Adult

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

Referring provider_____

MEMORIAL

Ear, Nose & Throat Institute

Name_____ DOB_____

Reason for visit_____

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over the counter or herbal)

Medication	Dosage	How often taken

Have you had a flu vaccine for this flu season? No Yes, date_____

If you are 65 or older have you had a pneumonia vaccine No Yes, date_____

Medical History (e.g. Diabetes, High Blood Pressure, Cancer, Sleep Apnea) PLEASE LIST THEM

_____

_____

_____

Medication Allergies LIST DRUG AND REACTION NONE_____

_____

_____

CONTINUED ON NEXT PAGE

Memorial Ear, Nose & Throat Institute

Surgical History (Year and Surgery) NONE_____

_____

_____

_____

Hospitalizations list year and reason (e.g. illness, sickness, accidents) NONE_____

_____

_____

Family History (check all that apply)

	Heart disease	Diabetes	Cancer	Stroke	Allergies	Asthma	Other
Mother							
Father							
Siblings							

Social History

Did you have a drink containing alcohol in the past year? Yes No

If yes, how often: Monthly or less 2 to 4 times per month

2 to 3 times per week 4 or more times per week

How many drinks do you have on a typical day? 1-2 3-4 5-6 7-9 10+

How often did you have 6 or more drinks on one occasion in the past year?

Never Less than monthly Weekly Daily

Smoking Status: Current Former Smoker, Quit Date:_____ Non Smoker

Current Smoker: Everyday, how many_____ Some days, how many_____

How soon after you wake up do you smoke your first cigarette?

Within 5 minutes 6-30minutes 31-60minutes after 60 minutes

If patient is a minor is he or she exposed to environmental tobacco smoke? Yes No

REVIEW OF SYSTEMS (circle all that currently apply)

weight gain weight loss fatigue fever eye pain double vison cough wheezing

chest pain palpitations shortness of breath heartburn nausea vomiting

trouble swallowing urinary frequency painful urination muscle pain muscle weakness

rashes lesions headache numbness hives hay fever eczema

MEMORIAL
EAR, NOSE & THROAT
AUTHORIZATION/REQUISTION (circle one)
FOR RELEASE OF INFORMATION
PHONE: (575) 556-1860 FAX: (575) 556-1861

SECTION A: (This section to be completed by the patient)

Patient's Name: _____ Medical Record #/ID number: _____
Date of Birth: _____ Social Security Number: _____

I hereby authorize MMC ENT to use/disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or health-care provider that my information may no longer be protected from further disclosure by state or federal law.

List the specific information that is authorized for disclosure:

Dates of Service/Encounter to be released: _____

☐ Anesthesia	☐ Consultation	☐ Discharge Sum	☐ EKG's	☐ Emergency	☐ Face sheet
☐ History/Phys	☐ Imaging Rpts	☐ Laboratory	☐ Medication	☐ Nursing	☐ Surgery/Proc
☐ Orders	☐ Outpatient	☐ Pathology	☐ Progress Nts	☐ Billing Rec	☐ UB 92
☐ Itemized Bill	☐ Acc of Discl	☐ Entire Record	☐ Other	☐ X-ray films	☐ _____

Information Released to/from: Name: _____
Address: _____
City/St/Zip _____
Phone #: _____ Fax #: _____

SECTION B: This section to be completed by Providers if disclosure is for own purposes:

Purpose of Disclosure: _____

Facility/Practice will receive financial or "in-kind" compensation for the use/disclosure of the information described above? ☐ YES ☐ NO

SECTION C: (Patient must read and complete information in this section)

- I understand my health care will not be affected if I do not sign this form.
- I understand that this authorization will expire on _____ (date) or _____ (event).
- I understand that I may revoke this authorization at any time by notifying MMC ENT in writing, except to the extent that has already taken in reliance of the previous authorization period.
- I understand that, if requested, I have the right to receive a copy of this authorization/request.
- I understand that if my records contain sensitive information, I may need to have my physician authorize the use or disclosure of it.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that unless restricted by individual state laws, that this information may contain information about HIV, AID, venereal disease, or mental health disorders. I understand, that the exception to this authorization applies to (in accordance with 42 CFR part 2) records containing drug/alcohol abuse or therapist psychiatric notes. These record types require a separate authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations.

Signature of Patient or Patient's Representative_____ **Date**_____

If not signed by patient, please indicate relationship: ☐ Parent or guardian of minor patient ☐ Guardian or conservator of incompetent patient ☐ Beneficiary or representative of deceased patient

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: _____