge determination.

______________________________ ______________________________

Patient Signature Date

____

Printed Name

FINANCIAL POLICY

Patient: ______________________ SSN: __________________ Date: ________

Thank you for choosing **Texas Centers for Infectious Disease Associates**, as your healthcare provider. This office is committed to your health and successful treatment. Please understand that payment of your services is considered part of your treatment. We ask that you please read the following FINANCIAL POLICY and sign this form prior to any treatment.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERVICE IS RENDERED. IF OTHER ARRANGEMENTS NEED TO BE MADE PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT.

WE ACCEPT CASH, CHECK, VISA,
And MASTERCARD.

INSURANCE

We do accept assignment on your insurance benefits. We must have your insurance information to do any insurance billing. In the event that your insurance company does not pay, we reserve the right to transfer balances to your responsibility

Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan.

If your insurance requires a referral, we request be sure we have one on file before your visit or bring a copy with you at the time of your visit.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A copy of the Assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges. I hereby authorize **Texas Centers for Infectious Disease** to release all information necessary to secure payment.

Signature Patient/Legal Guardian: ________________________________

Patient: ______________________ SSN: ________________ Date: _______

Financial policy continued.

MEDICARE GUIDELINES

I authorized any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I permit a copy of this request for payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature Patient/Legal Guardian: ____________________________________

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If your insurance deems any service we provide to you be non-covered or not medically necessary, you agree to pay for these services in full.

MISSED APPOINTMENTS

Unless canceled, at least 24 hours in advance, our policy is to charge $25.00 for missed appointments.

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any questions or concerns.

I have read the FINANCIAL POLICY. I understand and agree to this policy.

Signature Patient/Legal Guardian: ____________________________________

PATIENT PORTAL CONSENT FORM

The patient portal is a secure web portal that allows you access to your patient summary. The portal also allows you to communicate with our office via secure messaging for non-emergencies.

By using this patient portal, you agree to protect your password from any unauthorized individuals.

Print Patient Name: ______________________________
Print E-mail Address: ______________________________
Patient Signature: ______________________________
Date: ______________________________

Communications with Texas Centers For Infectious Disease

Patient Name: ______________________________

How would you like to be contacted by us? Check one

- ☐ Voice call
- ☐ SMS text

What is your preferred Phone #? ____________________

Preferred language?

- ☐ English
- ☐ Spanish

What is your preferred Time To Call?

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

Texas Centers for Infectious Disease Associates

Clinic

Due to our chemically-sensitive patients and employees, this office is a **FRAGRANCE-FREE** facility. Please **AVOID** wearing any of the following scented products while visiting TCIDA.

** Perfume or Cologne **

** After-Shave Lotion **

** Scented Lotion or Body Spray **

Thank you for your cooperation.

1025 College Avenue • Fort Worth, Texas 76104 • 817-810-9810 • Fax 817-810-9815