

Infectious Disease Partners of Nevada

PATIENT INFORMATION

FECHA: _____

NOMBRE _____ FECHA DE NACIMIENTO: ___ / ___ / ___
APELLIDO PRIMER NOMBRE ESTADO MARITAL: _____

DIRECCION: _____
CALLE APT #

CITY

ESTADO

CODIGO POSTAL

PLEASE CIRCLE: HOMBRE MUJER OTHER: _____

RACE: WHITE ASIAN, NATIVE HAWAIIAN, OR
BLACK OR AFRICAN AMERICAN PACIFIC ISLANDER
HISPANIC OR LATINO NATIVE AMERICAN INDIAN

SSN: _____ E-MAIL _____

NUMERO TELEFONICO: _____

MOBIL: _____ EMPLEADOR: _____

OCCUPACION: _____

NUMERO TELEFONICO DE TRABAJO: _____

LESION RELACIONADA CON EL TRABAJO? _____ ACCIDENTE DE AUTO: _____

DIA DE EL ACCIDENTE: _____

MANEJADOR DE EL CASO?: _____ COPIA DE EL ARCHIVO: _____

*****PLEASE NOTE PAYMENT IS DUE AT TIME OF SERVICE*****

INSURANCE INFORMATION:

SEGURO PRIMARIO: _____ POLIZA: _____

DIRECCION: _____ TELEFONO: _____

CIUDAD: _____ ESTADO: _____ CODIGO POSTAL: _____

NOMBRE DE EL ASEGURA: _____ RELACION CON EL ASEGUR: _____

SSN OF INSURED : _____ FECHA DE NACIMIENTO: _____

NOMBRE DE EL EMPLEADOR: _____ OCCUPACION: _____

SEGUNDA ASEGURANZA: _____ POLIZA: _____

DIRECCION: _____ TELEFONO: _____

CIUDAD: _____ ESTADO: _____ CODIGO POSTAL: _____

NOMBRE DE EL ASEGURA: _____ RELACION CON EL ASEGUR: _____

SSN OF INSURED : _____ FECHA DE NACIMIENTO: _____

NOMBRE DE EL EMPLEADOR _____ OCCUPACION: _____

AMIGO O FAMILIAR QUE NO VIVE CRUSTED: _____

RELACION: _____ NUMERO TELEFONICO: _____

WHERE YOU REFERRED HERE? Y ___ N ___ IF YES, BY WHOM? _____

NOMBRE Y NUMERI TELEFONICO DE LA FARMACIA:

Infectious Disease Partners of Nevada

NOMBRE DE PACIENTE: _____ FECHA: _____
 FECHA DE NACIMIENTO: _____

RAZON DE LA VISITA:
SINTOMAS:
POR CUANTO TIEMPO?:
QUE CREE QUE LO ESTA CAUSANDO?
TRATADO ANTERIORMENTE?

PREVIOUS MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU.

- | | | | |
|--------------------------|------------------|------------------|-----------------|
| ARTHRITIS | EDEMA | IRREGULAR MENSES | RHEUMATIC FEVER |
| ASTHMA | ESRD ON DIAYLSIS | KIDNEY DISEASE | STROKE |
| CANCER | GASTRIC ULCER | KIDNEY STONES | SEIZURE |
| CELLULITIS | GOUT | MIGRAINES | THYROID DISEASE |
| COPD | HEADACHE | OBESITY | TUBERCULOSIS |
| COVID 19 | HEART DISEASE | OSTEOPOROSIS | ULCER |
| DEPRESSION | HYPERCHOLESTRMIA | OSTEOMYELITIS | UTI |
| DIABETES | HYPERLIPIDEMIA | PNEUMONIA | VALLEY FEVER |
| DIVERTICULITIS | HYPERTENSION | PCOS | |
| CONGESTIVE HEART FAILURE | | POLIO | |
| CORONARY ARTERY DISEASE | | PSORIASIS | |

ETS HISTORIAL: PLEASE CIRCLE ALL THAT APPLY TO YOU.

- | | | | |
|-------------------------|---------------|---------------|----------------|
| AIDS/HIV DX YEAR: _____ | CHLAMYDIA | GENITAL WARTS | GONORRHEA |
| HEPATITIS | HERPES 1 OR 2 | HPV | SYPHILIS |
| | | | TRICHOMONIASIS |

PAST HOSPITALIZACIONES/ SIRUGIAS:

FECHA	HOSPITALIZACIONES/SIRUGIAZ	QUE HOSPITL

A TENIDO TRANSFUSION DE SANGRE: YES NO FECHA:

FAMILY HISTORY: PLEASE CIRCLE ANY DIAGNOSES ASSOCIATED WITH ANY FAMILY MEMBERS.

STROKE	TUBERCULOSIS (TB)	CANCER	DIABETES	HEART DISEASE
--------	-------------------	--------	----------	---------------

Infectious Disease Partners of Nevada

MEDICATIONS: LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND OVER THE COUNTER MEDS.

LISTA DE MEDICA	DOSE (I.E.- MG)	POR DIA	DIA QUE COMENZO

ALLERGIES OR REACTIONS TO MEDICATIONS:

ALLERGIAS A MEDICAMENTO	REACTIONS

IMMUNIZATIONS/VACCINES (PLEASE INCLUDE DATES)

TETANUS		MEASLES		OTRA:
FLU		HEPATITIS		OTRA:
PNEUMONIA		BCG		OTRA:
COVID	1 ST :	2 ND :	BOOSTER:	PFIZER/ MODERNA J&J

PERSONAL HABITS:

FUMA TOBACCO: YES NO	A FUMADO ALGUNA VEZ? YES NO
TYPE AND AMOUNT:	POR CUANTO TIEMPO: SI PARO DE FUMAR CIANDO?
TOMA ALCOHOL: YES NO	CADA CUANTO?
USA DROGAS: YES NO	QUE TAN SEGUIDO?

A FUMADO ALGUNA VEZ?

ADONDE?

ALGUNA OTRA INFORMACION QUE DESEA QUE EL DOCTOR SEPA?

FIRMA

DIA

Infectious Disease Partners of Nevada

YO _____ DOT PERMISO A RONALD A. SHOCKLEY, MD.
PC DBA INFECTIOUS DISEASE PARTNERS OF NEVADA, DE DAR INFORMACION MIA CON LAS
SIGUIENTES PERSONAS

_____ NOMBRE	_____ RELACION
_____ NOMBRE	_____ RELACION
_____ NOMBRE	_____ RELACION
_____ NOMBRE	_____ RELACION
_____ NOMBRE	_____ RELACION

YO SOY RESPONSIBLE DE NOTIFICAR A LA OFFICINA SI ALGUN CAMBIO LLEGA SUCEDER.

FIRMA _____ FECHA _____

Infectious Disease Partners of Nevada

NO SHOW FEE

YO SOY RESPONSIBLE DE PAGAR \$25.00 SI NO LLEGO A MI CITA O NO LA CANCELO 24 HORAS ANTES DE MI CITA.

NOMBRE DE PACIENTE

FIRMA DE PACIENTE

FECHA

Infectious Disease Partners of Nevada

FINANCIAL AGREEMENT

YOU HAVE THE RIGHT to receive a full explanation of your bill, whether payment is coming directly from you or a third party (such as insurance company). **RONALD A. SHOCKLEY, MD, PC dba INFECTIOUS DISEASE PARTNERS OF NEVADA HAS THE RIGHT** to receive prompt payment for services rendered. It is your responsibility to provide the accurate and complete information regarding your address, your insurance company, and any limitations or restrictions on your insurance policy.

ALL FEES ARE THE FULL RESPONSIBILITY OF THE PATIENT. Our insurance department will bill your insurance company free of all charge and we will do all that we can to help collect legitimate claims. However, it is up to you to provide our office with full and correct insurance information, and any forms which may be required. It is also your responsibility to know who your primary care physician is.

If you are a **MEMBER OF A PAID PROVIDER ORGANIZATION PLAN**, we will bill the insurance company for you. You will be required to pay a preset co-payment and/or deductible (as per your policy) at the time of your appointment. **WE ARE NOT EQUIPPED TO EXTEND CREDIT OR CO-PAYMENT/DEDUCTIBLE AMOUNT. PLEASE BE PREPARED TO PAY YOUR COPAY AT EVERY VISIT PRIOR TO YOUR VISIT WITH THE DOCTOR.**

In the event that your insurance company is slow to pay or denies the claim for any reason, you are responsible for payment of the account. The office does not have any authority to collect your insurance claim or to negotiate settlement of a disputed claim. You are responsible for payment of your accounts within the limits of your credit policy. We expect payment in full on any account within four months. Your eventual reimbursement will be determined by your insurance company. If you have any questions we will of course, assist you. However, your insurance agent or employer's insurance representative is equipped to answer questions and handle problems specific to your individual or group policy. Special arrangements for payment, if necessary, should be made in advance through our billing department.

You will receive a statement each month until your account is paid in full. Our statements show when your insurance company makes a payment on your behalf so you may understand what your balance is. We expect prompt payment of any balance not paid by your insurance company. If you have made prior arrangement with our billing department for a payment plan please honor those arrangements and pay as agreed.

I understand a \$25.00 return fee will be applied to my account if any check or credit cards are declined for insufficient funds. I also understand that if my account has no activity for three months, I will receive a 30 day notice before I am sent to collections. If your account is turned over to collections, you will be responsible for all cost of the outside collection agency.

I hereby authorize **RONALD A. SHOCKLEY, MD, PC dba INFECTIOUS DISEASE PARTNERS OF NEVADA** to render medical care to myself or my department. I authorize them to release any information acquired in the course of my treatment as needed for my care, or when they are presented with written authorization to do so, this includes releasing all medical records to referring physicians and primary care physicians.

FIRMA DE PACIENTE

FECHA

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Ronald A Shockley MD A Professional Corporation dba Infectious Disease Partners of Nevada (“Practice”) and Patient herein enter into this Electronic Communications Agreement for Personal Health Information (“PHI Agreement”) regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient’s Personal Health Information (“PHI”). The Patient agrees to inform the Practice of any changes to Patient’s authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient’s privacy and takes security measures such as encrypting the Patient’s data, password-protected data files, and other authentication techniques to protect the Patient’s privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient’s explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient’s information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims and damages to persons or property, losses and liabilities, including reasonable attorney’s fees, arising out of or caused by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney’s fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient’s express consent in the event that the Practice is required or requested to forward the Patient’s identifiable information to any third party, other than as specified in the Practice’s Notice of Privacy Practice’s, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient’s failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, an may lead to the termination of the Patient’s agreement for Practice services.
8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient’s PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient’s PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient’s PHI and an explanation or summary of the Patient’s PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronics information. However, the Patient’s PHR Support subscription fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient’s PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive) the Practice’s actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient’s ability to receive medical treatment, but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT FOR AGREEMENT FOR PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the Practice’s Electronic Communications Agreement for Personal Health Information (“PHI Agreement”) regarding the use of email or other electronic communications/transmissions:

Patient Name: _____

Patient Signature: _____ Date: _____ / _____ / 20_____



INFECTIOUS DISEASE PARTNERS OF NEVADA

CARE TEAM INFORMATION

We would like to be able to keep your doctors/providers up to date. Please provide the following information so we can send your office notes after each visit. Please note you do not have to fill out each one, please provide the information of the providers that pertain to your care with our office. Please provide name and phone number.

NOMBRE DE DOCTOR QUE LO REFIRIO: _____

NOMBRE DE SU DOCTOR PRIMARIO: _____

UROLOGO: _____

OTORRINOLARINGOLOGO: _____

PODOLOGO: _____

ORTOPEDICO: _____

SIRUJANO: _____

CENTRO DE CURACION: _____

PULMONOLOGO: _____

OTRO: _____