WIDC
WESTERN INFECTIOUS DISEASE CONSULTANTS, P.C.

Welcome to Our Office

Patient Name: _____ Birthdate (MM/DD/YYYY): _____

Are you the Patient: ☐ Yes (provide Insurance Cards) ☐ No

Sex: ☐ Male ☐ Female Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Other

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

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

Email Address: _____ Contact Preference: ☐ Cell ☐ Home ☐ Work ☐ Email

Patient Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Referring Provider: _____

Government Required Data

Race: ☐ American Indian ☐Alaskan Native ☐ Asian ☐ African-American ☐ Caucasian ☐ Pacific Islander ☐ Decline

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline Language: _____ Veteran: ☐ Yes ☐No

Patient Insurance

Primary Insurance

Insurance Company: _____ Policy #(Member ID): _____ Group #: _____

Patient is the Insured? ☐ Yes ☐No If no, relationship to patient? _____ Name: _____

Secondary Insurance

Insurance Company: _____ Policy #(Member ID): _____ Group #: _____

Patient is the Insured? ☐ Yes ☐No If no, relationship to patient? _____ Name: _____

Patient/Responsible Party, please read and sign below.

I understand that responsibility for payment of medical services at Western Infectious Disease Consultants, P.C. for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** ALL COPAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. I understand that it is my responsibility to provide the office with accurate insurance information, and that I should be prepared to present my insurance card on each and every visit. Should I ever need to cancel my appointment, I agree to notify the office at least 24 hours in advance.

I understand that I am responsible for all costs of collections including attorney fees, collections fees, and court costs. I also assign all benefits to Western Infectious Disease Consultants, P.C. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. A copy of this signature is as valid as the original.

X_____ Date: _____

WESTERN INFECTIOUS DISEASE CONSULTANTS, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Protecting the privacy and confidentiality of your health information is something we take very seriously. Everyone in this office understands how important it is to protect your information.

Recently a federal law went into effect known as HIPAA. Among other things, HIPAA has strict requirements for protecting patient health information. This practice has made special efforts to comply with both federal and state confidentiality laws.

As part of our commitment to your privacy, we are providing you with the attached "Notice of Privacy Practices". This outlines how we will use or disclose your "protected health information". Please take a few minutes to read this notice. If you would like a copy to take home with you, circle below. If you have any questions about how we handle your information, please feel free to ask to talk to our privacy officer.

The law requires that we ask you sign the acknowledgement of receipt of the Notice of Privacy Services. **Signing does not mean that you have agreed to any special uses or disclosures of your health records. Refusing to sign the acknowledgement does not prevent us from using or disclosing your health information as the law permits us to.** The acknowledgement is just our written record that you received the Notice of Privacy Services.

Check One

☐YES ☐NO

☐ I would like a hard copy of this notice

Personal Representatives

In accordance with HIPAA guidelines you may choose to designate whom we can talk to regarding your Medical Health and Records; this would include, but is not limited to, general information, laboratory and x-ray results. You are not required to choose anyone, and if you decline, your medical information will only be discussed with you. Please list representatives in the order you would like them to be contacted.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Confidential Communications Channel

May we leave confidential voicemails? If yes, list contact numbers below.

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

I hereby acknowledge that I reviewed the Western Infectious Disease Consultants, P.C. Notice of Privacy Practices.

X_____ Date: _____

If not signed by the patient, please print your name and indicate your relationship to the patient (check one):

Name: _____

☐ Parent/Guardian of a minor patient
☐ Guardian or Conservator of an incompetent patient
☐ Beneficiary or Personal Representative of deceased patient

For Office Use Only

___ Signed form received by: _____
___ Acknowledgment refused

___ Efforts to obtain: _____

___ Reason(s) for refusal: _____

WIDC
WESTERN INFECTIOUS DISEASE CONSULTANTS, P.C.

Patient Name: _____ DOB: _____

FAMILY HISOTRY

Please check all that apply, include Father, Mother, and Siblings.

Coronary Artery Disease

Family Member: _____ ☐ Living ☐ Deceased

Valvular Heart Disease

Family Member: _____ ☐ Living ☐ Deceased

Hypertension

Family Member: _____ ☐ Living ☐ Deceased

Diabetes

Family Member: _____ ☐ Living ☐ Deceased

Hepatitis

Family Member: _____ ☐ Living ☐ Deceased

Kidney Disease

Family Member: _____ ☐ Living ☐ Deceased

Tuberculosis

Family Member: _____ ☐ Living ☐ Deceased

Syphilis

Family Member: _____ ☐ Living ☐ Deceased

Immunodeficiency

Type: _____

Family Member: _____ ☐ Living ☐ Deceased

Splenectomy

Family Member: _____ ☐ Living ☐ Deceased

Lupus or Rheumatologic Disease

Family Member: _____ ☐ Living ☐ Deceased

Alcoholism or Drug Abuse

Family Member: _____ ☐ Living ☐ Deceased

WIDC
WESTERN INFECTIOUS DISEASE CONSULTANTS, P.C.

Western Infectious Disease Consultants, P.C. is excited to announce the arrival of our new Patient Portal! Through the Patient Portal you can access your test results, view parts of your medical chart, verify future appointments, and receive and send secure messages about your care.

Please fill out the information below. It will be used to create your personalized Patient Portal account. Complete instructions on how to log in are included in your take home packet.

What we need from you:

First Name:
Last Name:
Email Address:
Last Four Digits of your Phone Number:

Pick a Security Question:

- ☐ What street did you grow up on?
- ☐ What is the name of your favorite pet?
- ☐ What is your favorite hobby?
- ☐ What city were you born in?

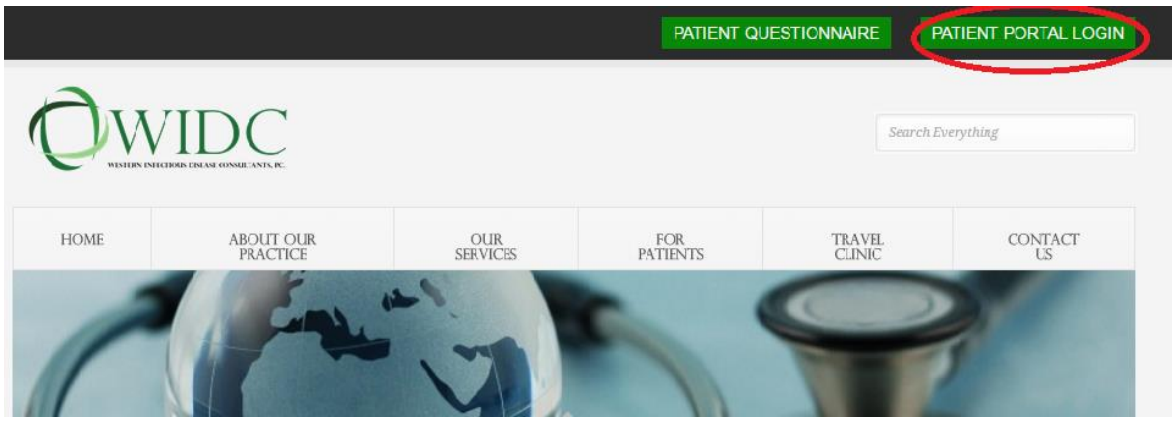
Security Answer:

Please return this form to the front desk staff.

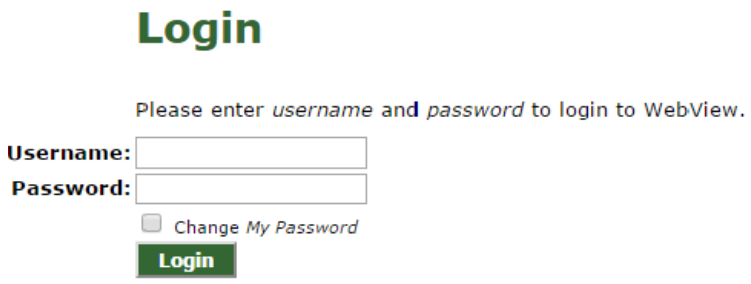
Patient Portal First Time Users

The following pages are for you, the patient, to keep.
Your portal will be available within 48 hours of your first visit.

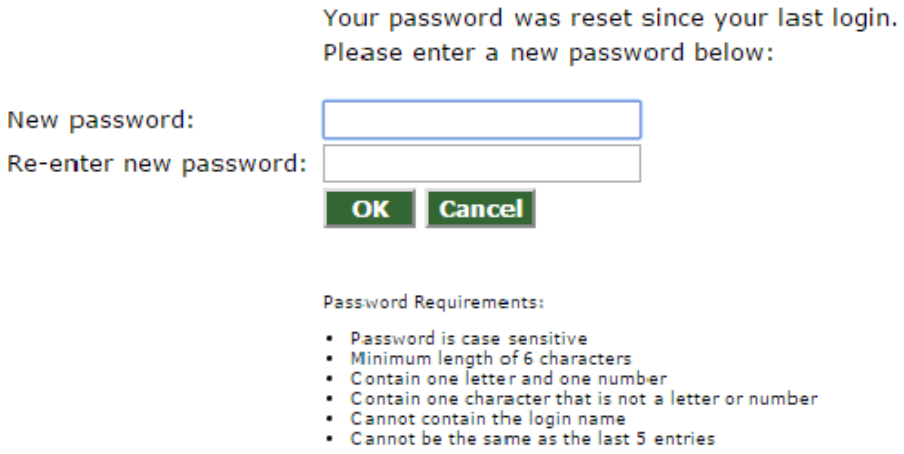
1. To access the Patient Portal visit www.widc.biz. In the upper right hand corner there is a Patient Portal link.



2. This is the Patient Portal login screen. Enter your username and your temporary password.
   Username: First letter of your first name, capitalized; last name, capitalized. (Ex. JDoe). Your username will always remain the same.
   Temporary Password: *Password!* and the last four digits of your phone number (Ex. Password!1234)



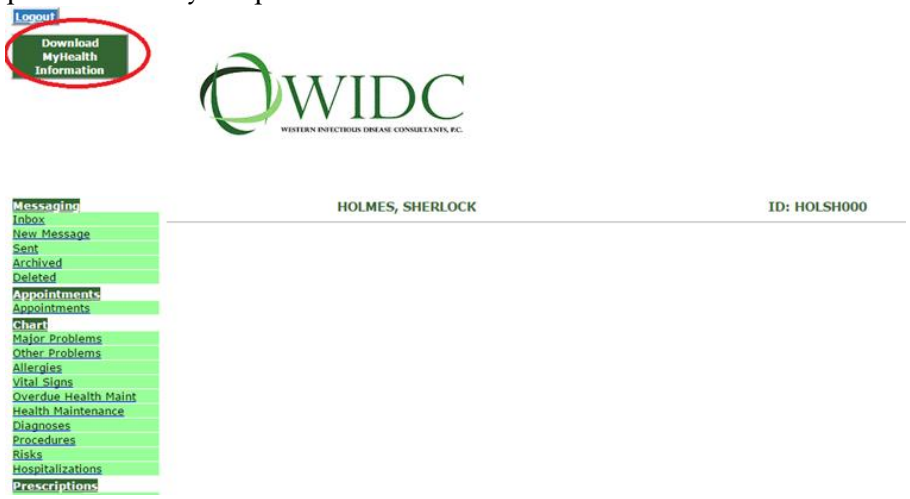
3. Once you have logged in using your temporary password you will be prompted to create a new password, this is required for security purposes. Your new password must contain: a minimum of 6 characters including; one UPPERCASE letter, one lowercase letter, one number, and one special character (ex. @#!$&). It cannot contain your username or a previous password.



4. Once you have created your new password you will have access to the Patient Portal. On the left hand side of the screen you will see options to access your messages, view your past appointments, and view parts of your medical chart.

   If you would like to contact your care team, please direct your message to:

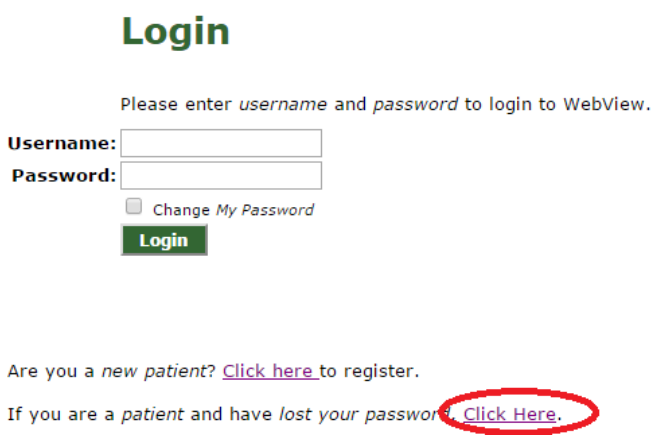
5. In the upper left hand corner there is a green button that says 'Download My Health Information'. By clicking this button you will be asked to either download or display your medical information and it will appear in an easy-to-print format.



WIDC
WESTERN INFECTIOUS DISEASE CONSULTANTS, P.C.

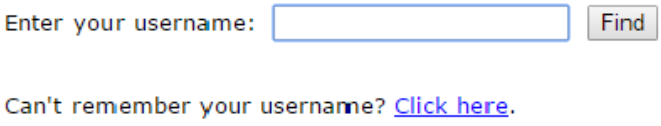
Patient Portal Forgotten Password

1.

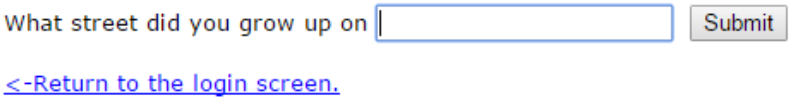


If you forget your password, there is a link beneath the login entry section that can help you retrieve this information. One you click this, you will be prompted to enter your username. On the following page you will be prompted to answer your security question. By correctly answering your security question, you will be sent an email with your password. Once you receive this email, you will be required to create a new password upon your next login. The steps to create your new password are the same as for your first time login.

2.



3.



If you do not have an email address, or if you encounter any other problems, please call our office at (303)425-9245 and press option 8.