Arizona Infectious Disease PLLC

NEW PATIENT FORM

Today's Date: _____

Name: _____

Last **First** **Middle Initial**

DOB: _____ **SSN:** _____ **GENDER: M/ F** **Marital Status:** _____

ADDRESS: _____

Street **City** **State** **Zip**

Cell phone: _____ **Home:** _____ **Work:** _____

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

Ethnicity: Hispanic: _____ **Non-Hispanic:** _____

Email: _____

WEIGHT: _____ **HEIGHT:** _____

PHARMACY: _____

EMERGENCY CONTRACT: _____

Name **Relation** **Phone**

Do you have a Living Will / Advance Directive? Yes / No

Code Status: Full Code (Want resuscitation) / DNR (Does not want resuscitation)

DRUGS: Illicit drugs/ marijuana: _____

SMOKING: Never Smoker: _____

Current user: Cigarettes / Cigars / Pipe/ Vape / Chew Tobacco Ex-tobacco user: Start year: _____ Quit Month/Year _____

ALCOHOL: Nondrinker/Socially/ 1-2 drinks a week/ Daily drinker

What type of alcohol: _____ Drinks: _____ per week

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: _____

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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: _____