PATIENT REGISTRATION FORM

Las Cruces PHYSICIAN PRACTICES

Today's Date ____/____/____

PATIENT INFORMATION					
Patient Name Last First Middle			◻ Mr ◻ Mrs ◻ Miss ◻ Ms		Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ◻ YES ◻ NO	If not, what is your legal name?		Birthdate / /		Age Sex ◻ M ◻ F ◻ T
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )	
Cell Phone Number ( )	E-Mail Address			Social Security - -	
Occupation	Employer		Employer Phone Number		

Employment Status: ◻1 – Full-Time ◻2 – Part-Time ◻3 – Not Employed ◻4 – Self-Employed ◻5 – Retired ◻6 – Active Military
Student Status: ◻F – Full-Time Student ◻P – Part-Time Student ◻N – Not a Student

Race: ◻American Indian/Alaska Native ◻Asian ◻Native Hawaiian/Pacific Islander ◻Black/African American ◻White ◻Hispanic ◻Other ◻Declined

Ethnicity: ◻Hispanic or Latino ◻Not Hispanic or Latino ◻Declined

Language: ◻English ◻Spanish ◻Indian ◻Japanese ◻Chinese ◻Korean ◻French ◻German ◻Russian ◻Other _____

Pharmacy:	**City:**	Do you have a living will? ◻ YES ◻ NO

Referred By (Please check one box)
◻ Dr. _____ ◻ Insurance ◻ Hospital ◻ Family ◻ Friend ◻Yellow Pages ◻ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION				
Responsible Party: ◻Another Patient ◻Guarantor ◻Self			◻Check here if information is same as patient	
Name		Address		Home Phone Number
Birth Date / /		E-Mail Address		( )
Occupation	Employer	Employer Address		Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ◻ WORKERS COMPENSATION (WC)
◻ OCCUPATIONAL MEDICINE (OM) ◻ MOTOR VEHICLE ACCIDENT (MVA) ◻ ACCIDENT DATE _____

Does the patient have healthcare coverage? ◻ YES ◻ NO			**Insurance Name**		
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Child ◻ Other _____					
Name of Secondary Insurance	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Child ◻ Other _____					

EMERGENCY CONTACT			
Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/ Guardian Signature Date

Las Cruces
PHYSICIAN PRACTICES

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information

disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

Las Cruces
PHYSICIAN PRACTICES

AUTHORIZATION TO OBTAIN INFORMATION FROM OTHER PROVIDERS
NAME: _____
DOB: _____
SOC SEC: _____

This authorization is to OBTAIN medical records from another provider. Please fill in ALL the information requested; leave no blanks. Print full name and address of individual or institution from whom records are to be requested.

Records Requested From: _____
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
The purpose of this disclosure is: _____
Please specify the extent of information you wish released.

A. Records of inpatient, outpatient, or emergency service for the following condition or injury:
_____
B. Records of the period from _____ to _____
C. Specific records needed are: _____

___ admission face sheet ___ pathology report ___ x-ray report ___ discharge summary
___ consultation report ___ electrocardiogram report ___ history/physical exam ___ orders/progress notes
___ emergency dept. report ___ operative report ___ laboratory report ___ entire chart
___ other _____

D. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness, I understand that I have a right to examine and copy any information disclosed under the terms of this release (N.M. Stat. Ann § 43-1-19.) (If the patient is a minor, the patient and legal representative must sign here and below. At least one signature is needed in this section in ALL cases.)

Signature: _____ Date: _____ Signature: _____ Date: _____

This authorization shall be considered invalid after 6 months, (60 days for drug and alcohol abuse records) from the date of signing. Medical information gathered by you after the date of authorization signing is not to be released. The authorizing party may revoke this authorization at any time by notifying the individual institution from which records were requested. I agree that my individual institution form which records were requested, received by written notice to revoke this authorization. I understand that I can receive treatment at General Surgery Associates even though I have not signed an authorization. I understand that I can receive treatment at General Surgery Associates even though I have not signed an authorization to obtain my medical records from other providers.

I hereby authorize you to provide the above medical information to General Surgery Associates. In furtherance of this authorization, I do hereby waive all provisions of law relating to the disclosures hereby authorized.

Patient Signature: _____ Date: _____

If patient unable to sign, give reason: _____ Date: _____

Signature of legally authorized representative: _____ Date: _____

Relationship to patient: _____ Witness Signature: _____ Date: _____

PLEASE ADDRESS TO THE ATTENTION OF:

General Surgery Associates
2530 S Telshor Blvd., Ste 103 Las Cruces NM 88011
Phone: 575-556-6400 Fax: 575-556-6405

GENERAL SURGERY ASSOCIATES

PERSONAL HEALTH HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PRESCRIPTION, OVER THE COUNTER, VITAMINS, SUPPLEMENTS, ETC. (INCLUDE DOSAGE AND FREQUENCY)

_____ _____

_____ _____

_____ _____

LIST ALL MEDICATION AND FOOD ALLERGIES:

_____

LIST PREVIOUS SURGERIES/OPERATIONS: (SURGERY TYPE AND YEAR DONE)

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

HEART DISEASE DIABETES HIGH BLOOD PRESSURE RECURRENT PNEUMONIA COPD ASTHMA

JAUNDICE HEPATITIS OR HIV ANEMIA COLITIS HEMORRHOIDS KIDNEY DISEASE

THYROID DISORDER LIVER DISEASE LUNG DISEASE CANCER (SPECIFY TYPE)_____

FAMILY HISTORY: (PLEASE SPECIFY AGE FOR EACH AND ANY MEDICAL CONDITIONS)

MOTHER _____ FATHER _____

BROTHERS _____ SISTERS _____

MATERNAL GRANDMOTHER _____ PATERNAL GRANDMOTHER _____

MATERNAL GRANDFATHER _____ PATERNAL GRANDFATHER _____

SOCIAL HISTORY:

DO YOU SMOKE? YES/NO HOW MUCH PER DAY? _____ TRYING TO QUIT? YES/NO

DO YOU CONSUME ALCOHOL? YES/NO HOW OFTEN? _____ HOW MANY DRINKS? _____

ANY RECREATIONAL DRUG USE? YES/NO CURRENT USE: _____ PAST USE: _____

GENERAL SURGERY ASSOCIATES

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY HAVING

GENERAL

- ○ FATIGUE
- ○ FEVER
- ○ WEIGHT GAIN
- ○ WEIGHT LOSS

SKIN

- ○ NAIL CHANGES
- ○ NEW LESIONS
- ○ RASH
- ○ SKIN COLOR CHANGES
- ○ SKIN BECOMING DRIER

HENT

- ○ DOUBLE VISION
- ○ HEARING LOSS
- ○ EARACHE
- ○ EAR RINGING
- ○ NOSE BLEEDS
- ○ DRY MOUTH
- ○ MOUTH SORES
- ○ SORE THROAT

RESPIRATOR

- ○ CHRONIC COUGH
- ○ SHORTNESS OF BREATH
- ○ COUGHING UP BLOOD
- ○ WHEEZING

CARDIOVASCULAR

- ○ CHEST PAIN
- ○ PALPITATIONS
- ○ HEART TROUBLE

GASTROINTESTINAL

- ○ ABDOMINAL PAIN
- ○ APPETITE CHANGES
- ○ CHANGE IN BOWEL HABITS
- ○ CONSTIPATION
- ○ DIARRHEA
- ○ NAUSEA
- ○ VOMITING
- ○ RECTAL BLEEDING
- ○ BLOOD IN STOOL
- ○ STOOL LEAKAGE

GENTIOURINARY

- ○ PAINFUL URINATION
- ○ INCREASED FREQUENCY
- ○ BLOOD IN URINE
- ○ LOSS OF BLADDER CONTROL
- ○ KIDNEY STONES
- ○ TEA COLORED URINE

MUSCULOSKELETAL

- ○ JOINT PAIN
- ○ JOINT REDNESS
- ○ JOINT SWELLING
- ○ JOINT STIFFNESS
- ○ MUSCLE CRAMPING
- ○ MUSCLE WEAKNESS
- ○ BACK PAIN

NEUROLOGICAL

- ○ DIZZINESS
- ○ FREQUENT HEADACHES
- ○ NUMBNESS
- ○ TINGLING
- ○ SEIZURES
- ○ TREMOR
- ○ HEAD INJURY

PSYCHIATRIC

- ○ ANXIETY
- ○ INSOMNIA
- ○ DEPRESSION
- ○ HALLUCINATIONS
- ○ MEMORY LOSS
- ○ CONFUSION

ENDOCRINE

- ○ COLD INTOLERANCE
- ○ INCREASE THIRST
- ○ INCREASED URINATION
- ○ HAIR CHANGES