Alamogordo Internal Medicine P.C.
2751 N. Scenic Drive
Alamogordo, NM 88310

Registration (PLEASE PRINT)
Date_____ Home Phone_____

Patient Name_____

Street Address_____

City_____ State_____ Zip_____

Sex: M F Age_____ Birth date_____

Patient employed by _____

Business Address _____

Business Phone_____

Spouse (or responsible party) name_____ Birth Date_____

Business Name and Address_____ Phone_____

Who is responsible for this account?_____

Relationship to Patient_____

Social Security #_____ Spouse Social Security #_____

Do you have medical insurance? No_____ Yes_____ if yes,

Name of Primary Insurer_____

Contract/Subscriber ID #_____

Name of Secondary Insurer_____

In case of emergency, who should be notified? _____ Phone_____

How did you learn of our practice?_____

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Dr._____ all medical benefits, if any, otherwise payable to me for service rendered. I am financially responsible for all charges, whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____ Date_____

Medicare Authorization

I request that payment of authorized Medicare benefits be paid to me or on my behalf to Dr._____ for any services furnished by him/her. I authorize any holder of medical information about me to release to health care financing administration and its agents any information needed to determine these benefits. I understand signature authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the doctor agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible.

Signature_____Date_____

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information (PHI) by the Alamogordo Internal Medicine (AIM) Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of the AIM Clinic. I understand that diagnosis or treatment of me by the physicians may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations of this practice. AIM Clinic is not required to agree to the restriction I request; however the restriction is binding on the part of AIM clinic and the physician and staff.

I have the right to revoke this consent, in writing, at anytime, except to the extent that the physicians of AIM Clinic have taken action in reliance to this consent.

My PHI means health information, including any demographic information collected from me or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearing house. This PHI relates to my past, present or future physical or mental condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the AIM Clinic's Notice of Privacy Practices prior to signing this document. The AIM Clinic's Notice of Privacy Practice has been provided to me. This document describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the AIM Clinic. The notice of Privacy Practices describes my rights and the AIM Clinic duties with respect to my PHI.

The AIM Clinic reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Print Name _____ Signature _____ Date _____

Alamogordo Internal Medicine, P.C
Financial Policy

Our office is committed to providing you the best possible service for your healthcare needs. We feel it is important that our patients are aware of the financial policies of our practice. If you have medical insurance, we want to help you receive your maximum allowable benefit. In order to achieve this, we would like your assistance and your understanding of our payment policies.

Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards. We require any co-pay or deductible be paid at the time of service. Returned checks will be subject to a $25.00 reprocessing fee. Balances over 90 days will be sent to collections.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit; therefore we must emphasize that as medical providers our relationship is with you, not your insurance company. While the filing of insurance claims for services is a courtesy we extend to our patients, all charges are your responsibility from the time services rendered. We realize temporary financial problems may affect timely payment of your account; we encourage you to contact us promptly for assistance in management of payments. If you are a private payer, payment is due at time of service.

Cases involving third-party payments or litigation

We are sometimes asked to evaluate and/or treat a patient relative to possible injury when a legal action may be pending or contemplated. In such cases: the fee for the evaluation or treatment is due and payable at the time the service is rendered, NOT following the resolutions of the case or claim. We consider the patient, not the attorney or third-party to be all fees incurred.

Your signature below acknowledges that you have read this financial policy and will comply with the terms. Your signature also authorizes us to release your medical records to your insurance company.

Because we are here to help you, if you have any questions about the information or are uncertain regarding insurance coverage, please do not hesitate to ask

Signature _____ Date _____

ALAMOGORDO INTERNAL MEDICINE P.C.
PATIENT HEALTH HISTORY

Patient name _____ Date_____

Age___ Birth date _____Date of last physical exam_____

Reason for today's visit _____

Do you have an advanced directive? Yes_____ No_____
Would you like information on advanced directive? Yes_____ No_____

Have you ever had or currently have a lawsuit pending against a medical practitioner? Yes_____ No_____

Past Medical History
Circle any of the following conditions:

Diabetes
Bleeding Disorder
High Blood Pressure
Asthma
COPD
Cancer
Liver Disease
Stroke
Heart Attack
Bypass/Stent
Murmur
Thyroid
Kidney Disease
Motor Vehicle Accident

Past Medical/Surgeries

Family History
Circle if any member has any of the following conditions, and their relationships to you:

Diabetes Stroke Heart Disease Heart Attack High Blood Pressure Cancer

Health Habits
Circle any that you have

Tobacco Smoking/Chewing Alcohol Beer Illicit Drug Use

CURRENT MEDICATIONS

Please list all current medications you are taking

Allergies

Please list all allergies/reactions to medications

Marital Status: Single Married Divorced Widowed

Number of Children?_____

Tobacco use? Yes No Former

Alcohol use? Yes No Former

What is your level of activity?Very Active Somewhat Active Inactive

Do you have diabetes? Yes or No

Do you take chronic medication (daily medication)? Yes or No

Race: Pacific Islander White African American Hispanic Asian
Other Refused

Primary Language_____

Last Tetanus Vaccination _____
Last Pneumonia Vaccination_____
Last Flu Vaccination _____

Women Only

Date of your last mammogram:_____