

Medical Associates of Northern New Mexico, PA

3917 West Road, Suite A, Los Alamos, NM -87544-

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URL: www.manm.com

PATIENT INFORMATION

In order to serve you properly, it is important to have the following information. Please Print. All information will be confidential.

Today's Date: _____ (mm/dd/yy)

Patient's Name: _____ SSN: _____ - _____ - _____

Email Address: _____

Male _____ Female _____ Date of Birth: _____ Main Contact Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address (if different): _____ City: _____ State: _____ Zip: _____

Make Appropriate Selection: Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Patient's Employer: _____ Work Phone: _____

Spouse's OR Parent's Name: _____ Employer: _____ Home Phone: _____

Referring MD: _____ PCP: _____

Emergency Contact: _____ Relationship: _____ Home Phone: _____

RESPONSIBLE PARTY (If different from patient)

Name of Person Responsible for This Account: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ - _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address (if different): _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Home Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ Group #: _____ ID #: _____

Address of Insurance Company: _____

Check here if all the information below is the same as the "RESPONSIBLE PARTY".

Name of Insured: _____ Relationship to Patient: _____ DOB: _____ SSN: _____

Name of Employer: _____ Phone: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO If "Yes", please complete the following.

Insurance Company: _____ Group #: _____ ID #: _____

Address of Insurance Company: _____

Name of Insured: _____ Relationship to Patient: _____ DOB: _____ SSN: _____

Name of Employer: _____ Phone: _____

PLEASE LIST MEDICATION ALLERGIES: _____

WHAT KIND OF REACTIONS? _____

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also authorize payment of insurance benefits directly to Medical Associates of Northern New Mexico.

Signature of Patient, or Parent, if Minor

Medical Associates of Northern New Mexico
Patient Personal History

Confidential Record: Information contained will not be released except when you authorize us to do so

Name: _____ **MR#** _____
Last **First** **MI** **Nickname** _____
Date _____

My last complete physical exam was done in (year) _____ by _____

Family History:

Family History	Year of Birth	Illnesses	Age at Death	Cause of Death
Father				
Mother				
Brothers/Sisters				
#1 M or F				
#2 M or F				
#3 M or F				
#4 M or F				
#5 M or F				
Children				
#1 M or F				
#2 M or F				
#3 M or F				
#4 M or F				
#5 M or F				

More siblings/children listed on attached sheet

Check if you or any close blood relatives (other than those mentioned above) have or had any of the following:

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Unusual bleeding after surgery or dental work	<input type="checkbox"/> Depression/Nervous breakdown
<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stomach or intestinal problems	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Cancer/tumor		<input type="checkbox"/> HIV Infection

Past Medical History:

Surgeries/Hospitalizations (women exclude normal deliveries): _____

List any other serious illnesses or injuries you have had: _____

Patient Personal History (cont'd)

More medications listed on attached sheet

Medication allergies:

Potential areas for stress:

Where do you work? What is your occupation?

Who lives in your household?

Any marital problems?

Any financial problems?

Does anyone in your household have drug or alcohol problems?

What are your biggest life stressors at this time?

Recreation:

What do you do for recreation/relaxation?

Habits/Risk Factors:

<p>Tobacco use:</p> <p><input type="checkbox"/> Age started _____ Age stopped _____</p> <p><input type="checkbox"/> Cigarettes _____ Cigars _____ Pipe _____</p> <p><input type="checkbox"/> Smokeless tobacco/snuff</p> <p>How long</p>	<p>Coffee/Tea</p> <p><input type="checkbox"/> Cups per day _____</p> <p><input type="checkbox"/> Caffeinated</p> <p><input type="checkbox"/> Decaffeinated</p>
<p>Alcohol use:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Seldom</p> <p><input type="checkbox"/> Regularly</p> <p><input type="checkbox"/> Occasionally excessive</p> <p><input type="checkbox"/> Have sought help</p>	<p>Drug use:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Seldom</p> <p><input type="checkbox"/> Regularly</p> <p><input type="checkbox"/> Occasionally excessive</p> <p><input type="checkbox"/> Have sought help</p>
<p>Sexuality:</p> <p><input type="checkbox"/> Heterosexual (straight)</p> <p><input type="checkbox"/> Homosexual (gay)</p> <p><input type="checkbox"/> Bisexual (both)</p>	<p>Sexuality:</p> <p><input type="checkbox"/> Multiple sexual partners in last year</p> <p><input type="checkbox"/> Sexual partners who had Hepatitis B, were intravenous drug users, or prostitutes</p>

Habits/Risk Factors (cont'd)

<p>Safety:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Use seat belts in vehicles <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Carbon monoxide detectors in home 	<p>Exercise:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exercise regularly <input type="checkbox"/> _____ time per week
<p>Work History:</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of working in mines <input type="checkbox"/> Current or past exposure to a lot of dust, asbestos, or chemicals 	

REVIEW OF SYSTEMS: Please check any condition you are experiencing or have experienced.

<p>Constitutional:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Change in appetite <input type="checkbox"/> Sleeping difficulty <input type="checkbox"/> Fevers/sweats <input type="checkbox"/> Loss of energy 	<p>Genito-urinary (GU)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Burning or pain with urination <input type="checkbox"/> Increased frequency of urination <input type="checkbox"/> How often do you get up at night to urinate? _____ times <input type="checkbox"/> Unable to control bladder <input type="checkbox"/> Blood in urine <input type="checkbox"/> Unable to start stream or weak stream <input type="checkbox"/> Any venereal/sexually transmitted disease <input type="checkbox"/> Kidney stones
<p>Skin:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes or changes in color <input type="checkbox"/> Persistent itching <input type="checkbox"/> Moles that have changed <input type="checkbox"/> Bruise easily 	<p>Musculo-skeletal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in bones or joints <input type="checkbox"/> Muscle pain <input type="checkbox"/> Joints that swell <input type="checkbox"/> Phlebitis or inflamed leg veins
<p>Eyes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of vision <input type="checkbox"/> Blurring or double vision <input type="checkbox"/> Eye pain 	<p>Endocrine:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thyroid problems
<p>Ears, Nose, Throat (ENT):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Ear pain <input type="checkbox"/> Frequent nosebleeds <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Constant nasal congestion or runniness <input type="checkbox"/> Persistent sore throat <input type="checkbox"/> Voice changes or hoarseness <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Bleeding gums 	<p>Gastrointestinal (GI):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Vomited blood or "coffee ground" material <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation or diarrhea <input type="checkbox"/> Bloody or black bowel movement <input type="checkbox"/> Changes in bowel movements <input type="checkbox"/> Pain during or after bowel movement <input type="checkbox"/> Yellow jaundice <input type="checkbox"/> Hemorrhoids
<p>Respiratory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Blood in sputum/phlegm <input type="checkbox"/> Exposure to TB <input type="checkbox"/> Positive TB test <input type="checkbox"/> Shortness of breath <ul style="list-style-type: none"> <input type="checkbox"/> Doing your usual work <input type="checkbox"/> Climbing a flight of stairs <input type="checkbox"/> Awakens you at night <input type="checkbox"/> Causes you to cough <p>Accompanied by wheezing</p>	<p>Cardiovascular:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain, tightness or heaviness in your chest <ul style="list-style-type: none"> <input type="checkbox"/> When exerting yourself <input type="checkbox"/> When upset or excited <input type="checkbox"/> Radiates down the arm <input type="checkbox"/> Disappears if you rest <input type="checkbox"/> Rapid, slow or irregular pulse <input type="checkbox"/> Sleep on more than one pillow <input type="checkbox"/> Rheumatic fever/heart murmur <input type="checkbox"/> Calf pain when walking <input type="checkbox"/> Ankle swelling

<p>Neurologic:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Recurrent headaches <input type="checkbox"/> Memory loss <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Blindness of one eye <input type="checkbox"/> Weakness in any part of your body <input type="checkbox"/> Numbness in any part of your body 	<p>Emotional:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Feel nervous often <input type="checkbox"/> Feel "down in the dumps" often <input type="checkbox"/> Worry a lot <input type="checkbox"/> Loss of interests <input type="checkbox"/> Loss of energy or ambition <input type="checkbox"/> Considered suicide <input type="checkbox"/> Rate sex life <p style="text-align: right;">Poor 1 2 3 4 5 Excellent</p>
<p>Men:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diminished sexual activity <input type="checkbox"/> Discharge from penis <input type="checkbox"/> Hernia <input type="checkbox"/> Prostate trouble 	<p>Women:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Last period _____ <input type="checkbox"/> Last Pap smear _____ <input type="checkbox"/> Last mammogram _____ <input type="checkbox"/> Diminished sexual activity <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Difficulties with periods <input type="checkbox"/> Recent vaginal discharge <input type="checkbox"/> Current method of birth control _____ <input type="checkbox"/> Number of pregnancies _____ <input type="checkbox"/> Number of miscarriages _____ <input type="checkbox"/> Bleeding after menopause <input type="checkbox"/> Hot flashes <input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain

Preventive Medicine

<p>Immunizations:</p> <p>I had my last vaccine in (please enter year):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tetanus _____ <input type="checkbox"/> Pneumonia _____ <input type="checkbox"/> Hepatitis A _____ <input type="checkbox"/> Hepatitis B _____ 	<p>Screening Exams:</p> <p>I had the following screening exams in (please enter year):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bone density _____ <input type="checkbox"/> Colonoscopy/colon cancer screening _____ <input type="checkbox"/> Prostate cancer screening (Males only) _____ <input type="checkbox"/> Dental exam _____
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Describe briefly your present medical problems and symptoms:

Patient's Signature

Date



**Medical Associates
of Northern New Mexico**

Cardiology, Nephrology, Endocrinology, Internal Medicine & Family Practice

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: _____ Date of Birth: _____
Address: _____

I have been given a copy of Medical Associates of Northern New Mexico's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Medical Associates of Northern New Mexico has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Medical Associates of Northern New Mexico web site at www.mannm.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Resident or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor-of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:

\Completed by:

Signature of Facility Representative

Date

Print Name

File original in resident's Business Office Record

Patient Name:

Patient Account #:

FINANCIAL POLICY OF MEDICAL ASSOCIATES OF NORTHERN NEW MEXICO

Financial Policy - Medical Associates of Northern New Mexico (MANNM) is committed to providing high quality medical care in a cost-effective manner. To accomplish this, we depend upon prompt payment for the services we provide.

Insurance Information: Insurance card(s) must be presented before each visit. Correct and current insurance information is required for prompt and proper payment of claims. You agree that MANNM may bill these payors and that these payors may make payments directly to MANNM, but you are primarily responsible for any charges incurred while you are a patient. MANNM will attempt to obtain prior authorizations required by insurance companies; however, patients are responsible for payment if prior authorization is approved but not paid or denied. MANNM files claims to secondary and supplemental insurance plans as a courtesy to our patients.

Payment Is Due at Time of Service: Your copays and any outstanding balances are expected to be paid at the time of service and before another appointment is scheduled. For your convenience, we accept cash, checks, and most credit cards or you may submit your payments online through your portal. A \$35.00 fee will be assessed to your account if a check is returned for non-sufficient funds.

After your visit, we will bill your insurance, and our billing office will send you a statement reflecting any remaining balance after your insurance company has paid their portion. Your payment responsibility is determined by your insurance company.

Patient Accounts: Accounts older than 60 days from the date of the first invoice are subject to a \$10.00 rebilling fee. For delinquent accounts, those past 90 days, MANNM utilizes a collection agency as allowed by law. Dismissal from the practice is mandatory once collection proceedings begin.

Out of Network Patients and Uninsured patients: If your commercial insurance carrier is not one that we participate with, you are responsible for a \$125.00 payment at the time of service. Uninsured patients are responsible for a \$125.00 payment at the time of service. MANNM offers a 20% discount to uninsured patients for bills paid in full at the time of service. Out of network and uninsured patients are billed for remaining balances and are subject to all provisions cited above.

Out of network and uninsured patients may ask for and should receive a No Surprise Act estimate.

Administrative Service Fees – Not Covered by Insurance

Many changes have taken place in the health care industry and amongst these changes is the rise in administrative costs of operating a medical practice. We value the opportunity to provide and maintain the most exceptional care. Unfortunately, this requires providing services that can no longer be absorbed by the practice. Thank you for understanding.

Cancellation/No Show Policy: Patients who are not able to keep their appointments are required to provide 48-hour notice of cancellation. Providing the required notice gives us the opportunity to schedule patients who may need to be seen urgently or from a wait list. Patients who DO NOT provide the required notification for cancellation, arrive late, or do not show up are subject to a no show/late cancellation fee of \$50 to \$150.00 based on the complexity and/or length of the scheduled visit.

Patient Name:

Patient Account #:

**FINANCIAL POLICY OF
MEDICAL ASSOCIATES OF NORTHERN NEW MEXICO**

Medical Records: Paper copies of medical records cost \$30.00 for the first 15 pages and 0.25 for every additional page.

Sports Physicals: A sports physical is \$65.00 and cannot be billed as your annual physical.

Provider Portal Consultations: If a patient contacts the provider through the portal and asks for advice, a new medication, or has a new complaint, patients are subject to a convenience portal fee of \$30.00. The patient may choose to make an appointment to avoid this fee. The patient may not contact the provider through telephone for the above issues in order to avoid this fee, and may be asked to make an appointment.

Forms: Providers may complete a form; patients are subject to a convenience form fee of \$25.00 for one page or \$40.00 for more than one page. The patient may choose to make an appointment to avoid this fee.

Patients who fail to pay the above fees for services will not be allowed to schedule future appointments until the fee is paid. Patients' accounts older than 60 days are subject to a \$10.00 rebilling fee. For delinquent accounts, those past 90 days, MANNM utilizes a collection agency as allowed by law. Dismissal from the practice is mandatory once collection proceedings begin. Patients who are dismissed are not able to come to any of the providers or the Walk in Clinic at Medical Associates of Northern New Mexico in Los Alamos.

Patient Financial Responsibility: I acknowledge full financial responsibility for services rendered by Medical Associates of Northern New Mexico. I understand that I am financially responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles, copays, and administrative fees. I understand that all payments are due at time of service and before scheduling another appointment unless a payment agreement is on file.

Consent to Treatment: Care will be provided according to your attending provider's orders. For most procedures you will be asked to sign a consent form. By agreeing to receive care, you are consenting generally to other medical treatments and orders such as x-ray examinations, laboratory tests, and minor procedures that your provider initiates. Your right to information about or refusal of any test or procedure is not altered by this agreement.

Print Name: _____

Date: _____

Signature: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Name: «FirstName» «LastName» DOB: «DOB» Acct#: «PatientAccountNumer»

Please note that this Patient-Health-Information Release Form overrides any past forms.

I hereby allow Medical Associates of Northern New Mexico to leave detailed voice messages for simple matters on (____)_____-_____, my primary phone number.

In the following boxes please list the name(s) of anyone who may contact us on your behalf regarding your medical care (ie. friend, family member, spouse, partner etc.) You may list as many people as you would like or you may leave these fields blank.

Name/ Relationship to Patient	Phone Number and/or Address (optional)	PHI Permissions Check all that apply.
		<input type="checkbox"/> Permission to speak to/ discuss medical care/ test results <input type="checkbox"/> Permission to access paper/ electronic records
		<input type="checkbox"/> Permission to speak to/ discuss medical care/ test results <input type="checkbox"/> Permission to access paper/ electronic records
		<input type="checkbox"/> Permission to speak to/ discuss medical care/ test results <input type="checkbox"/> Permission to access paper/ electronic records

I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____