NM Cardiac Care
Providing Comprehensive Cardiovascular Care, Interventional Cardiology and Peripheral Vascular Intervention

Name_____ Date_____ Ref Dr._____

Why are you here to see a cardiologist?

_____

Check off any heart problems or symptoms

- ☐ Heart Attack
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Abnormal Rhythm (Arrhythmia)
- ☐ Palpitations/Irregular Heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest Pain or Pressure
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Swollen Legs
- ☐ Heart Failure
- ☐ Blue Lips or Fingernails
- ☐ Leg cramps when you walk

Have you ever had:

- ☐ A stress test
- ☐ An echocardiogram
- ☐ Cardiac/ Heart Catheterization
- ☐ Coronary Angioplasty (balloon)
- ☐ Coronary Bypass Surgery
- ☐ Heart Valve Surgery
- ☐ An electrophysiology Study or Procedure
- ☐ A pacemaker of defibrillator

Tell us about your risk of heart Disease

Please check if you have:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Ever Smoked
- ☐ Diabetes

Do you exercise (including walking)?

_____

Has a close family member had a heart attack, angina, or bypass surgery?

_____

If yes, who?

_____

If you are a woman, have you passed menopause (change of life)?

_____

If yes, at what age?

_____

Do you take estrogen replacement?

_____

Please tell us anything else about your heart:

_____

Please tell us about your medications (names, dose or strength, how many times a day). Please include over the counter medications:

1.
2.
3.
4.
5.

Are you being treated now or have been treated for any illness? Please list them:

1.
2.
3.
4.
5.

Have you had any operations? Any injuries?

1.
2.
3.
4.
5.

Marital Status: S M W D

With whom do you live?

_____

Occupation:

_____

Leisure Activities:

_____

Education Level:

_____

Health Habits:

Do you smoke?

_____

If so, how many packs per day?

_____

For how many years?

_____

How much alcohol do you drink?

_____

Do you use any drugs?

_____

Check if any close family members (parents, brothers and sisters, children) have:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer

Are there any other health problems in your family?

_____

_____

Are you allergic to any medications?

_____

List any medications to which you are allergic?

_____

_____

Patient Name: _____ Date: _____

Please Circle any symptoms you have so we can find out more about it?

Lack of energy; Trouble sleeping; Loss of appetite; Weight changes; Fevers
Eye problems, Such as double or blurred vision; Glaucoma; Cataracts
Hearing problems; Buzzing or ringing in ears
Allergies; Hay fever
Sinus Problems
Breathing problems; Wheezing; Cough; Coughing blood
Asthma; Tuberculosis
Stomach problems; Indigestion; Change in bowel habits; Bloody or tarry stools; Jaundice; Liver problems; Ulcers; Gallstones
Urinary problems; Frequency; Infections; Stones; Men: Prostate problems, Night-time urination Women: Abnormal menstrual periods. Could you be pregnant?
Joint Pains swelling or redness; Arthritis; Back pain; Muscle aches or tenderness; Gout
Rash, Itching or other skin problems
Women: Breast lumps; Recent mammogram, pap smear and/ or pelvic exam
Paralysis (even temporary); Stroke; Numbness; Loss of balance
Unusual thoughts; Nervousness; Crying or sadness; Depression; Suicide attempts
Thyroid disorder; Diabetes; Excessive thirst, Hunger or urination
Bleeding; Easy Bruising; Risk Factors of HIV; Anemia; Cancer

REVIEW OF SYMPTOMS

Constitutional:

HEENT:

RESPIRATORY:

DIGESTIVE:

URINARY:

MUSCULOSKELETAL:

DERMATOLOGICAL:

FEMALE REPRODUCTIVE:

NEUROLOGICAL:

PSYCHIATRIC:

ENDOCRINOLOGY:

HEMATOLOGICAL:

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

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 New Mexico Cardiac Care even though I have not signed an authorization. I understand that I can receive treatment at New Mexico Cardiac Care 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 New Mexico Cardiac Care. 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:

New Mexico Cardiac Care
1160 Mall Drive, Las Cruces NM 88011
Phone: 575-521-3270 Fax: 575-521-3504

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: _____

NM Cardiac Care

We appreciate you choosing New Mexico Cardiac Care!

Please let us know how you heard about us by checking a box below or writing in your answer in the space provided.

- ☐ Bulletin
- ☐ Las Cruces Sun-News
- ☐ Flyer/Poster
- ☐ Post Card
- ☐ Billboard
- ☐ Radio
- ☐ Facebook
- ☐ Online Health Risk Assessment
- ☐ Google
- ☐ Magazine
- ☐ Word of Mouth
- ☐ Other _____

_____

_____

1160 Mall Drive
575-521-3270
www.NMCardiacCare.com

PRINT

Medicare Secondary Payer Questionnaire

(Short Form)

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. **Are you receiving benefits from any of the following programs?**

   Black Lung ☐ YES (Long form Part I) ☐ NO
   Research Grant ☐ YES (Long form Part I) ☐ NO
   Veteran Affairs ☐ YES (Long form Part I) ☐ NO

2. **Was illness/injury due to a work related accident/condition?**

   ☐ YES ☐ NO

   If **YES,** answer the following:
   ☐ Work related accident (complete Part I of long form).
   ☐ Non-work related accident (complete Part II of long form).

3. **Is the patient currently employed?**

   ☐ YES (answer next question) ☐ NO

   Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

4. **Is the patient's spouse currently employed?**

   ☐ YES (answer next question) ☐ NO

   Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

5. **Is the patient entitled to Medicare benefits as a result of:**

   Age _____

   End Stage Renal (Kidney) Disease? ☐ YES (Long form part VI) ☐ NO

   Disability? ☐ YES (Long form part V) ☐ NO

6. **Are you currently a patient in a skilled nursing facility such as a nursing home?**
   (Long form not required, ALERT: If yes bill SNF not Medicare)

   ☐ YES ☐ NO

   I confirm that the above information if correct.

   Patient Name: _____ Date: _____

   Patient Signature: _____

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdF