Alka Rebentish, MD
Joseph Poliquin, APRN
Monica Lynam, APRN

Infectious Disease Associates

NEW PATIENT
REGISTRATION FORM

TODAY'S DATE / /

PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST	MI	ADDRESS		
SUITE OR APARTMENT #	CITY		STATE	ZIP CODE	SEX
EMPLOYED YES NO	EMPLOYER		HOME PHONE ( )	CELL or ALTERNATE PHONE ( )	
DATE OF BIRTH / /	SOCIAL SECURITY #		MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER		

Preferred Method of Contact : ☐ Phone ☐ Text ☐ Email Address

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION #		GROUP #
ADDRESS	CITY	STATE / ZIP CODE	PHONE ( )
SUBSCRIBER NAME (INSURED)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH / /
EMPLOYER	ADDRESS		PHONE # ( )

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION #		GROUP #
ADDRESS	CITY	STATE / ZIP CODE	PHONE ( )
SUBSCRIBER NAME (INSURED)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH / /
EMPLOYER	ADDRESS		PHONE # ( )

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP CODE
CONTACT PHONE ( )	CONTACT PHONE ( )		

HOW WERE YOU REFERRED TO OUR OFFICE?

Assignment and Release: I hereby AUTHORIZE my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required to process my insurance claims. I hereby consent to examination and treatment by attending physician.

Patient Signature:

(Parent or Guardian if patient is a minor) **X** Date

updated 10/26/23

Infectious Disease Associates
Financial Policy

We would like to welcome you to our office. The following information is provided to avoid any misunderstanding concerning payment for services. Please take a moment to read this information sheet concerning our financial policy.

- All co-pays and deductibles are due at the time of check in. Payment for services for cash patients are due "In full" at the time of check in. For your convenience, we accept Cash, Checks, MasterCard, Visa, American Express and Discover.

- I fully understand that Infectious Disease Associates will bill my provided insurance as a courtesy. In the event of non-payment by your insurance carrier I fully understand that I am financially responsible for the payment of my treatment. If my account becomes delinquent I fully understand that I am hereby responsible for any subsequent collection and or legal fees related to repaying the amounts owed Infectious Disease Associates."

- If your insurance company changes, you must notify us immediately so that we can obtain a copy of your new card and submit claims to the correct insurance. If you do not you will be responsible for all denied charges.

- Your insurance policy is an agreement between you and your insurance company. It is your responsibility to know what is covered and what is not covered. Fees for non-covered services are due at the time service is rendered.

- If your insurance is through an Exchange you will be required to show proof of payment before services are provided.

- Please help us to better serve you by keeping all scheduled appointments. We require at least 24 hours advance notice for all appointment cancellations. If you miss your appointment or fail to cancel it with 24 hours advance notice our policy is to charge a **No Show Fee of $50.00.**

- Returned checks will be subject to a **$35.00** fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I herein authorize payment of medical benefits to Infectious Disease Associates when an assigned claim is filed. My signature authorizes Infectious Disease Associates to release any medical information necessary to process my insurance claims. My signature below indicates that I understand and accept these policies.

Print Name :_____ DATE:_____

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Infectious Disease Associates *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____
_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient Name:

_____ Date: _____
(Signature)

If not signed by patient, please indicate relationship to patient (i.e. spouse)

Relationship: _____ Witnesses by: _____

_____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this Acknowledgement.
Date: _____
Time: _____
Employee Name: _____

Infectious Disease Associates

www.IDAssociateslv.com

Alka Rebentish, M.D., FACP
Board Certified in Infectious Diseases

Joseph Poliquin, APRN Semmalar Rajamani, APRN Monica Lynam, APRN

Main Office:
6088 S. Durango Drive, # D-100
Las Vegas, NV 89113
Tel: (702) 380-4242
Fax: (702) 380-4141

Corporate / Billing Office:
1450 W. Horizon Ridge Pkwy. B304 #668
Henderson, NV 89012
Tel: (702) 868-8387
Fax: (702) 314-9134

Medical Records Release

I hereby request that Infectious Disease Associates, Alka Rebentish MD, Joseph Poliquin, APRN, Monica Lynam, APRN release my medical records, laboratory data, x-ray reports and other related information and materials to:

_____ Myself (a charge of .60 cents per page will apply. Payment is due when the records are picked up. If you want records mailed, an additional cost for postage will be added).

_____ Physician

_____ Other

_____
Physician Name or Person receiving records

_____
Address

_____
Telephone number and fax number

_____
Patient Name DOB Social Security#

_____
Address City State Zip Code

_____
Telephone Number Date Patient Signature

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CONSENT TO DISCUSS PATIENT INFORMATION

Patient: _____ Chart # _____

Nevada State Law prevents this office from discussing patient information without express written consent from the patient. If you would like someone other than yourself to be allowed to discuss your care, please list the names of the individuals below. Please keep in mind that you can change this list at any time. Any person on the list must be able to verify your date of birth as an added security.

NAME OF PERSON	RELATIONSHIP TO PATIENT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Patient Signature: _____ Date: _____

Date of Birth: _____

Infectious Disease Associates

Alka Rebentish M.D., Joseph Poliquin, APRN, Monica Lynam, APRN

6088 S. Durango Dr. Suite 100

Las Vegas, NV 89113

Tel: (702) 380-4242 Fax: (702) 380-4141 & (702) 314-9134

AUTHORIZATION TO RELEASE MEDICAL RECORDS

( ) Centennial Hills Hospital
Ph: (702) 835-9700 Fax: (702) 629-1645

( ) Desert Springs Hospital
Ph: (702) 733-8800 Fax: (702) 369-7556

( ) Mountain View Hospital
Ph: (702) 255-5000 Fax: (702) 255-5007

( ) North Vista Hospital
Ph: (702) 649-7711 Fax: (702) 649-1523

( ) St. Rose Delima Hospital
Ph: (702) 564-2622 Fax: (702) 616-4644

( ) St. Rose San Martin Hospital
Ph: (702) 492-8000 Fax: (702) 492-8165

( ) St. Rose Siena Hospital
Ph: (702) 616-5000 Fax: (702) 616-5235

( ) Southern Hills Hospital
Ph: (702) 880-2100 Fax: (856) 743- 4266

( ) Spring Valley Hospital
Ph: (702) 853-3000 Fax: (702) 853-3144

( ) Summerlin Hospital
Ph: (702) 233-7000 Fax: (702)233-7916

( ) Sunrise Hospital
Ph: (702) 731-8000 Fax: (702) 892-3686

( ) University Medical Center
Ph: (702) 383-2000 Fax: (702) 383-2012/383-6275

( ) Valley Hospital
Ph: (702) 388-4000 Fax: 388-4585

( ) Dr: _____
Ph: _____
Fax: _____

Patient Name: _____ Date of Birth: _____

Patient's Signature: _____

( ) Recent Progress Note
( ) Recent Lab Report
( ) Radiology Report
( ) Medication List
( ) Other Test Report
( ) All Medical Record(s)

Comments:

_____

_____

Please Fax Requested Records to (702) 380-4141 or (702) 314-9134

Medication Record

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am / pm