WEST COAST INFECTIOUS DISEASES

Brent W. Laartz, MD
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Lily N. Jones, DO
Arnoldo A. Gonzalez, MD
Jennifer Patterson, DO
Pamela Sherwood, APRN
James Desmarais, APRN

Dear Patient:

We are delighted to welcome you to our office. At West Coast Infectious Diseases we are dedicated to providing our patients with the best care. Our physicians are well-known throughout the Tampa Bay community for their friendly, compassionate, professional manner, and leading-edge treatment of infectious diseases.

Below please find our New Patient Packet. Please print out these forms, review and complete them as thoroughly as possible. Once completed you can either mail them to one of the addresses listed above or bring them with you at the time of your appointment.

Please arrive at least 10 minutes before your appointment, and bring any insurance cards, a form of identification, co-payments, a list of your current medications and other pertinent information with you.

If you need to reschedule or cancel your appointment, please give at least 48 hours advance notice by calling our office at 727-669-6800.

Thank you for choosing our office for your medical needs. Please feel free to contact our office with any questions or concerns. We look forward to meeting you.

Sincerely,
The Staff of West Coast Infectious Diseases

1840 Mease Drive, Suite 319
Safety Harbor, Florida 34695

8607 Easthaven Court, Suite 101
New Port Richey, Florida 34655

Phone: 727-669-6800
Fax: 727-669-2540

West Coast Infectious Diseases

Today's date:	❑ DR. LAARTZ ❑ DR. GROOM ❑ DR. JONES DR. GONZALEZ DR. PATTERSON ❑ PAMELA SHERWOOD, APRN ❑ JAMES DESMARAIS, APRN

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Race: (check one)	Ethnicity: (check one)	Preferred Language: (only one)	
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Declined	❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined (as directed by CMS)	☐ English ☐ Spanish ☐ Other ________________	Cell phone no.: ( )

Pharmacy (including address + Telephone #)	Employer Name:	Employer Phone #:	Occupation:

Mother's maiden name:	Other family members seen here:	Email:

PLEASE FILL OUT INSURANCE INFORMATION COMPLETELY

(Please fill out **FULLY** and give your insurance card and picture I.D. to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please list primary insurance: (including address please)

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Please list secondary insurance

Secondary Subscriber's name:	Secondary Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I agree and authorize West Coast Infectious Diseases to appeal any claim(s) on my behalf to my insurance company, if necessary. I understand that I am financially responsible for any balance. I also authorize West Coast Infectious Diseases or insurance company to release any information required to process my claims. I agree and understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any costs of collection including a reasonable attorney fee, whether or not suit is filed. I have read and understand the above and agree to comply. I also give my permission for my treating provider to download any electronic prescriptions that will help in my medical treatment. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

*Patient/Guardian signature:*_________________________________ *Date:*______________________

West Coast Infectious Diseases

Patient History

Date ______________ **Age** ____________

Patient's Name ____
First Middle Last

REFERRING PHYSICIAN: ____

Address: ____ Phone: _______________

PRIMARY CARE PHYSICIAN: ____

Address: ____Phone:_______________

May we contact these Physicians and send them reports of your progress/findings: **Yes** **No**

Signature: _____________________________________

ALLERGIES: ____

MEDICATIONS:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

PREVIOUS ANTIRETROVIRALS (HIV MEDICATIONS) ____

Have you traveled out of the country recently? If so where? **YES** **NO** _________________________________

Have you had contact with anyone who has recently traveled out of the country? **YES** **NO** _________________________________

HISTORY: (Yes or No)

Headaches: _______
Eyes Problems: _______
Thrush: _______
Heart Attack: _______
Chest Pain: _______
Lung Problems: _______
Liver Problems: _______
Hepatitis: _______
Stroke: _______

Kidney Disease: _______
Diabetes: _______
STD: _______
Bowel problems: _______
Cancer: _______
Ulcers: _______
Depression: _______
Bone infection: _______
Skin infection: _______

Blood transfusion: ______
Meningitis: _______
HIV: _______
Tuberculosis: _______
Pneumonia: _______
PCP pneumonia: _______
Toxoplasmosis: _______
Retinitis: _______
CMV: _______

Do you have any concerns about domestic violence in your household? _______
Do you have risk factors for HIV – unprotected intercourse, transfusions, IV drug use? _______

Comments: ____
____

SURGERIES AND DATES:
_____________________________________ ____

West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

West Coast Infectious Disease, PA

1840 Mease Drive, Suite 319 *Phone (727) 669-6800*
Safety Harbor, Florida 34695 *Fax (727) 669-2540*

Controlled Substances Agreement

Before receiving prescriptions for controlled medications, certain conditions must be acknowledged and agreed upon as follows:

INITIALS

_______ 1. I *have/have not* (circle one) been diagnosed with, treated, or arrested for substance dependence or abuse.

_______ 2. I have never been involved in the sale, illegal possession, diversion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers, etc.)

_______ 3. I agree to obtain all prescriptions and renewals for controlled medications from West Coast Infectious Diseases, and their physician and to notify the office immediately if other outside physicians prescribe the same.

_______ 4. I agree to use only one pharmacy for filling prescriptions and renewals of controlled medications, and to notify the office immediately if another physician prescribes same.

_______ 5. I agree to allow the staff of West Coast Infectious Diseases office to communicate with any other Physicians, any pharmacist and review of the state, federal and other database regarding my use of controlled substances and other medications.

_______ 6. I agree to take the medicines only as prescribed by West Coast Infectious Diseases, and their physicians, and I understand that **NO EARLY REFILLS** will be issued.

_______ 7. I will notify the office of a need for a refill up to 3 working days in advance, and understand that **no refills will be made after hours, on weekends, or on holidays.**

_______ 8. I agree to follow the advice of the physician(s) in regards to stopping controlled substances, should it be felt advisable.

_______ 9. I agree to a psychological evaluation if it is felt advisable.

_______ 10. I certify that I am not pregnant. I certify that I will use appropriate measures to prevent pregnancy during the course of my treatment with opioids and other controlled substances

_______ 11. I agree to submit to random drug screens as requested by the office.

_______ 12. I agree to keep all scheduled appointments related to my treatment plan. I will call in advance and reschedule if I am unable to keep an appointment.

_______ 13. I will be responsible for all prescriptions I receive and I understand that if they are lost, misplaced, etc, that they **cannot be replaced**. In the event that they are stolen, I will present a police report as evidence in order for a refill to be considered.

_______ 14. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, I understand that I must notify your office immediately. The pharmacy that I have selected is:

____ Phone: _______________________.

_______ 15. I understand that I may be discharged as a patient and/or receive no further pain medication if any of the following occur:

a. I give away, sell or misuse the drugs
b. The office finds me non-compliant with any terms of this Agreement
c. I obtain opioids and other controlled substances from sources other than this office

I have read this Agreement, understand it, have had the opportunity to ask questions, and have had all my questions answered satisfactorily. I acknowledge the conditions and consent to the use of controlled substances under the terms outlined in this Agreement. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

_______________________________________ _______________________________ __/___/____
Print Name Witness Date

________________________________ __/___/____ ________________________________ __/___/____
Patient signature Date Physician Date

West Coast Infectious Diseases

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Patient Authorization to Discuss Patient Protected Health Information (PHI) With Other Individual(s)

By Federal law, West Coast Infectious Diseases, PA, its physicians and staff must obtain your authorization to discuss your Protected Health Information (medical condition or test results) with other individuals. Examples are your spouse, partner, children, parents, family friends or caregivers. The exception to requiring your authorization is for treatment, payment, health care operations, and under certain law provisions:

I, ____, the patient, authorize West Coast Infectious Diseases, PA, its physicians and staff to discuss my medical Protected Health Information with the following persons or organizations:

INITIALS

Which is your Preferred Method of Contact (please provide information below)

Home ☐ **Cell** ☐ **Text** ☐ **Us Mail** ☐ **Patient Portal** ☐

______ To call me at work: (   ) ____________________________

______ To call me at home (   ) ____________________________

______ To call me on my cell (   ) ____________________________

______ To speak with the following family/friends (**Please list their Name, Relationship & Phone Number**): ___________________

____

____

______ To speak with me only

______ To leave messages on my answering machine or voice mail

______ To send my information to an address other than my home address:

____

______ Other: ____

By law, this authorization is good for one year (1-year). This authorization is revocable at any time in writing by the patient or West Coast Infectious Diseases, PA, its physicians and staff.

I have read, understand, and have identified individuals or organizations that I authorize or West Coast Infectious Diseases, PA, its physicians and staff to discuss any PHI with. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

____ ____________________________

Patient or Guardian's Signature of Authorization **Date of Authorization**

WEST COAST INFECTIOUS DISEASES

OFFICE FINANCIAL POLICY

PATIENT'S NAME______________________________ DATE: _________________________

Welcome to Our Office

Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of taking care of your health. Our practice will strive to provide you with the finest quality care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Appointments

If you are unable to keep an appointment please call the office to reschedule at least 72 hours in advance. Patients with two missed appointments will be charged a $15.00 no-show fee which is not reimbursable by any insurance. Patients with repeated missed appointments may be dismissed from the practice. Patients who are more than 15 minutes late may be asked to reschedule.

Transferring Records

Patient's requesting copies of their records are asked to submit a request in writing to include all relevant information, including your payment history **upon request**. Please be aware that our policy is to provide records within 30-days from receipt of request. The fee for copying your records is $1.00 for this first 25 pages, and .25 cents for each additional page. If you are requesting your records to be transferred from another doctor or organization to us, you have to authorize us to receive all relevant information including your payment history.

Financial Policy

This is an agreement between West Coast Infectious Diseases, PA, a Florida corporation, as creditor and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payment credited. The words "we", "us", and "our" refer to the West Coast Infectious Diseases, PA. By executing this agreement you are agreeing to pay for all services rendered.

Completion of Forms/Medical Letters

There is a **$20.00 fee** for completing of each Form (including but not limited to, FMLA, disability forms, and handicap stickers), and Medical Letters relating to your condition. This fee is not reimbursable or billable to your insurance company, and must be paid by you before the form is completed. Please allow 7 to 10 days for completion of any form.

Insurance

Insurance is a contract between you and your insurance company. (We are **not** a party to this contract, in most cases). We will bill your insurance company as a courtesy. We will accept secondary insurances, as long as it is medigapped (automatic crossover). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Referrals

If your insurance company requires a referral and/or preauthorization/pre-certification **you are responsible for obtaining it.** We most likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). Options at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

Workers Compensation

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept letters of protection and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Payments

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments

Any co-payment, deductibles or coinsurances, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payment Options: You may choose to pay cash, check, or credit card on the day that the treatment is rendered.

WEST COAST INFECTIOUS DISEASES

OFFICE FINANCIAL POLICY Continued

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what insurance coverage is available on your policy. This can only be done on the day of your appointment if time permits. **You as the policyholder are primarily responsible to verify benefits and provide our office with the current insurance coverage information and any other information that has changed on your account for each visit**. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Medicare Shared Savings Program

If applicable, please be aware they we do participate in a Medicare Shared Savings Program. Therefore, we may from time to time share medical data with our Accountable Care Organization. You have the right to opt out of this data sharing at any time by indicating below. By signing this form, you are authorizing us to share your medical data with our Accountable Care Organization and CMS as applicable under federal law.

Past Due Accounts

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to our collection attorneys, you agree to be responsible for all costs of collection, including a reasonable attorney fee, whether or not suit is filed. In case of a suit, you agree the venue shall be in Pinellas County, Florida. You expressly waive your right to jury trial.

Returned Checks

There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

Waiver of Confidentiality

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date

Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. If you have any questions or require clarification on this policy please ask to speak with our Billing Department or our Administrator.

Statement Clause

We reserve the right to interpret, change, suspend, cancel, or dispute with or without notice all or any part of our policy, and procedures, at any time without verbal or written notification.

☐ I hereby declined to participate in Medicare Shared Savings Program and will not allow any of my medical data to be shared with any Accountable Care Organization.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we urge you to contact us for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. We are here to help you. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

______________________________ ______________________________

Patient's Signature **Date**

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West Coast Infectious Diseases Patient Portal Authorization Form

Patient Name (please print clearly):________________________________DOB: ____________

Personal Email Address (please print clearly):

____

Purpose of this Form:
The patient portal is designed to enhance secure patient-physician communications and is provided as a requirement, by law to our valued patients. Please read this form thoroughly before signing.

How the Patient Portal Works:
A secure web portal is a kind of webpage 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 to log into the portal site. Once you are logged into the portal you will have access to only your records or those of whom you are legally responsible.

Via the Patient Portal you will be able to:

- Use the message function to communicate with our staff
- Communication of laboratory & diagnostic results from staff to patient
- View medication list and request refills
- View or print health summary information and send staff requests to update information
- View demographic/insurance information and send staff requests to update information
- Print or save an electronic copy of the health summary
- View or print immunization record
- View upcoming scheduled appointments
- Communicate about billing questions

Response time:

- We will respond to non-urgent portal inquiries within 48 hours.

Prescription refills 48-72 hours after receiving request

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The Patient Portal is NOT intended for the following:

- **NO** diagnosis or treatment is offered by portal email. Diagnosis can only be made and treatment rendered after the patient schedules and is SEEN (face-to-face encounter) by the physician
- **NO** emergent communications or services. Go to the nearest emergency room or dial 911
- **NO** request for controlled substances will be accepted

If there is persistent abuse or negligence with the use of the patient portal, we reserve the right at our own discretion to terminate offering patient portal, suspend user account, or modify services offered through the patient portal.

Protecting Your Private Health Information and Risks:

This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal. We understand the importance of privacy with regard to your health care and will continue to protect the privacy of you medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

How to Participate in the Patient Portal:

Once this form is agreed to and signed, you will be set up with an account for the patient portal. Immediately following the account set up you will receive a welcome email with the link to access the portal. In a separate email you will receive your user name and a temporary password. **Once you log in to the portal for the first time you must change your password.**

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communication between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from West Coast Infectious Diseases. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for the online communications.

Patient /Guardian Signature: ________________________________ Date: ________

Witness Signature: ____ Date: ________

Remember, **by law, we must make the portal available to ALL PATIENTS, however, if you do not wish to use the portal, simply ignore the welcome e-mails sent to you.