Infectious Disease Partners of Nevada

PATIENT INFORMATION

TODAY'S DATE: _____

NAME _____Date of Birth: ___ / ___ / ____
LAST FIRST MARITAL STATUS: _____
ADDRESS: _____
STREET APT #
_____
CITY STATE ZIP CODE

PLEASE CIRCLE: MALE FEMALE OTHER: _____
RACE: WHITE ASIAN, NATIVE HAWAIIAN, OR
BLACK OR AFRICAN AMERICAN PACIFIC ISLANDER
HISPANIC OR LATINO NATIVE AMERICAN INDIAN
SSN: _____ ___E-MAIL_____
HOME PHONE: _____
CELL PHONE: _____ EMPLOYER: _____
OCCUPATION:_____ WORK PHONE: _____

WORK RELATED INJURY? _____ AUTO ACCIDENT: _____
DATE OF INJURY/ ACCIDENT: _____

ADVANCED DIRECTIVE?: _____ COPY ON FILE: _____

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

INSURANCE INFORMATION:
PRIMARY INSURANCE: _____ POLICY: _____
CLAIMS ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP CODE: _____
POLICY HOLDER: _____ RELATIONSHIP TO INSURED: _____
SSN OF INSURED : _____ DATE OF BIRTH: _____
EMPLOYERS NAME: _____ OCCUPATION: _____

SECONDARY INSURANCE:_____ POLICY: _____
CLAIMS ADDRESS: _____ PHONE: _____
CITY: _____ STATE:_____ ZIP CODE: _____
POLICY HOLDER: _____RELATIONSHIP TO INSURED: _____
SSN OF INSURED : _____ DATE OF BIRTH: _____
EMPLOYERS NAME: _____OCCUPATION: _____

EMERGENCY CONTACT: _____
RELATIONSHIP: _____ PHONE: _____
WHERE YOU REFERRED HERE? Y___ N___ IF YES, BY WHOM?_____

PHARMACY NAME & NUMBER: _____

Infectious Disease Partners of Nevada

PATIENT NAME: _____ DATE: _____ DOB: _____

REASON FOR VISIT:
SYMPTOMS:
HOW LONG?:
WHAT DO YOU THINK MIGHT BE CAUSING IT?
TREATMENT TRIED?

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	

STD HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU.

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

PAST HOSPITILIZATIONS/ SURGERIES:

YEAR	ILLNESS OR OPERATION	PLACE OF HOSPITALIZATION

HAVE YOU HAD ANY BLOOD TRANSFUSIONS: YES NO DATES:

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

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

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

MEDICINE	DOSE (I.E.- MG)	TIMES PER DAY	START DATE

ALLERGIES OR REACTIONS TO MEDICATIONS:

MEDICATION	REACTIONS

IMMUNIZATIONS/VACCINES (PLEASE INCLUDE DATES)

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

PERSONAL HABITS:

TOBACCO: YES NO	HAVE YOU EVER SMOKED? YES NO
TYPE AND AMOUNT:	NUMBER OF YRS: IF STOPPED, WHEN?
ALCOHOL: YES NO	HOW MUCH AND HOW OFTEN?
DRUG USE: YES NO	WHAT AND HOW OFTEN?

TRAVEL IN THE LAST 2 YEARS?

WHEN AND WHERE?

IS THERE ANY OTHER INFORMATION YOU WISH YOUR DOCTOR TO KNOW?

PATIENT SIGNATURE DATE

Infectious Disease Partners of Nevada

I _____ GIVE RONALD A. SHOCKLEY, MD. PC DBA INFECTIOUS DISEASE PARTNERS OF NEVADA, AUTHORIZATION TO RELEASE AND DISCUSS ANY INFORMATION ABOUT MYSELF TO THE FOLLOWING PEOPLE:

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

I UNDERSTAND THAT IT IS MY FULL RESPONSIBILITY TO NOTIFY THE OFFICE IF ANY CHANGES OCCUR.

PATIENT'S SIGNATURE DATE

Infectious Disease Partners of Nevada

NO SHOW FEE

I UNDERSTAND THAT I WILL BE CHARGE A $25.00 NO SHOW FEE FOR ANY APPOINTMENT NOT CANCELLED WITHIN 24 HOURS OF MY SCHEDULED TIME. THESE FEES CAN BE WAIVED AT THE DECRETION OF THE PHYSICIAN.

PATIENT NAME

PATIENT SIGNATURE DATE

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.

SIGNATURE OF PATIENT **DATE**

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 causes 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.

REFERRING DR: _____

PCP: _____

UROLOGIST: _____

ENT: _____

PODIATRIST: _____

ORTHO: _____

SURGEON: _____

WOUND CARE CLINIC: _____

PULMONOLOGIST: _____

OTHER: _____