FARMINGTON FAMILY PRACTICE

Patient Registration

PATIENT ID# **PLEASE PRINT**

PATIENT INFORMATION:

LAST NAME	FIRST NAME & INITIAL		DATE OF BIRTH
MAILING ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	MARRIED/SINGLE/OTHER, SPECIFY	
SOCIAL SECURITY #	MALE/FEMALE	PRIMARY CARE PHYSICIAN	
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #	

RESPONSIBLE PARTY INFORMATION:

LAST NAME	FIRST NAME & INITIAL		DATE OF BIRTH
MAILING ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	MARRIED/SINGLE/OTHER, SPECIFY	
SOCIAL SECURITY #	MALE/FEMALE	PRIMARY CARE PHYSICIAN	
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #	

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Farmington Family Practice to release any information acquired in the course of my treatment that is necessary for the referral process and to process claims.

X

Signature (Patient or Responsible Party) Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Farmington Family Practice of any medical benefits otherwise payable to me.

X

Signature (Patient or Responsible Party) Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE: I have received a copy of Farmington Family Practice's "Notice of Privacy Practices".

X

Signature (Patient or Responsible Party) Date

Adult History Form

Patient Name: _____ **Today's Date:** _____

What is the main reason you are seeing the doctor today? _____

_____

Medications: (Please list any prescriptions, over the counter products, supplements, and herbal remedies)

_____

_____

Allergies: _____

Medical History:

- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Venereal Disease
- ☐ Other: _____

_____

_____

Surgeries/Hospitalizations:

Year	For What?
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

☐ Married ☐ Single ☐ Divorced or separated

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How long? _____

Do you use smokeless tobacco? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No If yes, how much? _____ How often? _____

Family History:

Father: ☐ Living ☐ Deceased Medical Problems: _____

Mother: ☐ Living ☐ Deceased Medical Problems: _____

Siblings: Medical Problems: _____

~ Please complete front and back ~

Adult History Form

If you have any of the following symptoms, please check the box:

General:

- ☐ unexpected weight loss or gain
- ☐ heat or cold intolerance

Eyes, ears, nose, throat:

- ☐ vision problems
- ☐ hearing loss
- ☐ recurrent sinus problems
- ☐ dental disease

Cardiovascular:

- ☐ chest pain
- ☐ heart pounding
- ☐ other heart problems
- ☐ ankle swelling

Respiratory:

- ☐ shortness of breath
- ☐ night sweats
- ☐ other lung problems

Gastrointestinal:

- ☐ swallowing problems
- ☐ heartburn/indigestion
- ☐ nausea/vomiting
- ☐ diarrhea
- ☐ black/blood in stool
- ☐ constipation
- ☐ hemorrhoids

Women:

Number of times pregnant? _____

Number of deliveries? _____

Miscarriages/abortions _____

Last menstrual cycle _____

Method of contraception _____

Last pap exam _____

Last mammogram _____

- ☐ abnormal pap smear
- ☐ abnormal menstrual bleeding
- ☐ sexual problems/painful intercourse

Skin:

- ☐ worrisome lumps or sores
- ☐ rash

Musculoskeletal:

- ☐ swollen or painful joints
- ☐ back problems
- ☐ leg cramps

Neurological/Psychological:

- ☐ headaches
- ☐ dizziness
- ☐ sadness/crying/depression
- ☐ anxiety/worries

Urinary:

- ☐ blood in the urine
- ☐ trouble controlling urination
- ☐ straining to urinate

Other:

- ☐ thyroid problems
- ☐ allergy problems
- ☐ easy bruising/bleeding

Men:

- ☐ lump on or around testicle
- ☐ sexual problems

PEDIATRIC HISTORY FORM

Childs Name: _____ Age: _____ DOB: _____ Today's Date: _____

Why is your child here today? _____

Birth History:

☐ Abnormal pregnancy? How? _____
☐ Abnormal birth? How? _____
How many days did baby stay in hospital when born? _____
☐ C-Section
☐ Early birth? How early? _____
Birth weight: _____
Birth length: _____

Growth and Development:

Problem with:
☐ Sitting
☐ Crawling
☐ Walking
☐ Toilet training
☐ Other: _____

Discipline or behavior problem:
☐ School problem: _____
☐ Behavior problem: _____
☐ Special Ed: _____
☐ Other: _____

Past Medical History:

Problem with:
☐ Sleeping
☐ Bed wetting
☐ Growth
☐ Nightmares

Diet:
☐ Nursed
☐ Bottle Fed

Has your child had all recommended shots?
☐ Yes ☐ No If no, explain:

_____
_____

Medications: Is your child taking any now?
☐ No
☐ Yes Please list what is being taken:

_____
_____
_____

Has your child had any:

☐ Hospitalizations: When, Where, Why?

_____
_____

☐ Surgery:

_____
_____

Serious Injuries: When, Where, Why?

_____
_____

☐ Allergic Reactions: Describe reaction and Cause

_____
_____

Family History:

Father: Living ☐ Yes ☐ No
If living, health: _____
Living at home? ☐ Yes ☐ No
Mother: Living ☐ Yes ☐ No
If living, health: _____
Living at home? ☐ Yes ☐ No
Brothers/Sisters: ☐ Yes ☐ No
How Many? _____
Healthy? ☐ Yes ☐ No

Any family history of:

☐ Diabetes ☐ Allergies
☐ Convulsions ☐ Heart Problems
☐ TB ☐ Cancer
☐ Other: _____

General:

Has your child had any unusual problems with the following?

☐ Head ☐ Eyes
☐ Ears/Nose/Throat ☐ Chest/Heart/Lungs
☐ Stomach ☐ Kidneys
☐ Bladder ☐ Bones/Muscles/Joints
☐ Skin ☐ Blood
☐ Other: _____

Any special comments about your child?

_____
_____
_____
_____
_____

PEDIATRIC HISTORY FORM

SAN JUAN MEDICAL GROUP, P.C.
CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby authorize San Juan Medical Group, P.C. to release the following protected health information: Follow-up Appointments, Test Results, or other information at the discretion of my Health Care Provider in the following manner:

Home/Cell or Office Telephone Answering Machines YES or NO

Mail Service YES or NO

Email Service _____ YES or NO

To Authorized Person YES or NO

I hereby authorize San Juan Medical Group, P.C. to release my protected health information to the following person/persons: (i.e. Family, Friends over the age of 18 yrs)

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

I understand that I have the right to revoke this authorization, in writing, at any time to the Privacy Office of San Juan Medical Group, P.C.

Protected Health Information will be limited to Minimum Necessary Standards as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature Date

_____

Relationship (if signing for a minor)

San Juan Medical Group, P.C.

To inform you of our financial policy, please review the sections below.

Patient without Insurance (Private Pay)
Payment in full is expected at the time of each patient visit.

Patient with Insurance
You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by the insurance company. **Co-pays, coinsurance and deductibles are expected at the time of service.** Any remaining patient balance should be paid within one month of notice from the insurance company. If you or your insurance carrier makes payment exceeding your balance, a refund will be issued.

Worker's Compensation
You may be covered by workers' compensation insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that you were injured at work**. If we are unable to obtain payment, the charges for the services rendered will be your responsibility**. Please give all information needed for billing.

Personal Injury (Third Party Liability/MVA)
If you are a personal injury patient, **payment in full is expected at time of service**. It will be your responsibility to get reimbursement from your insurance company.

Medicare
Our office will submit your charges to Medicare and your secondary insurance. **You are responsible for deductibles, coinsurance, and any non-covered services**.

Medicaid/Salud
Eligibility and primary care physician will be verified each visit**. If we are unable to establish eligibility, the visit will be self-pay and payment will be expected in full at time of service**.

All Accounts
NSF checks are collected through Automated Recovery Systems. Collections are processed through Automated Recovery Systems. **Patient balances over 60 days may be subject to collections and discharge from the practice**.

I have read and agree to the Financial Policy.

Signature (Patient or Responsible Party) Date

San Juan Medical Group, P.C.

E-Prescribing Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

• **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

• **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that San Juan Medical Group, P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to San Juan Medical Group, P.C. to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient's Date of Birth

_____ _____

Signature of Patient or Guardian

SAN JUAN MEDICAL GROUP, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (505) 327-4867, or by requesting one at San Juan Medical Group, 622 W. Maple Suite B, Farmington, NM.

_____ _____

(Date) (Signature)

_____

(Print or Type Name)

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____

(Signature) (Relationship)

Notice Of Privacy Practices

SAN JUAN MEDICAL GROUP, P.C.

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.

If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law II also describes your rights to access and control your protected health Information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past. Present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any lime. The new notice will be effective for all protected health formation that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are Involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice without your prior authorization.

Following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI protected. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

In addition, we may disclose your PHl from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to

your physician.

Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health Insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example: we may disclose your PHI to medical school students that see patients al our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "business associates· that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Other Permitted and Requited Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made In compliance With the law and will be limited to the relevant requirements of the law you will be notified, as required by law, any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this Information Include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI lo a public health authority that IS authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such Information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products: to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any Judicial or administrative proceeding, in response to an order of a court or administrative tribunal ("to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law. (2) limited Information requests for identification and location purposes, (3) pertaining to victims of a crime. (4) suspicion that death has occurred as a result of criminal conduct. (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for Identification purposes, deter· mining cause of death or for the coroner or medical examiner to perform other duties authorized by taw We may also disclose PHI lo a funeral director, as authorized by taw, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent With applicable federal and state laws, we may disclose your PHI. If we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to Identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities: (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority II you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, Including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with

workers' compensation laws and other similar legality established programs.

Inmates: We may use or disclose your PHI if you are an Inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are *not* present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: ·Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that

prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer's if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a written request to our Privacy Officer's.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to receive confidential communications about your own health Information by alternative means or at alternative locations. This means that you may, for example, designate that we contact you only al work rather than at home. To request communications via alternative means or at alternative locations, you must submit a written request to the Contact listed on the final page of this Notice. All reasonable requests will be granted.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this Information. In cel1aln cases, we may deny your request for an amendment. Your request may be denied If the information in question: was not created by us (unless you show that the original source of the Information is no longer available to seek amendment from), is not part of our records, is not the type of information that would be available for you for inspection or copying (for example, psychotherapy notes), or is accurate and complete. If your request to amend your health information is denied, you may submit a written statement disagreeing with the denial; which we will keep on file and distribute with all future disclosures of the information to which it relates. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment. payment of health care operations, (ii) disclosures made to you, (iii) disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes; (v) disclosures to correctional institutions or law enforcement officials who had you In custody at the lime of disclosure, (vi) disclosures that occurred prior to April 14, 2003, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are pal1

of a limited data set, (ix) disclosures that are Incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure, To request an accounting of disclosures, submit a written request to the Privacy Officer's.

3, Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer's at (505) 327·4867 for further Information about the complaint process.

This notice was published and becomes effective on April 14.2003.

Contact: **Privacy Officer's**
San Juan Medical Group, P.C.
622 W. Maple Ste. B Farmington, New Mexico 87401
(505) 327-4867