INFECTIOUS DISEASES ASSOCIATES OF NORTH FLORIDA, P.A
VIVEK MANIKAL, M.D
HEATHER CONLON, ARNP
NENA MORDEN, ARNP
101 Whitehall Drive, Ste. 104, St. Augustine, FL 32086 Tel: (904)829-6591 Fax: (904)592-5369

DATE_____

NAME_____
(Last) (First) (M)

SS#_____ Driver's License #_____

ADDRESS _____
(Street) (City) (State) (Zip)

TELEPHONE: Home _____ DATE OF BIRTH _____ AGE_____

Work or Cell _____ M ____ F ____ Single ☐ Widowed ☐
Employment_____
E-Mail _____ Married ☐ Divorced ☐

Patient's Employer: _____ Address: _____

Referred by: Doctor's name: _____ Friend's name: _____

Spouse's Name: _____ Spouse's Employer: _____
(if no spouse, person to notify in case of emergency)

Spouse SS#: _____ Spouse's date of birth: _____ Telephone: _____

INSURANCE INFORMATION

Primary insurance Co. Name: _____ Secondary Insurance Co. Name: _____

Primary Insured's Name: _____ Secondary Insured's Name: _____

Primary Insurance ID #: _____ Secondary Insurance ID #: _____

Primary Insurance Group #: _____ Secondary Insurance Group #: _____

Address for claim submissions: _____ Address for secondary claims: _____

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I also assign all medical benefits to include major medical benefits to which I am entitled to INFECTIOUS DISEASES ASSOC. OF NORTH FLORIDA, P.A. This assignment will remain in effect until revoked by me in writing. Furthermore, a photocopy of this assignment is to be considered as valid as the original.

I further agree to be solely responsible for any balances that my insurance carrier does not pay.

In signing this form, I am authorizing you to give me reasonable and proper medical care by today's standards and I consent to you retrieving my prescription history.

Person Responsible for Bill: _____
(Name) (Address)

Signature: _____

To determine if your medical services might be covered by another insurer, please answer the following questions:

1. Is your illness due to:

   A. A work-related accident/condition? Yes _____ No _____

   B. A condition covered under the Federal Black Lung program? Yes _____ No _____

   C. An automobile accident? Yes _____ No _____

   D. The fault of another party? Yes _____ No _____

2. Are you eligible for coverage under the Veteran's Administration? Yes _____ No _____

3. Are you employed?

   ___ No, retirement /last employment date:
   _____

   ___Yes, employer name and address:

   _____

   _____

   _____

4. Is your spouse employed?

   ___ No, date of retirement/last employment date:
   _____

   ___Yes, spouse's name: _____

   Spouse's employer name and address:

   _____

   _____

5. Are you covered under your spouse's insurance? _____ No _____ Yes, insurance name and address:

   _____

   _____

MEDIGAP ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare supplement benefits be made on my behalf to Infectious Diseases Associates of North Florida, P.A for any services furnished to me by the physician. I authorize any holder of medical information about me to release to

_____
(Name of Insurance Company)
any information needed to determine these benefits payable for related services.

Signed _____

INFECTIOUS DISEASES ASSOCIATES OF NORTH FLORIDA, P.A.
VIVEK MANIKAL, M.D

LIFETIME AUTHORIZATION

Medicare/Medicare Supplement/ Commercial Insurance Certification for Payment

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me including HIV / AIDS, Psychiatric or substance Abuse Treatment, to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare/ Medicare Supplement/ Commercial insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare/ Medicare Supplement/ Commercial Insurance of payment to me.

I REQUEST THAT THIS APPLY TO ANY INSURANCE I MAY HAVE.

Signed_____ Date_____

_____

Title or Relationship_____

If signed by other than beneficiary, state the reason the patient was unable to sign:

_____

_____

INFECTIOUS DISEASES ASSOCIATES OF NORTH FLORIDA, P.A.

VIVEK MANIKAL, M.D.

AUTHORIZATION FOR ROUTINE AND NONROUTINE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **SSN (Last 4 digits):**_____ **DOB:**_____

INFORMATION MAY BE DISCLOSED BY:
Person/Facility:_____ **Phone #:** _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:
Person/Facility: _____ **Phone#** _____

Address: _____ **Fax#** _____

I specifically consent to release information relating to: (initial selection)

STD _____ HIV/AIDS _____ TB _____ Drug/Alcohol _____ Mental Health _____ WIC Eligibility _____

Information to be disclosed (initial selection)

Early Intervention _____ **General Medical Record** _____ Problem List _____ Medication Profile _____
Immunization _____ Diagnostic test Reports _____ History and Physical _____ Most Recent _____
Referral Consultation _____ Discharge Summary _____ Radiology Reports _____ Cardiac Studies
_____
Other (specify) _____ New record Since Last request _____ CAT scan _____ Consult
Report_____
Prenatal Record _____ All Date _____ Procedure
Notes_____
X-Ray/Imaging Reports _____ All _____ From _____ To _____
Specific test Results _____
Laboratory Results _____ All _____ From _____ To _____
Specific test Results _____
Progress Notes _____ All _____ From _____ To _____

PURPOSE OF DISCLOSURE:

Continuity of Care _____Personal Use_____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____ I understand that if I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.
REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.
REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____
Client/Representative Signature Date

_____ _____
Printed Name Representative's Relationship to Client

_____ _____
May Release To: Date

No Show/Late Cancellation Policy

This policy has been established to help us at IDANF© to serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

A "no show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

A charge of $20.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Date:_____

Signature:_____

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101 Whitehall Drive, Ste. 104, St. Augustine, FL 32086 Tel: (904)829-6591 Fax: (904)592-5369

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. ***The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).***

_____ (Patient/Representative initials) **I consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

Revocation I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email. NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____
Patient/Patient Representative Signature: _____
Date: _____ Time: _____

Infectious Diseases Associates of North Florida, PA offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of web page that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgment and Agreement :

This agreement is to be signed by the parent or guardian if the child is under the age of 18. If the child is over the age of 18 the child must sign this agreement.

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Patient Name: _____

Patient Signature _____ Date _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

HIPAA

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of (Infectious Disease Associates of North Florida, PA) Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Patient's Date of Birth

_____ _____

Signature of Patient or Parent/Legal Guardian Date

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Infectious Disease Associates of North Florida, PA
101 Whitehall Drive, Suite 104
St. Augustine, FL 32086
Phone-904-829-6591

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

HIPAA

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER Phone-904-829-6591 email: info@idassoc.org

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

INFECTIOUS DISEASES ASSOCIATES OF NORTH FLORIDA, P.A.

VIVEK MANIKAL, M.D

NEW PATIENT INFORMATION

Date: _____
Name: _____ Age: _____ Date of Birth: _____
Emergency Contact: _____ Phone #: _____
Pharmacy: _____

Medical concerns **Infection related** that bring you to our office:

_____
_____

Current Medications (include over the counter medications and natural remedies):

Name of Medication/ Antibiotics	Strength (Dosage)	How many times a day

Allergies/Intolerances to Antibiotics, medicines, foods, or environmental factors:

Personal History: (Please circle) Single / Married / Divorced / Widow / Widower

Habits: Smoking: No / Yes, if yes _____ packs per day _____ years
Caffeine (coffee, tea cola): No / Yes, if yes_____ drinks/day
Alcohol: No / Yes, if yes _____ drinks/day
Prescription Drug Abuse: No / Yes, if yes, details_____
History of Intravenous Drug Use: No / Yes, If Yes date of last use: _____

Travel History:

1. Out of State: Where _____ When _____
2. Out of Country: Where _____ When _____
3. Camping/ Hiking: Where _____ When _____

PETS: No/ Yes
Any recent animal/ tick bites or scratches? _____
Exposure to animal feces: No/ Yes

VACCINATIONS:

NAME	Date last received
Flu Vaccine	
Pneumonia (Pneumovax & Prevnar)	
Hepatitis Vaccine (A & B)	
Zostavax (Shingles)	
Tetanus	
Other (Meningitis/ Typhoid/ Etc…)	

CHILDHOOD ILLNESS':

- Measles Yes No
- Mumps Yes No
- Rubella Yes No
- Rheumatic Fever Yes No
- Polio Yes No
- Chicken Pox Yes No
- Other _____

FAMILY HISTORY

	ALIVE	If deceased, cause of death
Father		
Mother		
Brother		
Sister		
Children		

Any FAMILY members with any active infections?

_____

_____

Family History:	Negative	If positive, in whom	Family History of:	Negative	If positive, in whom
TB			Kidney disease		
HIV			Cancer		
Thyroid			Seizures		
Cardiac Disease			Stroke		
Diabetes			Ulcers		
Infections			Other		

Past Surgery History: No / yes, if yes please provide details:

	What	When (year)	Where	Surgeon
1.				
2.				
3.				
4.				

Hospitalization history: Negative / positive, if positive, please provide details:

	What	When (year)	Where
1.			
2.			
3.			

Past Medical History:

	No	Yes, if yes please provide details		No	Yes, if yes please provide details
GENERAL:			**GU:**		
Weight loss			Stents		
Fever			Kidney Stones		
HEM/ ONCOLOGY:			STDs		
Anemia			Genital Discharge		
Transfusions			**MUSCULOSKELETAL**		
Blood Clots			Gout		
HEENT:			Bursitis		
Sinus Infections			Joint Infections		
PULMONARY:			**NEURO:**		
Bronchitis			Stroke		
Tuberculosis			Seizures		
CARDIO			Encephalitis		
High Blood Pressure			Spinal tap		
Rheumatic Fever			Meningitis		
Pacemaker/ Endocarditis			**ENDOCRINE**		
Heart Murmur			Diabetes		
GI:			Thyroid Disease		
Peptic Ulcer Disease			Anxiety		
Jaundice			**RESISTANT BACTERIAL INFECTIONS**		
Diverticulitis			MRSA, ESBL or/and C-Diff		
Hepatitis (A, B, or/and C)			**CANCER**		
Gallbladder/ Cholecystitis			**SKIN**		
Pancreatitis			Rash		
IMMUNOLOGY			Hives		
Recurrent Infections			Bites		
Low Immunoglobulin's			Boils		

Additional Info: _____

_____

SEXUAL HISTORY:

Are you sexually active? Yes No
If yes, are you trying to get pregnant? Yes No
If not, list contraceptive or barrier method: _____
Illness related to Human Immunodeficiency Virus (HIV), such as AIDS has become a major problem. Risk factors include intravenous drug abuse and unprotected sexual intercourse.
Would you like to speak with your provider about risk of the illness? Yes No

Past Work-up and health maintenance:

WHAT:	No	Yes	If yes, Where:	When:	Attending Physician:
Cultures:					
Blood					
Urine					
Radiology:					
Chest X-Ray					
MRI					
CT Scan					
Other_____					
Labs					
Cholesterol					
Glucose					
Thyroid					
CBC					
HIV					
Syphilis					
PPD/ Quantiferon TB Gold					
STD Test					
Other					

Do we have your consent to discuss your care with any person? No / yes, if yes, who:
_____
I want to be called with all test results even if normal. No / yes
I want to be called with only abnormal test results and normal results to be discussed with me during my next doctor visit. No / yes
Please list below the names and addresses of any physicians or hospitals that we can obtain past medical records from:
1. Name_____ 2. Name
_____ 3.Name_____ Address_____ Address_____
_____ Address _____
Phone no._____ Phone no._____ Phone _____

**NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

SIGNATURE: _____I authorize, until further notice, that any of my medical records may be released to any physician that I am referred to and I authorize that any of my medical records be released, on a continuing basis, to my chiropractor, dentist, optometrist, audiologist, psychologist, that I am seeing, unless specified otherwise.