ACID
Academic & Clinical Infectious Diseases
www.acidmd.com

Nicholas S. Camps, DO / Cynthia I. Rivera, MD / Claudio D. Tuda, MD
4308 Alton Road, Suite #860, Miami Beach, Florida 33140-2891
(305) 674-2766 tele
(305) 674-2765 fax

New Patient Questionnaire

Last Name, First Name, Middle Initial:		Date:
Date of Birth:		Age:
Gender at Birth: □ Female □ Male	Last four digits of your social security #:	
Family Status:	□ S □ Sig Other □ M □ Sep □ D □ W	
Address:		
Address Line 2:		
City, State and Zip Code		
Phone Number(s) *Check box representing preferred number for patient reminders, etc.*	□ Home □ Cell □ Work	
Email Address:		
Enable Patient Portal:	□ Yes □ No	
Contact Name and # in Case of Emergency / Relationship		
Name of Primary Care Provider:	City and State of PCP	

Employer Information

Employer Name:		
Employer Address:		
City, State and Zip Code		
Your Occupation:		

Insurance Information

Primary Insurance Company		
Telephone Number:	Policy Number:	Group Number:
Secondary Insurance:		
Telephone Number:	Policy Number:	Group Number:
Policy Holder / Subscriber's Name		
Financially Responsible Party:		

New Patient Questionnaire - Continued

Last Name, First, Middle Initial:

Race:
□ American Indian
□ Asian
□ Native Hawaiian
□ Black or African American
□ White
□ Hispanic
□ Other Race
□ Other Pacific Islander
□ Unreported / Refused to Report

Ethnicity:
□ Hispanic or Latin
□ Not Hispanic or Latin
□ Refused to Report

Preferred Language:
□ English □ Spanish □ Creole

Allergies:		YES	NO
Medications:	Any allergy to Penicillin?	□	□
	Any allergy to Iodine?	□	□
	Other Medication?		
Medical:	Any allergy to Latex?	□	□
	Any allergy to Tape?	□	□
Other:			

Please list all medications you are currently taking.
Please include Over-The-Counter Medications and/or Supplements.

	Address	Telephone Number
Name of Your Local Pharmacy		
Name of Your Mail Order Pharmacy		
What Lab Do You Use (Name)?		

I hereby consent to Academic & Clinical Infectious Diseases obtaining my **Prescription History** from any/all sources.

Patient's Signature:

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Patient Self Determination Act Questionnaire

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of the Florida Statutes, please answer the following questions by initialing the applicable response:

Declaration to decline Life-Prolonging Procedure (Living Will)

_____I have such a declaration

_____I have NOT made such a declaration

Health Care Surrogate

_____I have a designated health care surrogate

_____I have NOT designated a health care surrogate

Durable Power of Attorney

_____I have appointed a durable power of attorney

_____I have NOT appointed a durable power of attorney

24-Hour Cancellation & No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is unable to receive care. Academic & Clinical Infectious Diseases reserves the right to charge a fee of $25.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

"No-Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple no-shows in any twelve (12) month period by result in discharge from the Practice.

thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have reviewed this notice and understand the policy.

Printed Name:	Date:
Signature	

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Consents
Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that we ask your permission before disclosing certain healthcare information to certain people or entities.

In accordance with the Act, I _____
hereby authorize Academic & Clinical Infectious Diseases to release any information regarding my health to the following persons or entities:

Name	Date of Birth	Relationship

Insurance Authorization and Assignment

All Charges are payable at the time of service.

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage, it is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment: I hereby authorize Academic & Clinical Infectious Diseases to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Academic & Clinical Infectious Diseases. If one is NOT obtained, I understand that I will be held responsible for all charges.

Patient's Name:
Patient's Signature:

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I understand that under the Health insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient's Name:
□ Self or Relationship to Patient
Patient's Signature:
Date:

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Authorization for Release of Medical Records

I hereby request and authorize release copies of my medical records to Academic & Clinical Infectious Diseases.

Records can be sent to the address above **or sent electronically Physician to Physician.**

I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorize release of the following to Academic & Clinical Infectious Diseases.

Type of information to be disclosed:

□ Entire medical record	□ Radiology reports	□ All Hospital records
□ Consultation	□ Billing statements	□ Discharge summary
□ Dental records	□ Pathology reports	□ Laboratory reports
□ Office chart notes	□ Emergency Department reports	□ Other:

Patient Name:	DOB:
Patient's Signature	Date:
Last 4 digits of social:	