Revised 03/2016

Rio Grande Family Medicine

NAME_____ SEX: MALE (__) FEMALE (__)
Last First Middle

BIRTH DATE: _____/_____/_____ MARITAL STATUS: S M D W STUDENT? Y N Full Time ( ) Part Time ( )

PHYSICAL ADDRESS_____

CITY/STATE_____ ZIP CODE_____

HOME PHONE _____CELL PH. #_____ SOCIAL SECURITY #_____-_____-_____

MAILING ADDRESS_____CITY/STATE_____ZIP_____

( ) ***MAILING ADDRES IS THE SAME AS PHYSCIAL ADDRESS LISTED ABOVE.***

EMPLOYER_____ WORK PH. #_____

SPOUSES NAME_____SPOUSES WORK PH#_____

(IF UNDER 18) PARENT/GUARDIAN Printed Name: _____

EMERGENCY CONTACT(if other than Parent for a minor)
Full Name: _____PH#_____

BILLING & INSURANCE INFORMATION
(Mandatory to be filled in by the patient)

(1) INSURANCE COMPANY:_____ID#_____GROUP#_____

Is the patient listed above responsible for this account? _Yes _No. If answer is no please provide the following information:

Insured's Name _____Relationship to Patient _____

Employer _____ Work # _____ SOCIAL SECURITY #_____-_____-_____

BIRTH DATE: _____/_____/_____

(2) INSURANCE COMPANY: _____ ID#_____GROUP#_____

Insured's Name _____Relationship to Patient _____

Employer _____Work # _____SOCIAL SECURITY #_____-_____-_____

BIRTH DATE:_____/_____/_____

FAMILY MEMBERS (*currently living with you over 18*)

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____

PAYMENT AGREEMENT AND CONSENT FOR TREATMENT: I authorize Rio Grande Family Medicine to furnish medical information to insurance agencies as may be requested for any illness or injury.
I authorize payment of insurance benefits directly to Rio Grande Family Medicine and promise to assist in the processing of claims for benefits. It is important that I recognize that the insurance I have is a legal contract between me and my insurance company. It is my responsibility to be aware of my insurance benefits and coverage. I acknowledge that I am ultimately responsible for payment for services rendered and agree to pay for all charges not covered by my insurance or other third party payers. All co-pays are due at time of service and are **subject to a 5.00 service fee if not paid the same day.** I certify this information is true and correct to the best of my knowledge and have completed the above information.

_____ _____
Signature DATE

Rio Grande Family Medicine

Thank you for choosing Rio Grande Family Medicine as your medical home! We are grateful to have you as a patient and look forward to treating you and your family.

To better serve you, we ask for your help in following our policies. Please read over our company policies, then sign and date below:

Your first appointment will allow enough time for you and the provider to get to know each other, in other words "get established". Please note the first appointment is ***not*** the same as a physical exam. If you or your provider requests a physical exam, we can schedule that for another day when you check out.

All new patients are required to check in 20 minutes before the appointment time. For future appointments, once you are established we require you to check in ***10 minutes*** before your scheduled appointment time.

It is very important that you tell the scheduler what you would like be seen for. If you do not let them know all that you would like to discuss at your appointment, the provider may not have enough time to cover all of your healthcare needs and will ask you to make another appointment. Please keep in mind that this is done to ensure the provider has enough time to address each of your health issues thoroughly and you receive the highest level of care. Sometimes issues that seem simple need more time than you would expect to make sure it is not more serious!

Checking in Late Policy:

We strive to address the needs of all of our patients. In order for us to be able to do this, we kindly ask that patients show up for appointments at least 10 minutes early. If you are ***7 minutes late*** for a 15 minute appointment or ***10 minutes late*** for a 30 minute appointment, we will ask you to reschedule to another time.

Cancellation Policy:

There is a $50 charge for missed/"No-Show" appointments that are cancelled the same day as scheduled for. If you need to cancel or re-schedule an appointment, please notify us at least 24 hours in advance.

Prescription Refill Policy:

If you need refills of a medication, we ask that you call your pharmacy ***first***; often times there are available refills on file with your pharmacy. We are unable to process refills at *RGFM*. Please allow up to 24 business hours (3 working days) for your pharmacy to contact our office and to have it filled by your provider. Some prescriptions require an office visit or lab work to be completed prior to giving a refill. Prescriptions refilled "as needed" will not be renewed if they are more than 12 months old without an office visit. We also may not be able to refill a prescription if follow-up appointments have not been kept. Your provider will let you know how frequently you will need to be seen for follow-up care in order to keep your prescriptions from running out. *As a general rule, patients needing a narcotic prescription for chronic pain will be referred to a pain specialist.*

Financial Responsibility Policy:

1. We will file your insurance claims to your insurance provider. Patients are required to pay for services that are not fully covered by the insurance plan. Proof of current insurance must be presented at the time of service (check-in). We cannot file claims correctly without accurate information from you. If you do not have insurance, you will need to pay the full amount of your visit due at the time the services are given.
2. Any co-payments will be collected at the time of check-in. It is your responsibility as the patient to know what your co-pays and cost-sharing amounts are, also known as the benefits of your insurance plan(s). If you have any billing questions, please contact our office at (505) 224-7400 and choose option #3. Please pay any remaining balances promptly. Unpaid balances that are 90 days past due will be subject to collection action. Patients that fail to pay within this time frame may be dismissed.
3. If you have an acute issue, please let the scheduler know when you are scheduling your annual wellness or annual physical exam. *You may be asked to schedule a separate visit to accommodate all of your healthcare needs.* If you discuss any health issues with the provider beyond what is relevant to a physical or wellness exam, you will have a co-pay at the end of your visit.
   For more information regarding what is covered and included with a wellness/ physical exam please visit our website and click on the *Preventative Services Covered under the Affordable Care Act* – www.RGFMNM.com

Medical Records Policy:

For medical records, please fax a request to (505)224-7404. Certain requests may be subject to fees depending on how soon the records are needed and the complexity of the request. Medical records will be stored for up to ten years from the last date of service before they are subject to destruction. The information in the patient's record is confidential and can only be accessed by a qualified medical provider, unless otherwise authorized by the patient in writing. Any and all requests will need to include a signed release form from the patient.

Thank you for reading our policies and choosing us as your clinic. Please print your name and sign below to verify you have read, understand, and agree to the policies above:

_____

Name of Patient (PLEASE PRINT) Date

_____

Signature of Patient or Guarding (if signing for a minor) Date

RIO GRANDE FAMILY MEDICINE
AUTHORIZATION FOR *REQUEST OF MEDICAL AND PSYCHIATRIC RECORDS* AND INFORMATION

I hereby authorize Rio Grande Family medicine to, at any time, use a facsimile process or mail to request my medical records from a physician I have previously seen.

_____
Full Name of Provider/Facility, complete address and phone number or fax number

Specific Date Range of Requested Medical Records:_____
Patient's Full Name:_____
Date of Birth of Patient:_____

In addition, it is specifically acknowledged by_____
(PATIENT, Parent/Guardian or Personal Representative)

that such medical and/or psychiatric records and/or any other similar documentary/tangible materials may include and/or contain reference to any or all of the following subjects:

*the drug, alcohol, and/or substance abuse history, if any of PATIENT;
Name of Treatment Facility:_____ Today's Date:_____

*the emotional condition, mental health and/or psychological/psychiatric history, if any of PATIENT;
Name of Treatment Facility:_____ Today's Date:_____

*any history of Human Immunodeficiency Virus (H.I.V.) infection/testing results and/or Acquired Immunodeficiency Syndrome (A.I.D.S.), if any, in the case of PATIENT.
Name of Treatment Facility:_____ Today's Date:_____

This authorization shall remain in effect until actual receipt by the HEALTH CARE PROVIDER of a ***written notice*** from PATIENT which specifically withdraws and terminates the effect of this authorization, and a photocopy of this fully-executed authorization shall be considered as effective and valid as the original and shall be honored by those to whom it is presented. This authorization shall promptly be made a part of the PATIENT'S permanent medical/psychological records and a copy of this authorization shall accompany the copies of said confidential records, materials and/or information released by the HEALTH CARE PROVIDER to the above-named person(s), party(ties) and/or entity(ties).

TO THOSE RECEIVING CONFIDENTIAL RECORDS, MATERIALS AND/OR INFORMATION PURSUANT TO THIS AUTHORIZATION:

This information is released subject to the terms of Section 24-2B-7 N.M.S.A. (1978 as amended), and this Authorization to request records, documentary/tangible materials and information is subject to the following statement.

State law prohibits you from making any further disclosures of such information without specific written consent of the person to whom the information pertains or as otherwise permitted by state law.

_____
DATE

X_____
SIGNATURE OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE

Rio Grande Family Medicine

Privacy Policy Acknowledgement

I understand and acknowledge that I have received the Rio Grande Family Medicine Notice of Privacy Policy and have been offered a paper copy. I understand that if I have question regarding the privacy of my health information or want further explanation of this notice I should contact Rio Grande Family Medicine at (505) 224-7400.

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

****DUE TO THE HIPPA REGULATION WE MAY ONLY SPEAK TO OTHER HEALTHCARE PROVIDERS REGARDING YOU OR YOUR CONDITION, UNLESS DIRECTED BY YOU.****

I authorize the removal of restrictions for the following persons:

1. _____
2. _____
3. _____

Signature:_____ Date: _____

Print Name: _____

Our company policy requires that **we cannot leave a message** unless you an identifier on your phone.

Please advise us of your preferred method of contact for an appointment confirmations, treatment, and billing information: **(choose one method along with phone number)**

[ ] Home Phone

[ ] Cell phone Ph. #_____

[ ] Work phone

I authorize being contacted by Albuquerque Clinical Trials in regards to participate in future pharmaceutical clinical trials on behalf of Rio Grande Family Medicine. I also acknowledge that I revoke this authorization at any future date by signing a declination of services.

Print Name:_____

Signature: _____ Date: _____

Rio Grande Family Medicine Financial Policy (initial each one)

____There is a $40.00 service charge on all returned checks

____There is a $50.00 charge for appointments not cancelled within 24 hours

Medical History Questionnaire

Surgery History

Surgeries	Surgeon	Hospitalization	Date

Married Single Divorced Widow Partner Occupation:_____

Have you had a bone density: N Y If yes, When:_____ Normal Abnormal

Last colonoscopy:_____ Where:_____

How often do you exercise:_____Doing what:_____

Do you drink/how much: Coffee Tea Soda

How much alcohol do you drink? Beer, Wine, Liquior Per day_____

Per week:_____

Do/did you smoke? N Y cigarettes cigars pipes chewing tobacco dipping tobacco

When did you quit:_____ How many years:_____ How much per day:_____

Vaccines: _____

Female Patients:

Last Mammogram:_____ Where:_____ Normal Abnormal

Last Pap:_____ Where:_____ Normal Abnormal

Last Menstrual period:_____ Pregnancies:___Births:___

Contraception: N Y What:_____

Menopause: N Y Year:____ Do you/did you take hormones? N Y Problems: N Y

If yes, explain_____

Do you see any specialists? Yes,
Explain_____
_____
_____

Have you been diagnosed with any new conditions Yes or No

If Yes,
Explain_____
_____
_____
_____

Family History

Relative	Living: Yes or No	Health problem
Mother		
Father		
Son		
Daughter		
Brother		
Sister		
Mat Grandmother		
Pat Grandmother		
Mat Grandfather		
Pat Grandfather		

Rio Grande
Family Medicine

Medications

Name: Date of Birth:

Medication	Dosage & Frequency	Indication

Allergies	Reaction