NORTH TEXAS ID CONSULTANTS

Personal Information

Your Name: _____ Birthdate: _____ Date: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Race: _____ Ethnicity: Latin/Hispanic Other Prefer not to list

Home Phone: _____ SS# _____

Fax: _____ Work Phone: _____ Cell Phone: _____

Best way to reach you: Home Cell Work

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician _____ Phone: _____

Spouse: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ hm / cell / wk

*EmergencyContact _____ Relation: _____ Phone: _____ hm /cell / wk

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PRIMARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

SECONDARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA **Patient**
Consent for Use and Disclosure of Protected Health Information

North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St, Suite 710, Dallas, Texas, 75246.

You may disclose protected health information (PHI) about me to the people listed below. (You must include full name.)

1._____ 2._____ 3. _____

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

Email Address:_____ **N/A**

This office usues LabCorp. If your insurance requires that you use a different lab you must let the office know. My insurance prefers: (circle one)
LabCorp Quest Unknown (If unknown you must call your insurance to check)

With my consent, NTIDC may contact me regarding a possible research study.

Initials_____

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to prior consent.

_____ _____
Print Patient's Name Date of Birth Patient's Signature Date

_____ _____
Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian