New Patient Intake Form

Patient Name:_______________________________________Sex: M F Other

DOB:__________________ SS#:________________________

Address:____
Street City State Zip

Phone:____________________________ Email:__________________________________

Facility Name:______________________Phone:___________Fax:___________________

Insurance Information:

Primary:___________________________#ID:___________________Group #:_____________________

Secondary:_________________________#ID:___________________Group #:_____________________

Tertiary:__________________________#ID:___________________Group #:_____________________

Responsible Party:______________________________ Relationship:________________________

Phone:____________________________ Financial POA

Email:____ Healthcare POA

____

Address:____
Street City State Zip

Emergency Contact:__________________________________ Relationship:____________

Phone:____________________________ Email:__________________________________

Preferred Pharmacy:____

Phone:__________________________________ Fax:________________________

Medical Information

Allergies:

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Current Medical Issues:

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Surgeries:

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Current Medications (Please include strength and directions.):

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4940 Corrales Rd., Suite 150
Corrales, NM 87049

Phone: 505-436-7500
Email: accessmedicalcare@outlook.com

Assignment of Benefits and Authorization to Provide Treatment

An ACCESS Medical Homecare Practitioner will see you in your home or in your assisted living facility to provide medical care. Services include medical exams, evaluation and treatment of acute and chronic health conditions; lab tests (there may be a fee of up to $30.00 for the mobile phlebotomist/diagnostic tech to go to your home (that fee is due at the time of service); Prescriptions; on-going monitoring and treatment to detect problems before they become critical. Visits are typically every 4-6 weeks.

ACCESS Medical Homecare bills third parties for "medically necessary visits", as would any healthcare provider. Our medical services are reimbursed by Medicare in the same way as when you go to the doctor's office.

Last Name	First Name	MI	SSN#
Address			
City		State	Zip Code

I, ___________________________, authorize ACCESS Medical Homecare of New Mexico, LLC to release to the Social Security Administration and Centers for Medicare and Medicaid services (CMS) or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related health care service claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefit either to myself or the care provider who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I understand that Medicare and other insurance is considered a method of reimbursing the patient for fees paid to the physician, but are usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately my responsibility to pay the portion of the bill not paid by my insurance company (unless otherwise restricted by law or agreement ACCESS Medical Homecare may have with the insurer).

I also hereby grant my permission for Practitioners employed by ACCESS Medical Homecare to assess and treat me in my home or on-site clinic for medical problems. I understand that the Practitioner is a licensed health care professional in the state of New Mexico.

____ ____________________

Signature of Patient or Responsible Party Date

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Email: accessmedicalcare@outlook.com

Notice of Privacy Practices

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

ACCESS Medical Homecare is required by law to maintain the privacy and confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Health Information

- We may disclose your health information to other healthcare professionals for the purpose of treatment, payment or health care operations.
- We may disclose your health information to your insurance provider for the purpose of payment.
- We may disclose your health information to comply with state Workers' Compensation Laws, as necessary.
- We may disclose your health information to notify a family member or other responsible party about your medical condition if they are involved in your care:
- We may disclose your health information to public health authorities with the intent of preventing or controlling disease, Injury, or disability; reporting child or adult abuse or neglect; reporting domestic violence; reporting to the FDA problems with products or reactions to medications; and reporting disease or infection exposure, as required by law.
- We may disclose your health information to a law enforcement official if necessary for law enforcement.
- We may disclose your health information to coroners or medical examiners.
- We may disclose your health information In the course of any administrative or judicial proceeding.
- We may disclose your health information for military, national security, prisoner or government benefits purposes.
- In the event ACCESS Medical Homecare is sold or merges with another organization, your health records will become the property of the new owner.

Your Health Information Rights

You have the right to:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that ACCESS Medical Homecare is not required to agree to the requested restrictions.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location, upon your request.
- You have the right to Inspect and copy your health information.
- You have the right to request that ACCESS Medical Homecare amend your protected health information. Please be advised, however, that ACCESS Medical Homecare is not required to agree to amend your protected health information. If your request is denied, you will be given the reason for denial as well as information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by ACCESS Medical Homecare.
- You have the right to receive a paper copy of this notice and privacy practices at any time upon request.

Changes made to this form and the privacy practices:

ACCESS Medical Homecare reserves the right to amend these notices at any time making the new provision effective for all information it maintains. Until such amendment is made, ACCESS Medical Homecare is required by law to comply with these notices.

Complaints:

Questions or concerns about your privacy rights, or complaints about how ACCESS Medical Homecare has handled your health information should be directed to the office manager by phone 505-321-7295. If you are not satisfied with our response to your concerns, you may submit a formal complaint to:

DHHS Office of Civil Rights
200 Independence Ave. SW,
Room S09F HHH Building
Washington, DC 20201

Annual Patient Questionnaire

This form is so that you can update any of your Information that may have changed and provide us with any records that we may not already have on file. It is important that we stay informed of any medical preferences and health care decisions, known as "advanced directives", that you may have put in writing so that we can do our best to honor them. Please note that this is not a legal document: Use this questionnaire to indicate whether you have authorized an agent to make health care decisions on your behalf and whether you have made any end of life decisions.

It is important to provide ACCESS Medical Homecare with a signed copy of the documentation for these decisions, such as the New Mexico Advanced Directives Form. Please attach the copies to this form after you complete and return them together. Or alternatively, you can indicate if you would like us to contact a family member or your health care agent to get a copy of your directive. Lastly, advance planning is an ongoing process and we encourage you to continue discussing these issues with your doctor as needed. We will continue this process annually to make sure your information stays up to date.

What Family and Friends are involved in your medical care?

Please use this section to inform us of any friends and family who you would like us to share your medical information with. For example, are there other individuals in your household that may have to help you with any doctor's instructions? Please provide their name, phone number, and relationship (if need additional space please attach a separate page).

Name:______________________________ Relationship:_________________________

Phone number(s):____

Name:______________________________ Relationship:_________________________

Phone number(s):____

Advanced Directives
Please use this section to let us know about any advanced directive documents you may have signed.

Power of Attorney (POA):

____
Name Relationship Phone

Contact my POA for documentation at____

Do Not Resuscitate Order (DNR)

YES I have a DNR Order
NO I do not have a DNR

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