Welcome To Our Office

Patient Information

Patient's Name: ______________________________ Sex: Male Female

Date of Birth: ______________ Age: _______ Social Security Number: ________________

Mailing Address ____

City: ______________________ State: ______________ Zip Code: ____________

Physical Address ____

City: ______________________ State: ______________ Zip Code: ____________

Home Phone: ______________ Work: __________________ Cell: ______________

Employer: ____________________________ Employer's Phone: ______________

Emergency Contact: ____________________ Emergency Contact's Phone: ______________

Parent/Guardian's Information (if patient is under the age of 18)

Parent/Guardian's Name: ____________________ Relationship to Patient: ____________

Date of Birth: __________________ Social Security Number: ________________

Mailing Address ______________City: ______________ State: ______ Zip Code: ________

Physical Address ____

City: ______________________ State: ______________ Zip Code: ____________

Home Phone: ______________ Work: __________________ Cell: ______________

Employer: ____________________________ Employer's Phone: ______________

Insured's Name: ____________________________ Relationship to patient ______________

Social Security Number: ______________________ Date of Birth: ________________

Mailing Address ____

City: ______________________ State: ______________ Zip Code: ____________

Physical Address ____

City: ______________________ State: ______________ Zip Code: ____________

Referring Physician: ____________________ Primary Care Physician: ________________

Date of injury/onset: ____________________

Have you been a patient at our office before? YES NO

How did you hear about our office? ______________________________________

Are you receiving any health-related services at your home (home health nurse or aid)? YES NO

Is your injury work related? YES NO Date of injury: __________

Is your injury related to a motor vehicle accident? YES NO Date of accident: _________

What body part is being treated? ______________________________________

______________________________ ______________

Signature of Patient/Parent/Guardian Date

History & Physical

Today's Date ______________________

Name:______________________ Male/Female Age:______ Date of Birth:__________

Referring Dr.:______________________ Right/Left Hand Dominate? (Please Circle)

Primary Dr:______________________

Completely Explain Current Complaint (Indicate right or left):______________________

____

____

____

Medical History: Check to indicate all that apply to you:

____ Ulcer	____ Diverticulitis	____ Asthma
____ Chest Pain	____ High Blood Pressure	____ Cancer
____ Thyroid Disease	____ Diabetes	____ Irregular Pulse
____ Seizures	____ Heart Attack (MI)	____ Fainting Spells
____ Rheumatoid Arthritis	____ Stroke	____ Congestive Heart Failure
____ Osteoarthritis	____ Osteoporosis	____ Alcoholism
____ Currently Pregnant	____ Obesity	____ Glaucoma
____ Anesthesia Problems	____ Emphysema	____ Other

Past Surgical History: (Indicate dates and types of past surgeries) ______________________

____

____

Past Fracture/Injury History: ______________________

____

Family History: (Circle all that apply for mother/father side of the family)

1. Epilepsy	6. Stroke	11. Heart Attack
2. Diabetes	7. Alcoholism	12. Emphysema
3. Thyroid	8. Cancer	13. Other __________
4. Osteoporosis	9. Anesthesia problems	
5. Hypertension	10. Arthritis	

List all current medications you are taking: ______________________

____

____

List any medications you are allergic to with the reactions:______________________

____

Social History Occupation:______________________

Marital status (circle One) Married Single Widowed Divorced Separated

Tobacco Use: Smoke? Yes/No/Never Quit in____ Packs per day____ Years____

Chewing Tobacco Yes/No Quit in____ How much per day____ Years____

Alcohol Consumption? Yes/No____ Drinks per day/week (circle one)

History of Drug Use? Yes/No If yes, explain______________________

Currently Using (please circle) Cane Dentures Walker Crutches Wheelchair Glasses/contacts Hearing Aid Medical Braces

Physical Exam: (nurse will do this) %O2:______ Pulse:_______ Height:_____ Weight:_______

NAME: ______________________________ DATE: ________________

REVIEW OF SYSTEMS- Check all that apply to you

GENERAL	SKIN	HEAD / EYES / EARS / NOSE / THROAT
❑ Fever ❑ Chills ❑ Fainting ❑ None	❑ Nail Changes ❑ Mole ❑ Skin Rashes ❑ Skin Sores ❑ None	❑ Headaches ❑ Glaucoma ❑ Dry Eyes ❑ Dizziness ❑ Dental Problems ❑ Recurrent Infections ❑ Neck Soreness ❑ Neck Pain ❑ None
LUNGS	**HEART**	**BLOOD**
❑ Cough ❑ Shortness of Breath ❑ Wheezing ❑ None	❑ Palpitations ❑ Cold Extremities ❑ Chest Pain ❑ Blood Clots ❑ Pain in Legs when Walking ❑ None	❑ Broken Blood Vessels ❑ Easy Bruising ❑ Prolonged Bleeding ❑ Swollen Nodes ❑ None
GASTROINTESTINAL	**GENITOURINARY**	**MUSCULOSKELETAL**
❑ Nausea ❑ Vomiting ❑ Heartburn ❑ Constipation ❑ Diarrhea ❑ None	❑ Frequent Urination ❑ Urinary Burning ❑ Bed Wetting ❑ None	❑ Muscle Weakness ❑ Joint Pains ❑ Joint Swelling ❑ Joint Deformities ❑ Back Pain ❑ None
NEUROLOGICAL	**PSYCHIATRIC**	**ENDOCRINE**
❑ Seizures ❑ Loss of Sensation ❑ Paralysis ❑ Tingling/Burning/Numbness ❑ None	❑ Depression ❑ Anxiousness/Stress ❑ Alcohol Abuse ❑ Panic Attacks ❑ Drug Abuse/Addiction ❑ None	❑ Weight Gain/Loss ❑ Heat/Cold Intolerance ❑ Diabetes/High Blood Sugar ❑ None

***Please complete the following information regarding your injury*:**

(If you do not have any injury please go to the next page.)

Date injury occurred: ____

Place injury occurred: ____

Please describe briefly how injury occurred:____

____

____

____

____

____

____ ____________________

Signature of the Patient or Responsible Party Date

It is the policy of Alamogordo Orthopaedics that **24 hour cancellation** notice is required for all scheduled appointments. Any patient not giving a minimum of 24 hour notice of cancellation will be charged a $25.00 fee for the reserved appointment time. This charge is not covered by your insurance company and will be billed directly to you.

Thank you for your cooperation and understanding. Please do not hesitate to call our office with any questions or concerns. We are here to assist you (575-434-0693)

I have read and fully understand this policy:

____

(Print Please) Patient Name Date of Birth

____

Patient Signature Date

Alamogordo Orthopaedics and Sports Medicine
Financial Policy

Insurance claims (Primary and Secondary) are filed as a courtesy to our patients. Our office will normally assist you by verifying benefits/managed care requirements with your primary insurance only. Ultimately you are responsible for knowing and understanding your benefits and paying the balance of your account.

Managed Care: Co-Payment amounts are due at the time of service. If your insurance plan requires prior authorization or a referral our office will assist you in obtaining it. You are responsible for the balance of your account.

Commercial: Co-Insurance and deductible amounts are due at the time of service. We will estimate/collect any co-percentage due based upon an average of $150.00 per visit. This will be a DEPOSIT toward your out-of-pocket costs per visit. If the estimate is not enough, you will be billed for any remaining out-of-pocket expenses. If this estimate ends up being too much, you will be refunded any overpayments when your account is paid in full. If you owe towards your deductible we will collect $150.00 per visit until this is met. You are responsible for the balance of your account should our estimate be inaccurate.

Medicare: All covered services will be billed by our office directly to Medicare. IF you have a secondary or supplemental coverage, and you have provided us the necessary information, it will also be billed after Medicare has been paid. You are responsible for the 20% co-insurance, deductible and any uncovered service(s) that you choose to have provided, at the time of service. You are responsible for the balance of your account.

Medicaid/Salud: All covered services will be billed by our office directly to the appropriate Medicaid carrier. If payment denies for reasons of expired eligibility, payment in full will be due immediately. A current Medicaid card and appropriate prior authorization/referral from your primary care physician is due at the time of your appointment.

Workers' Comp: Verification of your work-related injury will be obtained by our office prior to your appointment. Claims are filed directly with your employer's insurance carrier. If the worker's compensation denies your claim, you will be responsible for the balance of your account.

Private Pay: If you have no insurance coverage, MVA, or we are unable to verify medical benefits, payment in full is due at the time of your service. We will collect $150.00 per visit as a deposit towards your account. You are responsible for the balance of your account should our estimation be inaccurate.

Litigated: If your injury is being handled by an attorney, payment in full is due at the time of service. We will collect $150.00 per visit as a deposit towards your account. You are responsible for the balance of your account should our estimation be inaccurate.

Out of Network: If our physicians are not in contract with your insurance, you will be responsible for the charges in full at the time of service.

Assignment of Insurance Benefits: I authorize my insurance company to make payment directly to Alamogordo Orthopaedics, Sports Medicine, and Podiatry for services rendered me or my insured dependent.
( ) Yes ( ) No _______ Initials

Medicare Assignment: Alamogordo Orthopaedics, Sports Medicine, and Podiatry aggress to accept the Medicare allowable amount as the full charge. I am responsible for the deductible, co-insurance, and non-covered services. My signature below represents authorization to bill Medicare for services rendered to me.
( ) Yes ( ) No _______ Initials

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sheets and have completed all answers. I certify this information is true and correct to the best of my knowledge. I agree to notify this office of any changes in my insurance status or the information given this date. I understand that failure to provide updated insurance information may result in denial of payment and will become my financial responsibility. Alamogordo Orthopaedics, Sports Medicine, and Podiatry WILL NOT BE RESPONSIBLE FOR SERVICES RENDERED THAT MAY REQUIRE PRIOR APPROVAL/AUTHORIZATION FROM PATIENT'S INSURANCE.

____
Signature of Patient, Guardian or Responsible Party

____
Date

____
Alamogordo Orthopaedics, Sports Medicine, and Podiatry

____
Date

Alamogordo Orthopaedics & Sorts Medicine, P.C.
2301 Indian wells Rd. Suite A, Alamogordo, NM 88310
159 Mescalero Trail, Suite 4, Ruidoso, NM 88345

Acknowledgement of Privacy Notice

Purpose of this Acknowledgement

This acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is pursuant to the requirements of 45 CFR §164.520(c)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Alamogordo Orthopaedics & Sports Medicine, P.C. (the "Practice") for the purposes of treating me, and as necessary in order to carry out any healthcare operations permitted in the Privacy Regulations.

2. I am aware the Practice maintains a Privacy Notice which sets for the types and uses and disclosures that the Practice is permitted to make under the Privacy regulations and sets forth in detail the in which the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice makes such use or disclosure.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Policy to the office of the Practice at the following address: 2301 Indian Wells Rd., Suite A, Alamogordo, NM 88310, Attention : Practice Compliance Director.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restriction requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my heath information (leave blank if no restrictions):____
   ____

   I understand the forgoing provisions, and wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

____ ____________________
Signature of Patient or Representative Date

____
Patient's Name (print)

____
Social Security Number

____ ____________________
Name of Personal Representative (if Applicable) Relationship to Patient

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To Be Completed By Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:
_____ Accepted _____ Denied _____ Not Applicable
______Other (explain) ____

____ ____________________
Signature of Authorized Practice Representative Date

Alamogordo Orthopaedics & Sorts Medicine, P.C.
2301 Indian wells Rd. Suite A. Alamogordo, NM 88310
159 Mescalero Trail, Suite 4, Ruidoso, NM 88345

NOTICE OF PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Purpose of Notice

Under the federal healthcare privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45CFR § 160.101 et. seq. (the "Privacy Regulations"), Alamogordo Orthopaedics and Sports Medicine, P.C. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of the Notice and make new notice provisions for all your health care information that we may maintain.

Permitted Uses and Disclosures of Your Health Information

1. Uses and Disclosures With Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of this Notice, we are permitted to use and disclose your health information for the following purposes:

   a. Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physician may disclose your health information when consulting with another physician regarding your medical condition.

   b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be release to an insurance company, third part payor or authorized entities involved in the payment of your medical bill and may include copies or portions of your record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

   c. Health Care Operations. We are permitted to use and disclose you health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing accreditation, certification, licensing or credentialing activities and for educational purposes.

2. Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations, with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such a revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

   a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

   b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

   c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

   d. Regulatory Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

   e. Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

   f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

   g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or a medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

   h. Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. Marketing. We may use or disclose your health information to make marketing communication to you, if such communication is conducted face to face, concerns, products or services of nominal value, or identifies us as the communicating party that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. Appointment Reminders. We may use and disclose health information to remind you of an appointment for treatment and medical care at our practice.

n. Other Uses and disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. Use and Disclosers to Business Associations. With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business Associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists, and third party billing companies. We require all Business Associates to protect the confidentiality of your health care information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree to such a request. If, however, we agree to the requested restriction, it is binding on us.

2. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy you own health information upon request. However, we are not required to provide you access to all the health information we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendment of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment, or healthcare operations or for other purposes without an authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. Right to Seek an Amendment of Your Health information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reason for the denial and the procedures for filing appropriate complaints and appeals.

5. Right to an Accounting of disclosure of your health Information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request; provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003. The accounting will not include disclosures related to treatment, payment or health care operations, disclosure made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14, 2003 compliance deadline under the Privacy Regulations. The accounting of disclosures shall include date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. Right to Revoke Your Authorization. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

8. Right to receive Copy of this Notice. You have the right to receive a copy of this Notice.

Contact Information and how to Report a Privacy rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 575-434-0639 (office phone number). Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201. To file a complaint with us please contact the Compliance Officer at 575-434-0639 (office phone number). All complaints must be submitted to the Practice in writing at 2301 Indian Wells Road, Suite A, Alamogordo, NM 88310. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is April 11, 2003.