Texas Centers for Infectious Disease Associates
1025 College Ave
Fort Worth, TX 76104
Phone: 817-810-9810 Fax: 817-810-9815
3410 Worth Street, Suite 740
Dallas, TX 75246
Phone: 214-716-0662 Fax: 972-791-8446

NEW PATIENT PAPERWORK - PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION

Primary Care Physician & Phone Number: _____

Referred by & Phone Number: _____

Patient Name: _____ DOB:_____ Race:_____ Sex: Male / Female

Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number: _____-_____-_____ Marital Status:_____ Email:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Employer/Occupation_____

INSURANCE INFORMATION

Please complete ALL Insurance Information OR provide insurance card to front office staff

Primary Insurance: _____ Phone: _____

Subscriber/Member #: _____ Group #: _____

Name of Insured: _____ Relationship to you: _____

DOB of Subscriber: _____ Copay Amount: _____ Is a Referral Needed? (HMO) _____

Secondary Insurance: _____ Phone: _____

Subscriber/Member #: _____ Group #: _____

Name of Insured: _____ Relationship to you: _____

DOB of Subscriber: _____ Copay Amount: _____ Is a Referral Needed? (HMO) _____

EMERGENCY CONTACT

Emergency Contact Name and Relationship: _____ ☐ Not Applicable

Address: _____ Phone: (_____) _____

Primary Caregiver Name and Relationship: _____ ☐ Not Applicable

Address: _____ Phone: (_____) _____

LOCAL PHARMACY

Name: _____ Phone: (____)_____

Address: _____

MAIL ORDER PHARMACY (**IF APPLICABLE**):

Name: _____ Phone: (____)_____

Address: _____

PREFERRED LAB COMPANY

LabCorp _____ Quest _____ Other _____

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Consent for Treatment, Payment, and Healthcare Operations

General Consent, Authorization, Patient Rights and Responsibilities
I hereby authorize Texas Centers for Infectious Disease Associates (TCIDA) through its appropriate personnel, to furnish and preform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand that doctors in training, medical and nursing students, and paramedical personnel may observe and participate in my care under the supervision of TCIDA staff and my physician(s). This consent is valid for each visit I made to Texas Centers for Infectious Disease Associates, including visits made to the associated Infusion Center, unless revoked by me in writing. I acknowledge receipt and understanding of a *Statement of Patient Rights and Responsibilities*. I also understand that TCIDA staff is available to explain the statement to me if necessary. (*Statement of Patient Rights and Responsibilities* is posted in the waiting area and on our website at texascentersid.com Please ask staff for a paper copy if you would like one)

Advanced Practitioner Consent for Treatment
TCIDA employs both Physician Assistants and Nurse Practitioners. Both are graduates of certified training programs and are licensed by the state board. Under the supervision of a physician, a physician assistant and nurse practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. I agree to see an Advanced Practitioner instead of a physician and understand that I may request to see a physician at any time.

Protected Health Information
I have been made aware of the *Notice of Privacy Practices for Protected Health Information*. This notice provides a complete description of the uses and disclosures of my Personal Protected Health Information (PHI). I consent to TCIDA and providers participating in my care releasing my PHI (either in writing or verbally) in order to carry out treatment, payment, or healthcare operations. This includes any medical information (including drug and alcohol abuse treatment, psychiatric treatment, and HIV related information including HIV testing results (if applicable), which may be needed to process claims for medical insurance or managed care benefits, or which may be needed to conduct continued care planning. (*TCIDA's Notice of Privacy Practices* is posted in the waiting area and on our website at texascentersid.com Please ask staff for a paper copy if you would like one.)

Financial Policy
I understand that as a recipient of medical care at TCIDA, I am financially responsible for all fees incurred regardless of my circumstances for reimbursement and that these fees may not be covered by my insurance plan. As a courtesy, TCIDA will attempt to verify your insurance coverage, if any, and estimate the amount you may owe for services provided (e.g. co-pay, deductible, co-insurance, etc.) should insurance apply. However, some or all of services rendered may not be covered by your insurance, and you are responsible for any and all fees not covered or only partially covered by insurance. I understand and agree that additional charges may come through from my treatments that are not included in my initial estimated bill.
I authorize payment of medical insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to any physician(s) participating in my care. This assignment of benefits will remain in effect until revoked by me in writing. A copy of this assignment is to eb considered as valid as the original. I understand that some insurances and managed care entities require pre-approval of certain procedures and treatments, and it may be my responsibility to obtain appropriate approvals. I also understand that if my insurance company requires an insurance referral/authorization to be on file before seeing a specialist, it is my responsibility to obtain this referral from my Primacy Care Physician (PCP) prior to my appointment. Failure to obtain this referral may result in reduced or refused payment from the insurance company and I will be responsible for all balances not paid.
Self-Pay: If there is no insurance carrier on file either with the state, employer, or self-funded plans it has been agreed upon that the visit rate will be an estimated **$200.00.** This amount will be due at the time of service and is solely an estimation based on general practices and procedures. If further assistance is required, please ask the front desk staff.
Missed Appointments: Unless cancelled 24 hours in advance, our policy is to charge **$50.00** for missed, no show, or cancelled appointments with less than 24-hour notice.
After Hours Calls: A Physician is available after hours to assist patients in emergency situations. Calls made to the physician after business hours are subject to a **$200** fee that will be billed directly to the patient and is not covered by insurance. Calling outside of normal business hours will constitute as implied consent to pay this fee.
Payments: We accept Cash, Visa, Mastercard, Discover, American Express, or Check. If your insurance company sends payments directly to you, you are then responsible for the insurance balance as well as your patient portion. You may submit payment by mail, in person, via telephone, or online. **There is a Nonsufficient Funds Fee of $35 for returned checks.**

Patient Name	DOB	Date

Signature of Patient or Legal Representative	Name (If different from patient)

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Consent for Treatment, Payment, and Healthcare Operations (con't)

Tardy and Late Cancellation Policy
In order to best serve all of our patients, it may be necessary to reschedule your appointment if you are fifteen (15) minutes late or more. Failure to come in for your appointment without giving our office at least 24 hours' notice will result in a **$50** charge on your account.

Patient Privacy Notification
As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside these offices who are involved in my care and treatment for the purpose of providing health care services. Although all TCIDA staff will attempt to conceal written medical information, I understand that other patients or staff may overhear the staff when medical information is provided to me. I further acknowledge that the TCIDA Infusion Center is an open treatment area that may be monitored by video surveillance. I give my consent to me monitored and recorded by video.

Employee Incident
In case of an employee needle stick injury or exposure to blood/body fluids, I consent to have my labs drawn by the TCIDA clinical staff which would include, but not be limited to, Hepatitis B, Hepatitis C, and HIV.

Release of Patient Information
I authorize my physician, the infusion center, office staff, and others outside this office who are involved in my care and treatment for the purpose of providing medical care to leave messages and/or voicemails and discuss medical information with the following persons:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

☐ I DO NOT authorize my health information to be disclosed to any parties other than myself, the patient. (Note: health information may still be used in accordance with the Statement of Privacy Practices).

_____ _____ _____
Patient Name DOB Date

_____ _____
Signature of Patient or Legal Representative Name (If different from patient)

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Evacuation Plan
Our office will attempt to contact you if there is advance warning of an emergency or disaster. I acknowledge that TCIDA has made available a copy of their emergency preparedness plan. (Please ask for a copy if you would like one)

Patient Portal
The patient portal is a secure web portal that allows you to access your patient information such as lab results, office notes, and visit summaries. The portal also allows you to communicate with our office via secure messaging for non-emergencies. I understand that my email address is required to sign-up for the patient portal. I agree to protect my password from any unauthorized individuals.

☐ **I agree to portal access and have provided my email address below:**

_____
Email Address of Patient or Authorized Representative

☐ I decline portal access or do not have an email address

Patient Communication
I agree to be contacted via the following methods:

Cell Phone # _____Home Phone #_____Work Phone _____

My preferred method of contact is:

☐ Voice Call ☐ SMS text

My preferred language is:

☐ English ☐ Spanish

My preferred time of contact is:

☐ Morning ☐ Afternoon ☐ Evening

I understand that email and/or text message is not a confidential method of communication and may be at risk of being intercepted by third parties or transmitted to unintentional parties. I also understand that any e-mail or text message communications between myself, my physician, or other members of the office staff may be made part of my medical record. I understand that in an urgent or emergent situation, I should call my provider or go to the Emergency Room and not rely on email or text messaging. I acknowledge that TCIDA cannot guarantee the privacy, security, or confidentiality of information transmitted via e-mail or text. I understand that by initialing below, I consent to have the staff at TCIDA communicate with me and other members of my care team via email or text. I further understand that any email or
text communication initiated by me to my physician or staff at TCIDA implies consent to communicate via that method from that date forward.

_____ _____ _____
Patient Name DOB Date

_____ _____
Signature of Patient or Legal Representative Name (If different from patient)

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MEDICAL HISTORY - PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION

Patient name: _____ **DOB:**_____

Reason for today's visit: _____

MEDICATIONS List (**PRINT**) **ALL** medications you are **CURRENTLY** taking. List those that are prescribed and not prescribed, include over-the-counter and herbal supplements **OR** attach a list with your paperwork.

NAME OF MEDICATION	DOSE (ex. 500mg)	HOW IS THIS TAKEN (ex. 1 tab once a day)	INDICATION (ex. High blood pressure)

If you need more room to list medications, please ask the office staff for additional pages

ALLERGIES □ No Allergies

Medication	Reaction	Medication	Reaction

PERSONAL MEDICAL HISTORY □ No Medical History □ Pregnant □ Breastfeeding

Disease/Condition	Date	Disease/Condition	Date

HOSPITALIZATIONS □ No History of Hospitalization

Hospital	Date(s)	Reason

SURGICAL HISTORY □ No History of Surgery

Type of Surgery (specify left/right)	Date	Location/Facility

VACCINATION HISTORY Please indicate if/when you have received the following vaccinations

Vaccine	Y	N	Approximate Date(s) (estimate if unknown)			
Flu Vaccine (current season)						
Pneumococcal (Pneumonia)						
Prevnar (Pneumonia)						
COVID-19 Vaccine						
Circle Brand: Moderna / Pfizer / J&J			*(Dose 1)*	*(Dose 2)*	*(Dose 3)*	*(Dose 4)*

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Patient name: _____ **DOB:**_____

FAMILY MEDICAL HISTORY □ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ Check all that apply	Hypertension	Heart Disease	Cancer (Type_____)	Diabetes	Stroke	Mental Illness (Type_____)	Kidney Disease	Other:_____	Other:_____
Mother Age: Alive? **Y N**									
Father Age: Alive? **Y N**									
Grandparent									
Sibling									

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination act of 1990 required that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called and Advanced Directive so that my wishes may be known when I am unable to speak for myself.

☐ I DO NOT have an Advanced Directive
If no, does patient have a surrogate health care decision maker? ___ No ___ Yes If yes, who?_____

☐ I HAVE an Advanced Directive (Mark all that apply and provide a copy to TCIDA)

☐ Advanced Care Plan	☐ Living Will	☐ Appointment of Healthcare Agent
☐ Durable Power of Attorney for Healthcare	☐ Do Not Resuscitate (DNR) Order	☐ POST Form

SOCIAL HISTORY

SMOKING	**Currently** Smoke Cigarettes? **Y N** *(If you have never smoked, please move to next section)* ***Past:*** Quit Date:_____	
	Interested in Quitting □ Ready □ Not Ready □ Thinking about it	
ALCOHOL USE	Do you drink alcohol? **Y N**	IF yes, how often? □ < monthly □ twice/month □ weekly □ Daily
	How many drinks on a typical day? □ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10 or more	How often do you drink > 6 drinks at once? □ Never □ Rarely □ Monthly □ Weekly □ Daily
DRUG USE	Recreational Drug Use □ Never □ Current □ Past: Quit Date:	Ever Use IV Drugs? **Y N**
	List all recreational drugs you have used:	
SEXUAL ACTIVITY	Have you ever been diagnosed with a sexually transmitted disease? **Y N** If so, which one(s):	
	Sexually Active? **Y N**	Sex with □ Men □ Women □ Both
	Protection □ Always □ Sometimes □ Never	Type:

Have you had any falls in the last year? Y N How many? _____ Have they resulted in injury? Y N

HOME ASSESSMENT

Do you have a reasonably clean area in your home to prepare and administer your medications**?**	**Y N**
Do you have electricity/refrigerator access and running water?	**Y N**
Are you capable of administering your own medications? If not, do you have a caregiver to help you?	**Y N**
Are you able to move around your home independently? If not, do you have a caregiver to help you?	**Y N**
Are you currently a victim of abuse, violence, or neglect at home?	**Y N**