PATIENT INFORMATION REVISED 12/1/09

HOME PHONE________________WORK PHONE________________CELL___________________

EMAIL ADDRESS____________________ FAX NUMBER________________________________

FULL NAME:____

MAILING ADDRESS:____

CITY __________________________ STATE_________________ ZIP CODE__________________

BIRTHDATE:____________________________ SSN:_____________________________

PATIENT'S RELATIONSHIP TO INSURED: SELF ____ SPOUSE___ CHILD__ OTHER____

INSURED NAME______________________ INSURED DOB:______________________________

EMPLOYER________________________ OCCUPATION__________________________________

EMERGENCY CONTACT__________________________ PHONE ___________________________

INJURY INFORMATION

IS YOUR CONDITION RELATED TO WORK? _______________ DATE OF INJURY:____________
IS YOUR CONDITION RELATED TO AUTO ACCIDENT? _________DATE OF INJURY: ________

**IF AUTO OR WORKER'S COMP RELATED: CLM#_____________________________________
ADJUSTOR, CASE MANAGER OR ATTORNEY NAME: ___________________________________

REFERRING DOCTOR'S NAME:_______________________SURGERY?______DATE:__________
WERE X-RAYS TAKEN? ______________ DATE:___________________
PRIMARY CARE PHYSICIAN:____

PAST MEDICAL HISTORY

DO YOU HAVE HIGH BLOOD PRESSURE? YES____ NO ______
PREVIOUS SURGERIES? YES _____ NO ____ IF YES, EXPLAIN
BRIEFLY____
ARE YOU DIABETIC? YES _____ NO_______ ASTHMA? YES_____ NO_______
HEART CONDITION? YES ______NO_______ LUNG CONDITION? YES ______ NO _______
HIV POSITIVE? YES _____ NO _______ ARE YOU PREGNANT? YES _____ NO _______
ANY CONTRAINDICATIONS TO EXERCISE? YES______ NO ______ IF YES, EXPLAIN

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Santa Fe Sports Medicine & Rehab, Inc.

104 Old Las Vegas Highway
Santa Fe, NM 87505

In compliance with the Health Care Portability and Accountability Act and Health and Human Services Regulations effective April 21, 2003.

This notice describes how medical information about you may be used and disclosed and how you can get to this information. Please review it carefully.

- Medical information about you is collected, stored, and disclosed by us as part of your treatment. This information is referred to as **Protected Health Information (PHI).** If you utilize insurance or a third party payer for your therapy. You will be required to disclose your diagnosis and frequency of visits for the purpose of payment. In addition, your insurance company may require more specific information from your PHI for authorization of treatment. Claims are filed and information requested is reported by fax, electronically, or by mail. If you would like specific information required by your insurance company or payer, please let us know.
- According to the laws of the State of New Mexico, we are required to disclose your PHI without your written consent in the event that you are a danger to yourself or another or if you are involved in or report to us the abuse or neglect of a child or elderly person.
- If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process, I may have to release some of your PHI. We will only do so after trying to tell you or by consulting your attorney.
- We may be required to disclose PHI for national security reasons.
- All other uses and disclosures of your PHI will be made only with your written authorization. You may revoke, in writing, any release of information that you have signed.

A statement of your rights with respect to your PHI and how you may exercise those rights:

- You have the right to request restrictions on certain types of your PHI. We will honor your request if possible and if we do not agree with your request, we will discuss it with you.
- You have the right to receive an accounting of disclosures of PHI other than for treatment, payment, and healthcare operations.
- You have the right to review your PHI unless we think it would cause harm to you or others if that request were approved.
- You have the right to amend your PHI.
- You have the right to receive a paper copy of this notice.
- If you have any complaints with how your PHI has been handled or if you believe your privacy rights have been violated, you may speak directly with us or you may file a formal complaint with the Secretary of Health and Human Services. Your care will not be limited or any action taken against you if you complain.

A statement of my duties under this act:

- We are required by law to protect the privacy of your individually identifiable health information and to provide you with this notice.
- We are required to be abiding by the terms of this notice.
- In the event that my privacy practices or duties change, I am required to advise you of this fact with a revised notice.
- If you have any questions or would like further information about this policy, please let us know.

I have read the above information. (Sign)______________________ (Date)_____________

CANCELLATION POLICY

There is a 24 hour cancellation notice for all appointments. Any appointment cancelled with less than 24 hours notice is subject to a charge of $50. We are unable to bill your insurance company for any missed appointments.

LATE ARRIVAL POLICY

We cannot bill your insurance company for time when you are not present. Therefore when you are more than 15 minutes late for your appointment, you will be charged for the amount of time you are late at the rate of $25 per 15 minutes.

If arrangements are made between you and the practitioner, and it is possible to stay late to make up the full hour, these fees will be waived. However, if the practitioner does not have the time available to stay late, you are responsible for the time that the practitioner waited as we cannot charge this to the insurance company.

You are personally are responsible for these charges.

I have read the above policy.

Signed ______________________________________

Date _______________________