Las Cruces Orthopaedic Associates

Today's Date: _____ Were you referred by a doctor? Please List:_____

Patient Name: _____ Insurance Carrier: _____

Address: _____

Age:_____ Sex:_____ Height:_____ Weight:_____ Marital Status: _____

Employer: _____ Occupation: _____

Nearest Relative or Emergency Contact: _____ Phone #: _____

What are you being seen for today? _____ Date of Injury? _____

Have you had X-Rays on this body part? NO YES, where: _____

Did you bring the films with you today? NO YES

Have you had an MRI on this body part? NO YES, where: _____

Did you bring the films with you today? NO YES

Health History -Answer YES or NO

_____ Heart Disease/MI
_____ Pacemaker
_____ Hepatitis/HIV/AIDS
_____ Kidney Disease
_____ Seizures/Epilepsy
_____ Asthma
_____ High Blood Pressure
_____ Ulcers/ Heartburn
_____ Diabetes
_____ Stroke
_____Cancer – Type: _____
Other: _____

Medications Currently Taking: _____

Are you taking any anti- coagulants? NO YES (i.e Coumadin/Plavix/Aspirin)

PREVIOUS SURGERIES: _____

_____

Allergies to Medications: _____

_____

Do You Smoke? NO YES How Much? _____

Do you drink Alcohol? NO YES How Often? _____

Do you exercise or play sports? _____

Las Cruces Orthopaedic Associates

PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE INT.
ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	EMAIL
EMPLOYER	OCCUPATION	WORK PHONE
SOCIAL SECURITY #	MARITAL STATUS (CIRCLE ONE) M S D W	SEX / D.O.B / AGE

RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST	MIDDLE INT.
ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	
RELATION SHIP TO PATIENT		

WHO SENT YOU HERE

☐ PHYSICAN (FAMILY PHYSICAN- YES/NO)
FULL NAME:_____

☐ OTHER:(please circle all that apply)
FRIEND RELATIVE INTERNET

FAMILY PHYSICAN:

EMERGENCY CONTACT

LAST NAME	FIRST NAME
HOME PHONE	CELL PHONE
RELATIONSHIP	

INSURANCE INFORMATION

Please provide us with a copy of your insurance card

INSURANCE COMPANY NAME (PRIMARY)	ADDRESS
INSURED NAME	I.D. NUMBER
EMPLOYER	GROUP NUMBER

INSURANCE COMPANY (SECONDARY)	ADDRESS
INSURED'S NAME	I.D. NUMBER
EMPLOYER	GROUP NUMBER

PREFERRED FORM OF COMMUNICATION

☐ CELL PHONE- SEND A TEXT WITH APPT INFO? YES NO ☐ EMAIL ☐ HOME PHONE

I authorize Las Cruces Orthopaedic Associates to release medical information to my insurance company(ies) and authorize my insurance company(ies) to pay medical benefits to Las Cruces Orthopaedic Associates for services rendered.

Signature of Responsible Party:_____ Date:_____

PLEASE COMPLETE ENTIRE FORM, SIGN & DATE

PHI Authorization and Disclosures

You have a right to request certain restriction on the uses and disclosures of your protected health information (PHI) and to request confidential communication or alternate communication methods. LCOA will release information only by the authorized means you have chosen, unless release is otherwise required/authorized by law. LCOA will take reasonable steps to limit the use and disclosure of, and requests for PHI to the minimum necessary for the treatment, payment and/or health care operations.

I wish to be contacted in the following manner (s): (check all that apply:)

	Home Telephone _____		**Cell Phone _____**
	OK to leave message with detailed information		OK to leave information with _____ (specify the name of the person(s)
	OK to leave message identifying LCOA and with call-back number only.		
	Work Phone _____		OK to leave message with detailed information
	OK to leave message identifying LCOA and with call-back number only.		OK to mail information to my home address (if necessary)
	OK to fax information to _____		

I authorize the following individual(s) to receive my protected health information:

Name	**Relationship to Patient**

I understand I have the right to review and/or request a copy of LCOA"s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that may occur and describes my rights and LCOA's duties with respect to my PHI.

_____ _____
Patient signature Date

_____ _____
Signature/identify on behalf of patient/relationship Date

_____ __
Signature/identify on behalf of patient/relationship Date

Las Cruces Orthopaedic Associates

Cancellation Policy

In order to ensure effective scheduling and patient flow, LCOA requires a 24 hour cancellation notice for all scheduled appointments. A $50.00 charge will be billed directly to you if you cancel a scheduled appointment with less than 24 hour notice without the presence of an emergency that could not be avoided. The determination of an "emergency" shall be at the sole discretion of LCOA.

LCOA will not bill your insurance company for this charge.

Thank you for your cooperation and understanding. Feel free to call out office anytime with questions or concerns. 575-525-3535.

I have read and fully understand this policy:

_____	_____
Print Name of Patient	Date
_____	_____
Signature of Patient	Date of Birth
_____	_____
LCOA Representative	Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I _____consent to the use or disclosure of my protected health information (PHI) by Las Cruces Orthopaedic Associates (LCOA) for the following purposes:

- Diagnosing or providing treatment to me;
- Obtaining payment for the cost of my treatment;
- Conducting the operations of LCOA.

I understand that my diagnosis or treatment by LCOA may be conditioned upon my consent as evidenced by my signature of this document.

Definition of "Protected Health Information": means health information , including demographic information collected from me as well as that created or received by my physician, another healthcare provider, my employer, or a healthcare clearinghouse. PHI applies to my past, present, or future physical and/or mental health condition and identifies me, or for which there is a reasonable basis to believe the information may identify me.

I understand I have the right to review and/or request a copy of LCOA"s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that may occur and describes my rights and LCOA's duties with respect to my PHI.

I _____ (print or type name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I give LCOA and its designees permission to use my information as described in the LCOA Notice of Privacy Practices.

_____ Patient Initials

_____ _____
Patient signature Date

_____ _____
Signature/identify on behalf of patient/relationship Date

_____ __
Signature/identify on behalf of patient/relationship Date

Financial Policy

Patients with Private Insurance Coverage (s)

It is the policy of LCOA to bill your primary insurance company as a courtesy to you for all services, however, you remain responsible for the entire bill for services provided. You are required to pay the estimated patient portion of the bill at the time of service. Your primary insurance company will be billed and we will not bill you for the estimated insurance payment for a period of 60 days. If your insurance does not remit payment for the services rendered within 60 days, you will be billed and should remit that payment to us immediately. If we receive any payment in excess of the estimated balance due from your insurance company, we will promptly refund the excess amount to you.

Patients with and HMO/PPO Insurance Plan

Patient copayments are due at the time of service. If your insurance plan requires a referral or authorization, you must present this at the time of service along with your insurance identification card. Payment for any non-covered services is due at the time of service.

Patients Self-Paying for Services

All self-paying patients are required to pay for services rendered at the time of service unless other arrangements have been made.

Patients with Medicaid or Workers' Compensation Claims

LCOA will bill all services directly. No payment will be expected from you unless the services are denied for reasons of expired Medicaid eligibility. Proof of Medicaid eligibility is required at the time of service.

Patients with a Workers' Compensation Claim

LCOA will bill all services directly. No payment will be expected from you unless the services are denied by Workers' Compensation. You are required to present your regular insurance card at the time of service and a Workers' Compensation claim will not be filed for you without this information.

Patients with Medicare

LCOA is a participating Medicare provider; therefore all covered services will be billed to Medicare on your behalf. You are required to pay only the patient coinsurance and/or deductible amount(s).

I have read and understand this Financial Policy:

_____ _____

Print Name of Patient Date

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

LCOA Representative Date

Las Cruces Orthopaedic Associates

Insurance Billing Information

In order to bill your insurance company, we need the following information:

Date:	
Name of Cardholder:	
Social Security Number of Cardholder:	
Birth Date of Cardholder:	
Employer:	
Patient's Name:	

If there is no insurance that applies to your appointment today, please skip Numbers 1-5.

1.	What is the date of the injury?	
2.	How and where did the injury occur?	
3.	Was the injury related to your employment?	
4.	Was the injury related to an automobile/motorcycle accident?	
5.	Is there another insurance company involved in the payment of claims for this injury? If yes, please provide the following information?	
	Name of Insurance Company	
	Address:	
	Policy Holder	

_____ _____

Patient Signature Date

Las Cruces Orthopaedic Associates

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

(Pain Medication, Muscle relaxant, Sleeping Pills)

The purpose of this agreement is to protect your access to controlled substance and to protect our ability to prescribe for you. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications.

Prescriptions and bottles of medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medications and/or prescription.

1. _____I will not request or accept any controlled substance medication from any other physician or individual. All controlled substances must come from my Physician who is providing my care/treatment at LAS CRUCES ORTHOPAEDIC ASSOCIATES (LCOA). Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted to a hospital.

2. _____I understand that I may not share, sell distribute or otherwise permit others to have access to these medications. Refills will be made during REGULAR BUSINESS hours. Refills will not be made at night, holidays or weekends. Please allow 24 hours for refills.

3. _____I understand that if my medications are lost, misplaced, stolen, get wet, destroyed or otherwise no longer in my possession, they will NOT be replaced or prescription refilled.

4. _____I understand that any medical treatment is initially a trial and that continued prescriptions are contingent on evidence of benefit. Refills will not be made "If I run out early."

5. _____I understand that failure to adhere/follow these policies may result in cessation/termination of therapy with controlled substance prescribing by the physician or referral for further specialty assessment.

6. _____Unannounced Urine or Serum toxicology screens (Drug Testing) may be requested and your cooperation is MANDATORY. If you refuse, you will still be treated by the Physician, but will not have any medication/controlled substance prescribed for you.

I have read this contract and it has been explained to me by LCOA staff. In addition, I understand the consequences of violating this contract.

_____	_____
Patient Signature Date	Witness - LCOA Staff Member Date