Infectious Diseases & Internal Medicine Associates

(Please complete both sides of the form)

DIRECTIONS: Please check (√) only those that apply & provide dates & numbers where indicated. Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____ Referring Physician: _____

MEDICATIONS YOU ARE CURRENTLY TAKING AND HOW OFTEN

1		mg		6		mg		11		mg	
2		mg		7		mg		12		mg	
3		mg		8		mg		13		mg	
4		mg		9		mg		14		mg	
5		mg		10		mg		15		mg	

DRUG ALLERGIES: _____

HISTORY OF PRESENT ILLNESS (Why are you here today?) _____

ANY OTHER ISSUE YOU WISH TO DISCUSS TODAY? _____

◄ **PAST MEDICAL HISTORY/HOSPITALIZATIONS** (please list dates and details)

Problem	Problem	Problem
Diabetes	Cancer	Gastrointestinal
Heart Disease	High Blood Pressure	Other
Thyroid Disease	Lung Disease	

◄ **SURGICAL HISTORY**

Procedure	√	Date	Details		Procedure	√	Date	Details
Bones/Joints					Sinus/Face/Eyes			
Appendix					Cosmetic			
Gallbladder					Other			
Uterus/ovaries								

◄ **SOCIAL HISTORY**

My Occupation				Use Alcohol?	Yes No		Sexual Orientation	
# of children		Ages:		Use Tobacco?	Yes No		Other	
Spouse / Significant Other				Exercise/Type				

◄ **FAMILY HISTORY** (Please check (√) all that apply)

Diabetes			Prostate			Colon Cancer			Hypertension			Other	
Breast Cancer			Heart Disease			Tuberculosis			Uterine/Ovarian Cancer				

◄ **MENSTRUAL HISTORY**

Are periods regular?	Yes No		Onset of Menopause	Date		Last Mammogram	
Date of last period			Last Pap Smear			Method of Birth Control	

◄ **HEALTH SCREENING: When was your last?**

TEST	DATE		IMMUNIZATION	DATE		IMMUNIZATION	DATE
Colonoscopy/Sigmoidoscopy			Flu			Typhoid	
EKG			Hepatitis A			**Other**	
PSA (Men)			Hepatitis B				
Treadmill			Pneumonia				
Cholesterol			Tetanus				
Chest X-Ray			Yellow Fever				
Eye Exam							

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(Please complete both sides of the form)

Patient Name: _____ **Current PCP:** _____

Are there any other physician offices that you want a copy of your note sent to?

If Yes, List the physician(s) full name: _____

DIRECTIONS: Please check all that apply & elaborate as appropriate

◄ GENERAL	√	DETAILS
Weight Gain or Loss		
Fevers or Night Sweats		
Fatigue		
Sleep Problems		
Transfustions (ever?)		

◄ SKIN	√	DETAILS
Rash		
Change in mole		
Sore that doesn't heal		
Infections		

◄ HEAD, EYES, EARS, NOSE THROAT	√	DETAILS
Headaches		
Dizziness		
Ringing in ears		
Decreased hearing		
Pain in ears or eyes		
Blurred Vision		
Double Vision		
Persistent running or bloody nose		
Sinus Problems		
Bleeding Gums		
Trouble Swallowing		
Sores in mouth		
Swelling in neck		

◄ CHEST	√	DETAILS
Heart Problems		
Heart Murmurs		
Chest Pain		
Palpitations		
Lung Problems		
Short of breath		
Cough		
Asthma/Wheezing		

◄ ABDOMEN	√	DETAILS
Heartburn		
Abdominal pain		
Gas		
Diarrhea		
Constipation		
Blood or change in stool		
Swelling or Bloating		
Hepatitis (ever?)		

◄ URINARY SYSTEM	√	DETAILS
Kidney Problems		
Frequent Urination at night		
Pain with urination		
Blood in urine		
Difficulty starting/stopping		
Discharge		

◄ FEMALE/MALE	√	DETAILS
Sexually Active		
Problems with intercourse		
Problems with periods		
Problems with breasts		
Prostate problems		
Problems with testicles		

◄ MUSCLES, JOINTS & BONES	√	DETAILS
Arthritis		
Swollen joints		
Gout		
Broken Bones		
Osteoporosis		
Muscle problems		
Swelling in feet		

◄ NEUROLOGIC	√	DETAILS
Seizures		
Numbness or tingling		
Weakness of arm or leg		
Problems with memory		

◄ PSYCHOLOGICAL	√	DETAILS
Depression		
Anxiety/Nervousness		
Stress		
Have you seen a counselor / Psychiatrist		
Sleep Problems		
Problems with family, significant other, children or job		

Anything else we should know?

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

_____ _____

Medical Assistant Signature Date

Infectious Diseases Internal Medicine Associates, PC
5901 Harper Dr NE
Albuquerque, NM 87109
Phone: (505) 848-3730

Patient Information:

Last Name: _____ First Name: _____ M: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Sex: ☐ Male ☐ Female Marital Status: S M W D

Social Security #: _____ Email: _____

Who referred you to us? _____

Primary Care Physician? _____ Phone: _____

Employment Information:

☐ Check if Retired ☐ Check if Unemployed ☐ Student

Name of Your Current Employer: _____ Phone: _____

Address of Your Employer: _____

Occupation: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Alt Phone: _____

Do you authorize your emergency contact to have access to your medical records (HIPAA Release)? ☐ Yes ☐ No

Health Insurance Information:

(Do not need to complete if you gave us copies of your insurance card(s))

Insurance Name: _____ Policy #: _____ Group #: _____

Are you the primary person for this insurance? ☐ Yes ☐ No

If "No" who is the primary? _____ Relationship to patient: _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE BELOW:

Insurance Name: _____

Are you the primary person for this insurance? ☐ Yes ☐ No

If "No" who is the primary? _____ Relationship to patient: _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also understand that I am financially responsible for all charges not covered by my insurance.

_____ _____

Signature of Responsible Party Date

Additional Pt Information:

Name: _____

E-Mail: _____

(We must have a valid e-mail for you to access your patient portal)

Preferred Phone Number for Reminder Calls: _____

Can you speak & understand English: Yes No

Preferred Language: _____

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Refuse

Ethnicity

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Refuse

Preferred Lab Company: (Circle only one (1)) Tricore Quest

Preferred Pharmacy:

Pharmacy Name: _____ Phone: _____

Address or Intersection: _____

Please assist our practice in obtaining this additional information, Medicare and many other insurances are asking medical offices to collect & enter in this data.
You always have the right to refuse. Thank you for your cooperation

Please list any additional people you allow Infectious Diseases & Internal Medicine Associates, PC to discuss your medical care with:

Name	Relationship	Phone

_____ _____

Signature of Responsible Party Date

Infectious Diseases & Internal Medicine Associates, PC

5901 Harper Dr NE
Albuquerque, NM 87109-3587
505.848.3730
Fax 505.848.3732

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Infectious Diseases & Internal Medicine Associates, PC (IDIMA) to use and disclose protected health information (PHI), including HIV STATUS, about me to my primary care provider, referring physician and/or consulting physicians and to carry out treatment, payment and health care options. (This Notice of Privacy Practices (NOPP) provided by IDIMA describes such uses and disclosures more completely.) I also authorize payment of medical benefits to IDIMA and its physicians.

I have the right to review the **Notice of Privacy Practices (NOPP)** prior to signing this consent. IDIMA 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:

Infectious Diseases & Internal Medicine Associates, PC (IDIMA)
Attn: Revised NOPP
5901 Harper Dr NE
Albuquerque, NM 87109

With this consent, IDIMA may call my home or other alternative numbers provided and leave a message on the voice mail or in-person in reference to any items that assist the practice in carrying out treatment, payment and health care options, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results and prescription refills among others.

By signing this form, I am consenting to allow IDIMA to use and disclose my PHI to carry out treatment, payment and health care options. I also consent to the release of my prescription history that may be pulled from the New Mexico Board of Pharmacy.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, IDIMA may decline to provide treatment to me.

_____ _____

Print Name of Legal Guardian, if applicable **Signature of Patient or Legal Guardian**

_____ _____

Print Patient's Name Date

Infectious Diseases & Internal Medicine Associates, PC

5901 Harper Dr NE
Albuquerque, NM 87109-3587
505.848.3730
Fax 505.848.3732

I, _____,
acknowledge that I have been given and understand the Notice of Privacy Practices (NOPP) & office guidelines from Infectious Diseases & Internal Medicine Associates, PC.

_____
Patient Signature

_____
Date

Infectious Diseases & Internal Medicine Associates, PC

David W. Stryker, MD Jeffrey P. Ross, MD Thomas C. Roberts, MD
Joseph A. Gorvetzian, MD Felix Cerna, MD Julianna Ferreira, FNP-BC

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Updated 1/18/2021

The following information will provide you with our office guidelines.

Our office is open Monday – Friday from 8:15 AM – 5:00 PM
Due to safety protocols all visitors must enter the building through the "Directory B" entrance for COVID screening. All patients, visitors & staff are REQUIRED to wear a surgical mask while in the building.
Please be considerate of others & ensure your mask covers your nose & mouth at all times.

PATIENT PORTAL:

Once we have entered your email into our electronic medical record system you will receive an email of how to connect to your patient portal. You can also get to our Patient Portal by visiting our website: **www.idimanewmexico.com** & there is a link near the bottom of our Home Page, just click on the Patient Portal > button & you will be directed to the sign-on page. Please contact our office if you have any trouble signing into your chart.

MEDICAL STAFF:

We have an outstanding group of specialty physicians all certified by the American Board of Internal Medicine for Infectious Disease & Internal Medicine. Thank you for choosing Infectious Diseases & Internal Medicine Associates, PC (IDIMA). We look forward to building a strong and trusting relationship with you!

Each physician has a rotating schedule of patients in the office & new consults for patients while admitted at the hospitals. Due to the multiple locations of incoming consults our physicians are not always in the office.

Once a patient has established with one of our physicians, in the office, that will be your designated physician through the course of your treatment. Any questions or concerns you have regarding your care while being treated by IDIMA can be addressed during your appointment(s) with your treating physician or directed to your physician's medical assistant.

In addition to being a specialty office for infections & diseases we also have an IV Infusion clinic and a Wound Care clinic. The IV & Wound clinic staff is trained and experienced in all aspects of IV Infusion & Wound care.

BILLING & PAYMENTS:

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Co-payments are due at the time of service. We will bill for your services using the health insurance card(s) / information you provide our office on your initial visit. If your insurance information should change in anyway during the course of your treatment with our office, **it is THE PATIENTS responsibility to make sure our office has the most updated information on file**.

If you have more than one (1) insurance, we will bill your *primary* insurance for services rendered. Billing a secondary insurance will be done as a courtesy. If amounts due from the secondary insurance are not paid, the balance will be transferred to the patient.

In the event an account is turned over to collections, a $100.00 collection fee will be added to your balance and the account will be made "inactive".

MOTOR VEHICLE ACCIDENTS/WORKERS COMPENSATION:

If your visit is in relation to a Motor Vehicle Accident (MVA) or a Workman's Compensation related injury, you will be required to fill out our "Accident Form". This form **MUST** be complete to ensure proper billing on your behalf. If any of the information is left incomplete you will be billed privately for all services provided to you by our office.

APPOINTMENTS - "NO SHOW" & "LATE CANCELLATION":

Please arrive thirty (30) minutes prior to appointments to update changes to your insurance coverage, address or phone number(s). If you arrive for your appointment **more than five (5) minutes late**, we ***may*** need to reschedule your appointment with a fee. Your co-payment is due at the time of service.

We **require 24 hour notice OR one (1) business day advance notice** if you need to cancel or reschedule an appointment. Any cancellation or rescheduling done under the 24 hours or one (1) business day notice is considered a "Late Cancellation" and will be subject to a fee. A "No Show" appointment is when a patient fails to show or fails to call for a scheduled appointment. **We do charge a $50.00 fee for a "No Show" or "Late Cancellation" appointment**.

This fee will need to be paid prior to scheduling your next appointment.

We understand that situations, such as, medical emergencies occasionally arise and adequate notice is not possible. These situations will be considered on a case by case basis. When an appointment is made, it takes an available time slot away from another patient. "No Show" and "Late Cancellation" appointments delay the delivery of health care to other patients, some who are quite ill.

Our practice makes ***courtesy*** reminder calls prior to your appointment, if you know you will be unable to make your appointment please call our office at least 24 hours before your scheduled appointment and we

can cancel or reschedule your appointment, if it is after hours you may leave a message. We also reserve the right to terminate any patient with excessive No Show/Late Cancellation fees; excessive is considered any more than three (3) instances.

REFERRALS, PRIOR AUTHORIZATIONS & FORMS/LETTERS:

When a provider gives you a referral for a specialist such as "Cardiology", many times a specific provider's office is not named. **A referral from our office does not guarantee coverage by your insurance**. If you have any questions regarding your health insurance coverage you will need to contact your insurance by calling the customer service number on the back of your card.

Please note for prior authorizations, we do ask for 5-7 business days to complete any prior authorization. Once we receive a prior authorization approval we will contact you with that information.

If a patient needs forms/letters completed or written by a provider or medical staff, we require 7-10 business days to have the paperwork completed. You also have the option of scheduling an appointment with the provider to complete the paperwork. If you drop off your paperwork please ensure all portions that can be filled out by you are complete **PRIOR** to dropping the information off at our office. In some cases an appointment may be required to complete the paperwork.

PRESCRIPTION REFILLS:

Call your pharmacy and request the refill. Please do not call our office directly for a prescription refill, unless you consider it to be an emergency. The pharmacy will fax us your refill request. Don't wait until you are out of medication, we require **3-5 business days** to review your chart and process each request. Please plan ahead for the weekends, holidays and vacations.

LABS, X-RAY & DIAGNOSTIC IMAGING RESULTS:

We send our patients to outside labs for blood tests and x-rays. If your labs indicate you need a prescription or a follow-up appointment, we will contact you. Our policy is to schedule a return visit to thoroughly discuss the results of your studies. Please have all labs done 2 weeks prior to your appointment.

When the provider gives a diagnostic imaging order (ex: MRI / CT Scan), we will get a prior authorization from your insurance, if one is required. If a prior authorization is needed we will contact you with the prior authorization information once we have received the approval. When you check-out you will be given a copy of the order with all the information so **you can schedule your appointment** to have the diagnostic imaging completed.

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Please note that labs are ordered based on the clinical judgement of the physician, **NOT** by what is covered by your insurance. If you have labs drawn it is the patient's responsibility to check with the lab company **PRIOR** to having your labs drawn, if the labs ordered will be covered by your insurance.

URGENT VISITS / WALK-INS:

We are not an emergency or "walk-in" practice. **If you have an emergency, call "911", go to the nearest urgent care or emergency room**. If you have an urgent matter your call will be given to the appropriate medical assistant to advise you.

INFECTIOUS DISEASES & INTERNAL MEDICINE ASSOCIATES, PC
NOTICE OF PRIVACY PRACTICES (NOPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be with your primary care physician, other specialists, etc
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer (medical records):

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post this notice and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

5901 Harper Dr NE, Albuquerque, NM 87109 – Phone: (505) 848-3730 – Fax: (505) 848-3732