SUNRISE MEDICAL GROUP
• 117 CAMINO DE VIDA SUITE 300 •
SANTA ROSA • NEW MEXICO • 88435
(Please Print)

Today's Date:	E-mail:

PATIENT INFORMATION

Patients last name: First: Middle:	Mr. Mrs.	Miss Ms.	Marital Status (Circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Birth date: - -	Age:	Sex: M F

Mailing Address:	Social Security No.:	Home Phone No.: ( ) Cell Phone No: ( )

City	State	ZIP Code:

Occupation:	Employer:	Employer Phone No.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? Yes No

Occupation:	Employer:	Employer Address:	Employer phone no.: ( )

Is this patient covered by insurance? Yes No

Please indicate primary insurance	Pres Health Plan	Pres Salud	BCBS	Blue Salud	Molina

Lovelace Health	Lovelace Salud	Medicare	Amerigroup	Evercare	Other

Subscriber's Name:	Subscribers S.S. no:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	Self	Spouse	Child	Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:	Self	Spouse	Child	Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Santa Rosa Medical Clinic or insurance company to release any information required to process my claims.

Signature: **Date:**

FINANCIAL POLICY

SUNRISE MEDICAL GROUP
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We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. WE have prepared the material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS

(Initial)

_____I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____I understand I am responsible *at the time of service* for paying any required co-payment and deductible.

MEDICARE/SECONDARY INSURANCE

For Medicare Patients Only

_____
Medicare Number

_____I authorize Santa Rosa Medical Clinic to release any information needed to Center for Medicare and Medicaid Service (CMS), its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to Santa Rosa Medical Clinic. I understand it is mandatory to notify the health care provider of any other insurance I may have, that may be responsible for paying my treatment. I understand that I am responsible for any services not covered by my insurance(s), such as my yearly deductible of 130.00 (one hundred thirty dollars) plus the 20% that is not covered by Medicare.

SECONDARY INSURANCE(S)

_____I authorize Santa Rosa Medical Clinic to release any information to my secondary insurance carrier needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Santa Rosa Medical Clinic.

There will be a $25.00 charge on all returned checks.

I have read and understand the payment policy of this office and agree to abide by the said policy.

_____ _____
Patient/Parent/Guardian Date

Please present both your insurance card(s) and your driver's license so we may make a copy for our records.

HEALTH INFORMAITON

SUNRISE MEDICAL GROUP
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FINANCIAL POLICY

This Financial Policy is not intended to offend you but to establish a long standing Doctor/Patient Relationship.

FOR OUR PATIENTS WITH INSURANCE: We are happy to assist you in filing necessary forms to help you receive full benefits of your coverage; however, we can make no guarantee of any estimated coverage for payment. The insurance policy is between the insured and the insurance carrier. Please understand we will do everything we can to see that you receive the full benefits of your policy, and if you have any questions or concerns we do advise you to communicate with your insurance carrier. We encourage you to file a pre-determination of benefits with your insurance carrier. Unfortunately, on occasion an insurance company will not pay as much as reported in the pre-determination of benefits. Regardless of the amount paid by your insurance company, you are responsible to pay the entire balance of the fee for medical services. Any claim not paid by the insurance carrier sixty days past the date of completion will be billed to the patient. This office will expect payment in full of any outstanding balance at that point and time. Each patient is directly responsible for all charges on his/her account.

CHILDREN: A parent or legal guardian must accompany patients who are minors on the patient's first visit. The accompanying adult (who consents to the treatment) is responsible for payment of the account, according to the policy outlined in the Financial Policy.

PAYMENT FOR SERVICES: We accept payment by cash, check, VISA, and MasterCard. Payment plans may be available upon completion of a financial statement analysis. Please contact our billing office to set up an appointment. For your convenience, our billing office is staffed Monday through Friday from 9:00 AM to 5:00 PM. The phone number is (575) 461-8631. Ask for the billing department.

FINANCE CHANGE: All Balances outstanding for 45 days or more are subject to a finance charge of 1.5% monthly. After an account balance have been outstanding for 120 days it will be turned over to collections for resolution.

SALES TAX: Please consider that New Mexico adds a sales tax to your fee for medical services. This has been added to your fee, excluding the insurance carriers we are contracted with.

REMINDER CALLS: We ask that each of our patients be responsible for remembering the appointment he/she schedules at our office. We make reminder calls as a courtesy. There are instances in which we may not have the staff available to make these calls. Please do not rely on us to remind you of your upcoming appointments. No shows will be billed an additional $25 on their next statement.

MEDICINE REFILLS: Our policy is for the patient to call their pharmacy and ask them to fax the request for your medication to Santa Rosa Medical Clinic. Requests are usually handled within 48 business hours. Processing times may vary depending on the availability of your doctor, who for your safety must review each request prior to completion. No refills are handled on Fridays.

OTHER SERVICE CHARGES: If the decision is made to see a patient who does not have his/her co-pay or deductible, a service charge of $25 will be added to the patient's next statement. If the patient consistently does not have their co-pay or deductible, we will notify their insurance company which may result in loss of insurance.

REFERRALS: If you have an HMO plan which we are contracted, you will need a referral authorization from your primary care physician. Your referring physician will request important patient information which must be received before surgery can be scheduled.

MEDICAID: We do not accept assignment of out of state Medicaid.

LEGAL FEE: any patient sent to collections will be responsible for all collection fees. IF a patient is taken to small claims court, the patient will be responsible for all associated charges.

EMERGENCY AFTER HOURS: If you need medical care outside of normal office hours, please go to the Emergency Room located at Guadalupe County Hospital.

I have read and understand the above policy and fully accept responsibility for payment of all treatment costs.

Patient Name **Signature** **Date**

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Please indicate any medical condition for you or your immediate family.

Self	Family		Self	Family		Self	Family	
		Alzheimer's			Hemorrhoids			Osteoporosis
		Anemia			Hepatitis			Seizures
		Arthritis			High Blood Pressure			Skin Disorders
		Asthma/Bronchitis			Irritable Bowel			Smoking/Tobacco Use
		Blood Disorders			Cancer-Type			Stroke
		Clotting Disorders			Kidney Disease			Thyroid Disease
		Diabetes			Liver Disease			Tuberculosis
		Drug/Alcohol Abuse			Lung Disease			Ulcers
		Frequent Bladder Infections			Lupus			Other_____
		Gall Bladder Disease			Mental Illness			_____
		Heart Disease			Migraines			

List all medication allergies and adverse reactions

_____

List all environmental allergies (Hay fever, Latex, Food Etc.)

_____

Please indicate any medical testing you have had within the last 5 years.

Barium Enema	Cholesterol Screen	Lipid Profile	Surgery
Blood Count	Colonoscopy	Mammogram	Thyroid Testing
Bone Density	EKG	Pap Smear	X-Ray
Chemistry Profile	HIV Test	Stool Blood Test	Other

For Women

_____How old were you when you started menstruating?
_____When was your last period?
_____How many times have you been pregnant?
_____How many children have you had?
_____Have any of your children weighed over 9 lbs. at birth?
_____Have you ever had an abnormal Pap result?
_____Do you have problems controlling your urination?

For Men

_____How many times do you have to get up at night to urinate?

_____Do you have any difficulty with erection or ejaculation?

Please list all medications you currently use.

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name

Signature

Relationship to Patient

Date

ALLERGY AND ASTHMA ISSUES

Date: ____________________

Name: ____________________________ **D.O.B:** ___________ **Height:** _______ **Weight:** _______

1. Do you suffer from allergies, including seasonal allergies? Yes _______ No _______

2. If yes, what allergies do you suffer from: ____

3. SYMPTOMS: Do you have any of the following? (Check all that apply)

NASAL:		**SINUS:**		**EYES:**	
Runny or Stuffy Nose		Headaches		Red	
Sneezing		Sore Throat		Itching	
Itchy Nose		Post Nasal Drainage		Watery	
Nose Bleeds		Bad Breath		Dark Circles	
Mouth Breathing/Snoring		Hoarseness		Puffiness	
Sniffing		Throat Clearing		**SKIN:**	
CHEST:		Itchy Throat		Rash	
Wheezing		**EARS:**		Hives	
Coughing		Full		Eczema	
Tightness		Painful		Swelling	
Shortness of Breath		Ringing		Itching	
Bronchitis		Hearing Loss		**OTHER:**	
		Itching			

4. Do you have family members with allergies? Y / N If yes, relationship: ____________________

5. Have you ever been diagnosed with asthma? Details: ________________________________

6. Diagnostic studies done: ___ allergy testing ___ pulmonary function ___ allergist exam

7. Allergy shots? Y / N Frequency? ___________ Date begun: ________ Date ended: __________

8. Adverse reactions to allergy shots? (Describe) ______________________________________

PLEASE GIVE THIS TO THE MEDICAL ASSISTANT WHEN YOUR NAME IS CALLED.

* *

TO BE COMPLETED BY PHYSICIAN

☐ Patient's allergy history is completed.

☐ Patient is not on beta blockers

☐ Patient does not have uncontrolled asthma

Patient has been informed to discontinue:

☐ Antihistamines for 3 / 5 / 7 days prior to testing.

☐ Ranitidine 24 hours prior to allergy testing.

This patient is cleared for allergy testing. ______________________________ ______________

Signature Date