New Mexico Medical

PATIENT INFORMATION & CONSENT FORM

Last Name _____ First Name _____MI _____ Male/Female
Mailing Address _____ City_____ State_____ Zip_____
Physical Address _____City_____ State _____ Zip_____
Email Address _____
Home # _____ Work # _____ Cell # _____
SS # _____/_____/_____ Birth Date _____ Driver's License # _____
Employer Name_____ Employer Phone Number _____
Emergency Contact _____ Relationship to patient_____
Emergency Contact Phone Number _____

Race:	**Ethnicity:**	**Language (Preferred)**
Caucasian/White____	Hispanic or Latino___	English_____
Black___	Not Hispanic___	Spanish_____
Native American	Mexican___	Other_____
Asian____	Other_____	
Pacific/Aleutian Islander		
Declined to Specify____		

RESPONSIBLE PARTY

(This section must be completed if patient is under the age of 18)

Name_____ DOB_____ SS # _____
Phone Number _____ Mailing Address _____
City_____ State _____ Zip_____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber Name_____
Subscriber Birth Date_____
Subscriber SS # _____/_____/_____
Phone # _____ Policy # _____ Group # _____
Secondary Insurance_____ Subscriber Name _____
Subscriber Birth Date_____
Subscriber SS # _____/_____/_____
Phone # _____ Policy # _____ Group # _____

AUTHORIZATION & AGREEMENT BY PATIENT

Please READ & SIGN the following Authorization and Assignment

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance payment. It is customary to pay for services when rendered unless arrangements are made in advance.
I hereby authorize New Mexico Medical to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to New Mexico Medical all payments for medical services rendered to myself or my dependents. I understand that I am fully responsible for any amounts not covered by my insurance.

Signature: _____ Date: _____

Relationship to Patient: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of New Mexico Medical's "**NOTICE OF PRIVACY PRACTICES**". This notice describes how New Mexico Medical may use and disclose my protected health information, and rights that I have regarding my protected health information.
I have also been offered a copy of New Mexico Medical's **"Notice of Advanced Directives"** and I have accepted or declined to fill out the Advanced Directives forms and have them included in my chart.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Relationship to Patient

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AUTHORIZATION OF ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND CONSENT FOR TREATMENT:

I hereby authorize payment directly to NEW MEXICO MEDICAL for services rendered and supplies provided by NEW MEXICO MEDICAL. I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to said Clinic. I authorize NEW MEXICO MEDICAL to release any information acquired in the course of treatment or examination. I understand that I am financially responsible to NEW MEXICO MEDICAL for charges not covered by this assignment. I authorize the release of any and all medical information necessary to process these claims and I request payment of any benefits due me or for my benefit to be made directly to NEW MEXICO MEDICAL.
I hereby authorize and consent to be treated by NEW MEXICO MEDICAL providers and staff. The undersigned consents to any X-Ray, examination, laboratory procedures, anesthesia, minor surgical procedures or any medical services rendered under the general or specific instructions of the NEW MEXICO MEDICAL physicians or providers. The undersigned recognizes that some persons furnishing professional medical services, including but not limited to radiology and pathology, may independent contractors and not employees or agents of the Clinic.

AGE OF CONSENT—WHERE MINORS ARE INVOLVED, THE FOLLOWING SHALL PREVAIL:

1) The consent of parent or legal guardian if patient is unmarried and has not yet attained the age of (18).
2) If a patient under (18) years of age is married, or has been married and such marriage has been dissolved by dissolution or annulment, then the consent of a parent or legal guardian is not required.
The undersigned hereby acknowledges that he or she has read and fully understands the foregoing, and has voluntarily executed this document. The undersigned further acknowledges that he or she is the patient, or is duly authorized by and on behalf of the patient to execute this document, and accepts its terms personally and upon the patient's behalf. The release of information set forth herein above is valid, and the assignment of benefits and financial agreement is valid and binding until final settlement of the account is received.

SIGNATURE: _____ DATE: _____
Relationship to Patient: _____

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