Arizona Infectious Disease PLLC

PATIENT FORM

Today's Date: _____

Name: _____

Last First Middle Initial

DOB: _____ SSN: _____

GENDER: Male/ Female Marital Status: _____

RACE: African American / Caucasian / Hispanic / Asian / Other

Ethnicity: Hispanic: _____ Non-Hispanic: _____ Declined: _____

ADDRESS: _____

Street City State Zip

Cell phone: _____ Home: _____ Work: _____

How can we reach you? Phone: _____ Ok to leave message: _____

Email: _____

WEIGHT: _____ HEIGHT: _____

RETAIL PHARMACY: _____

INFUSION PHARMACY (IV MEDS): _____

HOME HEALTH COMPANY:_____

LAB: SonoraQuest LabCorp CCL Honorhealth Unique Other: _____

IMAGING: SMIL Simonmed Banner Imaging Arizona Diagnostic _____

EMERGENCY CONTRACT: _____

Name Relation Phone

PRIMARY INSURANCE (Or provide a copy) SECONDARY INSURANCE

Insurance name: _____
Policy Holder: _____
Policy ID #: _____
Group #: _____

Insurance name: _____
Policy Holder: _____
Policy ID #: _____
Group #: _____

Do you have a Living Will / Advance Directive? Yes / No (If yes, provide a copy)

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/hers associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

Signature: _____ Date: _____
Printed Name: _____
If representative signed on patient's behalf, please state relation: _____

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.

Signature: _____

Name: _____

Date: _____

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:

_____

_____

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