117 Camino De Vida St 300
Santa Rosa, NM 88435
575-472-4311

Fax # 575-432-4313

10401 Montgomery Parkway, NE
Albuquerque, NM 87111
505-433-5572

INTERVENTIONAL PAIN MANAGEMENT PROGRAM

QUESTIONS ABOUT SANTA ROSA VISITS? PLEASE CALL ODESSA 575-472-4311
QUESTIONS ABOUT ALBUQUERQUE VISITS? OPTION 2 505-433-5572

Dear ____

Congratulations!

You have made an important decision to address your Pain Relief and we appreciate that you have chosen to take this step with our team here at Sunrise Medical Group. We will continue to earn your trust each step of the way as we work with you to relieve your pain.

Your appointment with Pain Clinic is scheduled for

_____________________________ Please arrive at ___________________________

For best results, we require you to bring the following four (4) things with you:

____ 1. **Insurance and ID Cards**

____ 2. **X-ray Imaging Disc and/or MRI Imaging Disc (Paper reports also)**

____ 3. **Medical Records, related to your visit**

____ 4. **ALL CURRENT MEDICATIONS YOU ARE TAKING IN THEIR BOTTLES**

To make sure you have a reminder of this appointment (including a reminder to arrange for any necessary transportation, you will get a phone, text message and email 5 days before your appointment. You can confirm your appointment using any one of those three options. We'll know if we have your cell # correctly in our system, if you confirm via text. You'll get a second group of reminders the day before your appointment, if you haven't already confirmed using our automated system. If you do not confirm we will call you again the day before.

See you soon!

Randal Brown, M.D., Chief of Medicine

David Calkins, M.D., Anesthesiologist
Mark Grossetete, M.D, PhD, Neurologist

Pamela Ammons, NP - Med Management
Seven Lackey, NP - Med Management

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PLEASE FILL OUT EACH QUESTION AND PRINT CLEARLY

PATIENT NAME:____ DATE OF BIRTH: ____________________

SOCIAL SECURITY #: ________________________________ CHECK ONE: (SEX) M_______ F________

ETHNICITY (RACE) : _____________________________ LANGUAGE: ______________________________

(PHONE#'S) HOME: _________________________ CELL: _______________________ WK: ______________________

MAILING ADDRESS:__________________________________ CITY:__________________ STATE:________ ZIP:___________

EMERGENCY CONTACT: __________________________________ RELATIONSHIP:__________________________

PHONE #: ________________________________

ALLERGIES TO MEDICATIONS:____

PRIMARY CARE PHYSICIAN/PHONE NUMBER: ____

INSURANCE INFORMATION NAME OF PRIMARY INSURANCE

(Please give your Insurance Card to the Receptionist)

COMPANY: _______________________________________

POLICY/ID#____ GROUP #_____________________________

POLICY HOLDER:______________________________________RELATIONSHIP:________________________________

SECONDARY INSURANCE

COMPANY NAME:_________________________________

POLICY/ ID#____ GROUP#_____________________________________

POLICY HOLDER:____________________________________ RELATIONSHIP:________________________________

PATIENT SIGNATURE: _____________________________________ PRINT:_____________________________________

Sunrise Medical
GROUP, P.C.

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DATE: ________________________

HEALTH INFORMATION

Please circle 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______________________
•	•	Gallbladder Disease	•	•	Mental Illness			____________________________
•	•	Heart Disease	•	•	Migraines			

List all Medication Allergies and any reactions you may have to them

____

____

Have you have had scans or surgeries within the last 5 years

Surgery/Where on the body:	X-Rays:	CT Scan:
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________

Please list medications: ______________________________ ________________________

________________________ ______________________________ ________________________

________________________ ______________________________ ________________________

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PAIN CLINIC

PATIENT CONSENT FORM

Please read carefully before you sign

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

1. **Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.**
2. **Obtain payment from third-party payers**
3. **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 out treatment, payment, or health care operations. I also understand that 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.

PERMISSION TO CALL, TEXT OR EMAIL YOU: We ask permission from you to accept Calls, Text Messages and/or Emails. We use an automated system that will reach out to you for 5 days and then 24 hrs before your scheduled apts. This may be helpful with making contact with our office a lot easier plus you will never wonder when your apt is because you will hear from us many times throughout your care with us.

REMINDER CALLS: We ask that each of our patients be responsible for remembering the appointment he/she schedules at our office. Reminder calls are meant to help make sure that you are on time for your scheduled apts with our office, if you do not want reminder calls please let us know ahead of time.

________________________________	________________________________
Patient Name	**Signature**
________________________________	____________________
Relationship to Patient	**Date**

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FINANCIAL POLICY (1)

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 predetermination of benefits with your insurance carrier. Unfortunately, on occasion an insurance company will not pay as much as reported in the predetermination 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: We DO NOT treat Children under the age of 18

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 (725-502-2265).

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.

MEDICINE: We have 2 Doctors that prescribe medications, follow the rules or you will be discharged from pain clinic so please ask questions and make sure you show up for your apts on time.

REFERRALS: If you have an HMO plan which we are contracted with, 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 or the one closest to you.

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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FINANCIAL POLICY (2)

We strongly feel that 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.

(Initial Below)

________ I understand I am responsible *at the time of service* for paying any required copayment and deductible.

MEDICARE/SECONDARY INSURANCE

For Medicare Patients Only **Medicare Number ______________________________________**

(Initial Below)

________ 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 a 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)

(Initial Below)

________ 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 it

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.

Thank You

(Initial Below)

________ 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.

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