WEST COAST INFECTIOUS DISEASES

Brent W. Laartz, MD
Todd M. Groom, PhD, MD
Lily N. Jones, DO
Jennifer Patterson, DO
Mario A. Torres Solano, MD
Frank Sanchez, MD, MBA

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

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. PATTERSON ◯ DR. TORRES SOLANO ◯ DR. SANCHEZ

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 and my electronic Florida Shots, vaccine records (if applicable) 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

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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: _____	Kidney Disease: _____	Blood transfusion: _____
Eyes Problems: _____	Diabetes: _____	Meningitis: _____
Thrush: _____	STD: _____	HIV: _____
Heart Attack: _____	Bowel problems: _____	Tuberculosis: _____
Chest Pain: _____	Cancer: _____	Pneumonia: _____
Lung Problems: _____	Ulcers: _____	PCP pneumonia: _____
Liver Problems: _____	Depression: _____	Toxoplasmosis: _____
Hepatitis: _____	Bone infection: _____	Retinitis: _____
Stroke: _____	Skin infection: _____	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:

_____ _____

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Patient Name:_____

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), not limited to, blood borne diseases, such as, Hepatitis C, HIV and AIDS 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.

DISCLOSURE TO FAMILY, FRIENDS AND OTHERS:

I give permission for my medical Protected Health Information to be disclosed for purposes of communication results, findings, care decisions to family members and others listed below:

	Name	Relationship	Contact number
1			
2			
3			

COMMUNICATION, CONSENT AND TELEPHONE CONSUMER PROTECTION ACT

I authorize West Coast Infectious Diseases, PA, its providers, associates, assignees, successors, agents and staff to contact me at the numbers provided below or any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text regarding scheduling or scheduling appointments, my services or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequences of providing this consent, I may receive further calls or text messages that deliver pre-recorded messages by or on behalf of West Coast Infectious Diseases. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

You may be contact via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletter and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number(s) or email addresses provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

Preferred Method (Chose only one) **SMS/Text** ☐ **Voice** ☐ **Email** ☐

Home Phone: _____ Cell Phone: _____

Authorization email address: _____

OR (Initials)_____ I decline to receive communicate via text

(Initials)_____ I decline to receive communicate via email

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, I have read, understand, and have identified individuals or organizations that I authorize or West Coast Infectious Diseases, PA, its providers, associates, assignees, successors, agents and staff to discuss any PHI with.

_____ _____

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

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Patient: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. I acknowledge that I have received the 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.

_____

Signature of Patient or Patient's Representative Date

_____

Print Name Relationship to Patient

Interpreter (if applicable)

(FOR OFFICE USE ONLY)

Please document your efforts to obtain acknowledgement and reason it was obtained or not obtained.

- ن Notice of Privacy Practices Given – Patient Able to Sign
- ن Notice of Privacy Practices Given – Patient Unable to Sign
- ن Notice of Privacy Practices Given – Patient Declined to Sign
- ن Notice of Privacy Practices and Acknowledgement Mailed to Patient
- ن Other Reason Patient Did Not Sign _____

_____ _____

Signature of Office Representative Date

8607 Easthaven Court, Suite 101
New Port Richey, Florida 34655
Phone: 727-669-6800 Fax: 727-669-2540

NOTICE OF PRIVACY PRACTICES

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.

September 3, 2025

OUR COMMITMENT TO YOUR PRIVACY

WEST COAST INFECTIOUS DISEASES, P.A. (referred to as "WCID", "we," or "us") is dedicated to maintaining the privacy of your/your child's health information. We are required by law to maintain the confidentiality of your/your child's health information, provide you with this Notice of our legal duties and the privacy practices that we maintain concerning your/your child's health information, and to notify you of a breach of your unsecured health information. We are required to follow the terms of this Notice that are in effect at the time.

Applicability and Changes to this Notice. The terms of this Notice apply to all records containing your/your child's health information that are created or retained by us. This Notice will be followed by all health care professionals, employees, medical staff, and other individuals providing services at WCID. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your medical records that we have created or maintained in the past, and for any of your records that we may create or maintain in the future. We will post a current copy of this Notice on our website. You may also request a copy of the current Notice at any time by reaching out to us at the contact information provided at the end of this Notice and we will provide you with a paper copy or electronic copy.

YOUR RIGHTS

When it comes to your/your child's health information, you have certain rights. This section explains your rights and some of our responsibilities to help you exercise those rights.

Right to Inspection and Copies. You have the right to get an electronic or paper copy of your/your child's medical records, billing records, and other records maintained by us that are used to make decisions about you/your child. This right does not include psychotherapy notes or health information that is not part of your designated record set. To obtain copies or request inspection of your/your child's health information, or request that we send such records to a third party, we require that you submit your request in writing to the WCID Privacy Officer. We may charge a reasonable fee that will be in compliance with applicable state and federal law. We may deny your request to inspect and/or copy your/your child's medical records only in limited circumstances. If your request is denied, in some instances you may request a review of our denial. Another licensed health care professional chosen by us will conduct such reviews and we will follow their findings.

Right to Request an Amendment. You can ask us to correct your/your child's health information if you believe it is incorrect or incomplete for as long as we have the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer whose contact information is included at the end of this Notice. Please provide us with a reason that supports your request for amendment. If we agree to the amendment request, we will notify you and amend your/your child's health information. Please note that we cannot delete information contained in medical records and the change requested by you will appear as an addendum to the existing record. In certain circumstances, we may deny

your request. If your request is denied, we will inform you in writing and explain your rights.

Right to an Accounting. You can ask for a list (accounting) of the times we've shared your/your child's health information for six years prior to the date of your request, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months. To request an accounting, submit your request in writing to the Privacy Officer whose information is contained at the end of this Notice.

Right to Request Restrictions. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If we agree to your request, our agreement will be in writing and we will comply with the restriction unless the information is needed to provide you with emergency care or we are required or permitted by law to disclose it. If you pay for a service or health care item out- of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Confidential Communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will agree to all reasonable requests. To request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact for billing purposes, or the location where you wish to be contacted. You do not need to give a reason for your request.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of this Notice at any time, even if you agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Officer whose contact information is included at the end of this Notice. All complaints must be submitted in writing, unless you require an accommodation. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office for Civil Rights, by sending a letter to, 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You alerting us of any concerns you have is a necessary part of a continuous quality process we employ. You in no way will be retaliated against or penalized for filling a complaint.

Right to a Personal Representative. Personal Representatives (including parents and legal guardians) can exercise the rights described in this Notice. If you have given someone the legal authority to exercise your rights and choices covered by this Notice, we will honor such requests once we verify their authority. This Notice also applies to minors, disabled adults, or others that are not able to make health care decisions for themselves and individuals that choose to designate someone to act on their behalf. There are also some situations under State Law where prior authorization of a minor patient is required before certain actions can be taken related to their health information. We comply with applicable State Laws related to the confidentiality of information related to minors.

YOUR CHOICES

In some cases, you can tell us your choices about what health information we share, and who we share it with.

Family Members & Friends. We may disclose you/your child's health information to individuals who you have chosen to involve in your/your child's medical care unless you object. For example, if you have involved your child's caretaker in your child's medical appointments, the caretaker may have access to your child's health information if you do not object. We may also share your/your child's information when needed to lessen a serious and imminent threat to health or safety.

Disaster Relief. In the event of a disaster, we may disclose your/your child's health information to organizations assisting in disaster relief efforts unless you tell us not to, and that decision will not interfere with our ability to respond in emergency circumstances.

Disclosures Requiring Your Authorization. Uses and disclosures that are not identified by this Notice will be made only with your written authorization. Certain sensitive diagnosis/test results are afforded additional protections under State Law and with limited exceptions, will be made only with your written authorization. We will never sell or use your/your child's health information for marketing purposes without your authorization. Most uses and disclosures of psychotherapy notes and substance abuse treatment notes require your prior authorization. Any authorization you provide to us regarding the use and disclosure of your/your child's health information may be revoked at any time by notifying us in writing. After you revoke your authorization, we will no longer use or disclose your/your child's health information for the reasons described in the authorization. However, uses and disclosures made before we received your withdrawal will not be affected as we cannot take back any disclosures that have already been made based on your authorization.

Fundraising. We may contact you for fundraising efforts, but you will be given an opportunity to opt-out of further fundraising communications.

Reproductive Health, (if applicable): We understand that information related to reproductive health is highly sensitive. This includes information about contraception, pregnancy, fertility treatments, abortion services, miscarriage management, and other reproductive healthcare services.

We are committed to protecting your privacy and only use or disclose your reproductive health information in accordance with applicable federal and state laws. Unless otherwise permitted or required by law:

- We will not disclose your reproductive health information to law enforcement or government agencies without your written authorization or a valid court order.
- We will not release, without your authorization, reproductive health information to a party conducting a criminal, civil, or administrative investigation, when such reproductive services were rendered and sought in an legally compliant manner.
- We will not share your reproductive health information with third parties for marketing purposes without your explicit written consent.
- If you receive reproductive health services out-of-state or from providers in states with different laws, we will take reasonable steps to safeguard your information in accordance with our privacy obligations.

You have the right to request restrictions on how we use or disclose your reproductive health information,

and we will accommodate reasonable requests when possible.

If you have questions or concerns about how your reproductive health information is protected, or if you would like to request additional privacy protections, please contact our Privacy Officer at the contact information listed below.

USES & DISCLOSURES OF YOUR INFORMATION

We may use or share your/your child's health information in the following ways.

Treatment. We may use your/your child's health information as needed to provide you with medical treatment and share it with other professionals who are treating you/your child. For example, we may use and disclose your/your child's health information to order laboratory tests or prescriptions, to assist other health care providers in their treatment of you/your child, or to inform you of potential treatment alternatives or programs.

Payment. We may use and disclose your/your child's health information to bill and collect payment for the services and items provided by us. For example, we may share your/your child's health information with your health insurance plan so it will pay for the services provided to you. We may also disclose your/your child's health information with other health care providers to assist in their billing and collection efforts.

Health Care Operations. We may use and disclose your/your child's health information to operate our practice, improve your/your child's care, and contact you when necessary. For example, we may use or disclose your/your child's health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities. In some circumstances and subject to any additional restrictions under State Law, we may also share health information with other health care providers for their health care operations.

Health Information Exchanges and Affiliations. We may participate in one or more Health Information Exchanges ("HIE"). HIEs allow health care entities participating in the same HIE to quickly share health information as necessary to support timely care coordination and quality health care. For example, your/your child's health information related to a recent hospital visit may be shared via a HIE with us so that we can promptly coordinate necessary follow-up treatment with you. If we participate in a HIE, we will follow applicable State Law related to consent and/or opt-out requirements.

Research. If the location where you/your child receives health care services from us participates in clinical research, we may use or share your/your child's health information for research purposes and medical records may be reviewed to determine whether you/your child may be eligible to participate in certain research studies. We have to meet many conditions in the law before we can share your/your child's information for research purposes, including for example, ensuring your/your child's identity is protected, obtaining approval by and institutional review board, and/or obtaining prior authorization from you.

OTHER USES & DISCLOSURES.

Public Health & Safety. Subject to certain conditions, we can share your/your child's health information for the following purposes:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Compliance with Law. We will share your/your child's health information if state or federal laws require it, including with the Department of Health and Human Services for the purpose of confirming our compliance with federal privacy laws.

Organ & Tissue Donation Requests. We can share your/your child's health information with organ procurement organizations.

Medical Examiners and Funeral Directors. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation. We may release your/your child's health information for workers' compensation and similar programs subject to the requirements of State Law.

Law Enforcement & Other Government Requests. We may share health information for law enforcement purposes or with law enforcement officials when permitted by law. We may also share health information with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Court Orders and Subpoenas. We can share your/your child's health information in response to a court or administrative order, or in response to a subpoena. We will comply with applicable State Laws when certain information is afforded additional protections.

Electronic Communications Not Secure. We provide mechanisms that can be used by you to communicate with us via secure electronic messaging platforms. Using any unsecure electronic communication methods (such as regular email) to communicate with us can present risks to the security of information. These risks include possible interception of information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices. We do not advise that you communicate with us via unsecured email or text message.

We recognize, however, that there may be times when you choose to communicate with us using unsecure email or standard text messaging for convenience purposes. If you provide us with an email address or mobile phone number, we may communicate with you using unsecured text or email related to general information or reminders. You will be provided with an opportunity to opt-out of these communications and can opt out at any time by notifying us at the contact information included below.

By choosing to correspond with us via unsecure electronic communication platforms, you are acknowledging and accepting the risks involved and understand that you are responsible for any charges applied by your telecommunications carrier. The use of any form of electronic messaging is not appropriate for medical emergencies.

Question & Concerns

If you have any questions about this Notice or would like to notify us of a privacy concern, please contact:

Privacy Officer

Renee Mancine
West Coast Infectious Diseases, P.A.
8607 Easthaven Court, Suite 101
New Port Richey, Florida 34655
Phone: (727) 669-6800
Email: privacyofficer@westcoastid.com

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 WCID strives 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.

This financial policy is an agreement between you and West Coast Infectious Diseases, P.A. ("WCID"), as a creditor, and you, as the patient/debtor named on this form. The words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name or the patient's name listed above to which charges are made and payment credited. The words "we", "us", and "our" refer to the West Coast Infectious Diseases, PA.

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 $25.00 no-show fee which is not reimbursable by any insurance. Patients with repeated missed appointments may be dismissed from the WCID. 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.

Assignment: You agree to assign all medical benefits, to include without limitation "major medical" benefits, which your are entitled inclusive of Medicare and all other health care payors to the WCID and its providers. You authorize WCID to file a claim, as a courtesy, for payment with your insurance company and/or Medicare (if applicable) for services provided to the you/patient and you request that payments for such services be made directly to WCID and/or any physician providing services to you/patient, as applicable. If the insurance company fails to pay for any reason, you understand that you will be responsible for prompt payment of all amounts owed to WCID. Payment is due at the time services are provided unless other arrangements have been made actions.

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. 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.

Referrals: If your insurance company requires a referral or preauthorization/pre-certification, **you are responsible for obtaining it.** We likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). If the referral is not obtained, you understand that you have the option of rescheduling the appointment or paying for the visit out of pocket. You should 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.** You understand that if you do not secure a pre-authorization or pre-certification, benefit payments may be reduced or denied, and you will be responsible for any amounts not reimbursed by your insurer/benefits program.

Completion of Medical Forms/Letters: There is a $25.00 fee for completion 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.

Personal Injury: If your treatment by WCID is related to 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.

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.

WEST COAST INFECTIOUS DISEASES

OFFICE FINANCIAL POLICY CONTINUED…

Returned Checks & Refunds: There is a fee (currently $25) for any checks returned by the bank. Refunds will be issued as soon as possible, but refunds can take 4-6 weeks from the date requested in some cases.

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.

Effective Date & Changes to Polices: 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. 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.

Release of Information & Confidentiality: You authorize the release of medical information by WCID to your insurance carrier, any physician participating in your health care, and any physician or health care provider to whom you may be subsequently referred. You understand that this authorization specifically includes all health information and medical records related to the patient for the purposes specified herein, including without limitation, the results of HIV or AIDS tests and related information, reproductive health information, substance use disorder ("SUD") treatment information, genetic information, information related sexually transmitted diseases ("STD"), and information related to mental health conditions, if on file with WCID. You understand that if You do not consent to the release of information for payment purposes, WCID and other health care providers will not be able to bill your insurance other third party and you may be billed directly for these services. In the event you do not pay the amount you are responsible for, 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.

Good Faith Estimates: You understand that as a requirement of the No Surprises Act, self-pay and uninsured patients will be provided with a good faith estimate, in writing or electronically, of the total expected cost of any health care items or services to be received by the Patient upon request or when scheduling such items or services, and such good faith estimates are only an estimate. You also understand that WCID attempts to provide all insured patients with a good faith estimate of the expected costs for scheduled items or services, but such good faith estimates are not required by statute or regulation, and such costs may change based on my insurance or benefits plan's coverage of services rendered and any changes to such insurance of benefits plan.

By signing below, you acknowledge that you are a legally competent adult, and you are responsible for any applicable payments for the services rendered by WCID to the patient named above (the "Patient"). You hereby assume and guarantee prompt payment of all expenses incurred for the services rendered to the Patient, including any applicable coinsurance, copayments, or deductibles due if such services are covered by an insurance plan or state or federal benefits program and claims are submitted by WCID for such services, or self-pay rates in the event that the Patient is not covered by an insurance plan or state or federal benefits program or in the event that the Patient and I choose not to submit claims to any applicable payor source. By signing below, you accept financial responsibility and agree to pay charges for all services ordered or otherwise provided to the Patient by the WCID, as applicable. You understand that any balance due for non-covered services, or as a result of being uninsured or under-insured, is payable immediately by cash, check, Visa or MasterCard. You further understand that if you fail to make payments upon their due date, your account associated with the Patient may be referred to a collection agent and/or attorney, and you agree to pay all collection related charges, including attorneys' fees.

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**

_____

Relationship to Patient

WEST COAST INFECTIOUS DISEASES

Brent W. Laartz, MD
Todd M. Groom, PhD, MD
Lily N. Jones, DO
Jennifer Patterson, DO
Mario A. Torres Solano, MD
Frank Sanchez, MD, MBA

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. You are automatically being assigned a patient portal for access to your medical chart. If you wish to access this, please let us know and we will provide you with a temporary password. If you choose to activate it at a later time, simply give us a call and we will provide your login details.

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

8607 Easthaven Court, Suite 101
New Port Richey, Florida 34655
Phone: 727-669-6800 Fax: 727-669-2540

WEST COAST INFECTIOUS DISEASES

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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.

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West Coast Infectious Disease, PA

8607 Easthaven Court, Ste 101 *Phone (727) 669-6800*
New Port Richey, Florida 34655 *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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3
3. Trouble falling or staying asleep, or sleeping too much	○ 0	○ 1	○ 2	○ 3
4. Feeling tired or having little energy	○ 0	○ 1	○ 2	○ 3
5. Poor appetite or overeating	○ 0	○ 1	○ 2	○ 3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○ 0	○ 1	○ 2	○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	○ 0	○ 1	○ 2	○ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	○ 0	○ 1	○ 2	○ 3
9. Thoughts that you would be better off dead, or of hurting yourself	○ 0	○ 1	○ 2	○ 3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

WEST COAST INFECTIOUS DISEASES

PATIENT NAME: _____ DATE:_____

AHC Health-Related Social Needs Screening Questions

Living Situation

1. **What is your living situation today?**

   - ○ I have a steady place to live
   - ○ I have a place to live today, but **I am worried** about losing it in the future
   - ○ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**
   PLEASE CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors are missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ○ Often true
   - ○ Sometimes true
   - ○ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ○ Often true
   - ○ Sometimes true
   - ○ Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**
   - ○ Yes
   - ○ No

Utilities

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

PATIENT NAME: _____ DATE:_____

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**
   - ○ Yes
   - ○ No
   - ○ Already shut off

Safety
Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

7. **How often does anyone, including family and friends, physically hurt you?**
   - ○ Never (1)
   - ○ Rarely (2)
   - ○ Sometimes (3)
   - ○ Fairly often (4)
   - ○ Frequently (5)

8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ○ Never (1)
   - ○ Rarely (2)
   - ○ Sometimes (3)
   - ○ Fairly often (4)
   - ○ Frequently (5)

9. **How often does anyone, including family and friends, threaten you with harm?**
   - ○ Never (1)
   - ○ Rarely (2)
   - ○ Sometimes (3)
   - ○ Fairly often (4)
   - ○ Frequently (5)

10. **How often does anyone, including family and friends, scream or curse at you?**
    - ○ Never (1)
    - ○ Rarely (2)
    - ○ Sometimes (3)
    - ○ Fairly often (4)
    - ○ Frequently (5)

National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/
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WEST COAST INFECTIOUS DISEASES

Notice of Non-Discrimination and Accessibility Requirements

West Coast Infectious Diseases, P.A. ("WCID") complies with applicable Federal civil rights laws, including Title VI, Section 504, Title IX, and the Age Act and Section 1557 of the Affordable Care Act, and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 C.F.R. 92.101(a)(2), including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). Our practice does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Appropriate Auxiliary Aids and Services: WCID provides at no cost reasonable modifications, appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters, and written information in other, alternative formats (i.e., braille, large print, audio, accessible electronic formats, other formats) in a timely manner, when such modifications or aids and services are necessary to ensure accessibility and equal opportunity to participate to individuals with disabilities.

Reasonable Modifications. WCID will provide reasonable modifications for qualified individuals with disabilities when necessary, to ensure accessibility and equal opportunity to participate in our programs, activities, services, or benefits. To learn more about your rights, please refer to the WCID Patient Rights and Responsibilities and this notice.

Language Assistance Services: WCID also provides language assistance services at no cost to people whose primary language is not English, including qualified interpreters and information in electronic or written in different languages or oral translation. If you need these services, please contact Renee Mancine, Civil Right Coordinator and let them know of your needs, and such services will be provided in a timely manner.

Grievances: If you believe WCID has failed to provide these services or discriminated against you in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator, Renee Mancine, 8607 Easthaven Court, Suite 101, New Port Richey, FL 34655, 727-669-6800 or fax 727-669-2540, or renee.mancine@westcoastid.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to assist you. For more information on our non-discrimination policy, please visit our website at: westcoastid.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C., 20201
1-800-368-1019, 1-800-537-7697 (Toll Free).

Complaint forms are available at: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html or at https://www.hhs.gov/ocr/complaints/index.html.
This notice is available at WCID's website at westcoastid.com

ATTENTION: If you speak [insert language], free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call [insert phone number] or speak to your provider.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al [insert telephone number] o hable con su proveedor.

French Creole (Haitian Creole): ATANSYON: Si w pale kreyòl ayisyen, sèvis asistans pou lang gratis disponib pou ou. Èd oksilyè ki apwopriye ak sèvis pou bay enfòmasyon ki nan fòma aksesib yo disponib tou gratis. Rele [insert telephone number] oswa pale ak founisè ou.

Vietnamese: Nếu bạn nói tiếng Vitname, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các hỗ trợ và dịch vụ phụ trợ thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi [insert telephone number] hoặc nói chuyện với nhà cung cấp của bạn.

Portuguese: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para [insert telephone number] ou fale com seu provedor.

Chinese:
注意：如果您会说中文，可以使用免费的语言协助服务。此外，还免费提供适当的辅助设备和服务，以无障碍格式提供信息。致电 [insert telephone number] 或与您的提供商交谈。

French: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir de l'information dans des formats accessibles sont également disponibles gratuitement. Appelez le [insert telephone number] ou parlez à votre fournisseur.

WEST COAST INFECTIOUS DISEASES

Tagalog: PANSIN: Kung nagsasalita ka ng Tagalog, may libreng serbisyo sa tulong sa wika para sa iyo. Ang mga naaangkop na pantulong na pantulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag [insert telephone number] o kausapin ang iyong provider.

Russian: ВНИМАНИЕ: Если вы владеете русским языком, вам доступны бесплатные услуги языковой помощи. Также на безвозмездной основе предоставляются соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Позвоните по телефону [insert telephone number] или обратитесь к своему провайдеру.

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مجانا الوسائل المساعدة والخدمات المساعدة المناسبة لتوفير المعلومات بأشكال ميسرة. اتصل [insert telephone number] أو تحدث إلى مزودك.

Italian: ATTENZIONE: Se parli italiano, sono disponibili servizi gratuiti di assistenza linguistica. Sono inoltre disponibili gratuitamente ausili ausiliari e servizi adeguati per fornire informazioni in formati accessibili. Chiama [insert telephone number] o parla con il tuo fornitore.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachhilfen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie [insert telephone number] an oder sprechen Sie mit Ihrem Anbieter.

Korean: 주의: 한국어를 구사하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. [insert telephone number] 전화하거나 제공업체에 문의하십시오.

Polish: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Bezpłatne są również odpowiednie pomoce i usługi pomocnicze służące do dostarczania informacji w przystępnych formatach. Zadzwoń pod [insert telephone number] lub porozmawiaj ze swoim dostawcą.

Gujarati: ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાયતા સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સહાયક સહાયકો અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. [insert telephone number] કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Thai: ข้อควรระวัง: หากคุณพูดภาษาไทย มีบริการช่วยเหลือด้านภาษาฟรีสำหรับคุณ นอกจากนี้ยังมีบริการเสริมและบริการที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โทรหา [insert telephone number] หรือพูดคุยกับผู้ให้บริการของคุณ.

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

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Brent W. Laartz, MD
Todd M. Groom, PhD, MD
Lily N. Jones, DO
Jennifer Patterson, DO
Mario A. Torres Solano, MD
Frank Sanchez, MD, MBA

Patient: _____

NOTICE OF NON-DISCRIMINATION ACKNOWLEDGEMENT RECEIPT

The Notice of Non-Discrimination and Accessibility Requirements provides information about how we provide language services to patients if needed. I acknowledge that I have received the Notice of Non-Discrimination. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

_____

Signature of Patient or Patient's Representative Date

_____

Print Name Relationship to Patient

Interpreter (if applicable)

(FOR OFFICE USE ONLY)

Please document your efforts to obtain acknowledgement and reason it was obtained or not obtained.

ن Notice of Non-Discrimination and Accessibility Requirements Given – Patient Able to Sign
ن Notice of Non-Discrimination and Accessibility Requirements Given – Patient Unable to Sign
ن Notice of Non-Discrimination and Accessibility Requirements Given – Patient Declined to Sign
ن Notice of Non-Discrimination and Accessibility Requirements and Acknowledgement Mailed to Patient
ن Other Reason Patient Did Not Sign _____

_____ _____

Signature of Office Representative Date

8607 Easthaven Court, Suite 101
New Port Richey, Florida 34655
Phone: 727-669-6800 Fax: 727-669-2540