DE BACA FAMILY PRACTICE CLINIC

PO BOX 349, FORT SUMNER, NM 88119

DEMOGRAPHIC INFORMATION SHEET

NAME:		**GUARDIAN - IF UNDER 18:**	
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME #:	**CELL#:**	**SSN#:**	
SEX: MALE FEMALE	**DOB:**	**PREFERRED COMMUNICATION:** ENGLISH SPANISH OTHER_____	
MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED PARTNER LEGALLY SEPARATED			
RACE: BLACK AFRICAN-AMERICAN ASIAN WHITE AMERICAN INDIAN/ALASKA NATIVE HAWAIIAN NATIVE OTHER PACIFIC ISLANDER			
ETHNICITY: HISPANIC NON-HISPANIC METHOD OF REMINDER FOR APPOINTMENTS: TEXT_____CALL_____			
PATIENT EMAIL:		**PATIENT OCCUPATION:**	

EMERGENCY CONTACT

NAME:_____	**NAME:**_____
RELATIONSHIP:_____	**RELATIONSHIP:**_____
PHONE #:_____	**PHONE #:**_____

PROTECTED HEALTH INFORMATION:	**RELATIONSHIP:**
PRIMARY CAREGIVER/LEGAL GUARDIAN	**RELATIONSHIP:**

INSURANCE INFORMATION

MEDICAL INSURANCE CARRIER:_____	**DENTAL INSURANCE CARRIER:**_____
GROUP#:_____	**GROUP#:**_____
ID#:_____	**ID#:**_____
SECONDARY INS CO:_____	**SECONDARY INS CO:**_____
GROUP#:_____	**GROUP#:**_____
ID#:_____	**ID#:**_____

PREFERRED PROVIDER

PRIMARY CARE PROVIDER: (CIRCLE ONE)	**DENTAL PROVIDER:** *(CIRCLE ONE)*	**DENTAL HYGIENIST:** *(CIRCLE ONE)*
DR. JACK VICK, MD	DR. MCALLISTER, DDS	
DR. JAMES GONZALES, MD	DR.BEST, DMD	DANA PATTERSON, RDH
CANDACE KERNELL, CNP		
LANEY PIERCE, FNP		

PLEASE CIRCLE YOUR SEXUAL ORIENTATION:	**PLEASE CIRCLE YOUR GENDER IDENTITY:**	**WOULD YOU LIKE TO RECEIVE A REMINDER THAT YOU ARE DUE FOR IMMUNIZATIONS?**
LESBIAN/GAY	MALE	YES NO
STRAIGHT (NOT LESBIAN/GAY)	FEMALE	
BISEXUAL	TRANSGENDER MALE/FEMALE-MALE	**HAVE YOU SERVED IN THE US MILITARY OR ARMED SERVICES (Air Force, Army, Navy Coast Guard, Marines, National Guard or Reserves) ?** YES NO
SOMETHING ELSE	TRANSGENDER FEMALE/MALE-FEMALE	
DON'T KNOW	OTHER	
CHOOSE NOT TO DISCLOSE	CHOOSE NOT TO DISCLOSE	

THE FOLLOWING INFORMATION IS GATHERED FOR NUMBER REPORTING PURPOSES ONLY.

If you would like to meet with our Insurance Guide about options available to you, please let us know.

Estimated Annual Income For Your Household *(circle one)*

Household Size:_____

Less than $12,000	$24,001 - $30,000	$42,001 - $48,000	
$12,001 - $18,000	$30,001 - $36,000	$48,001 - $54,000	More than $60,000
$18,001 - $24,000	$36,001 - $42,000	$54,001 - $60,000	Refuse

DO YOU HAVE ONE OF THE FOLLOWING? IF YES, PLEASE PROVIDE US A COPY

ADVANCE DIRECTIVES: YES NO **DO NOT RESUSCITATE (DNR): YES NO**

LIVING WILL: YES NO ☐ **PLEASE CHECK BOX IF YOU WOULD LIKE MORE INFORMATION ABOUT ONE OF THESE**

De Baca Family Practice Clinic

ANNUAL CONSENT FOR MEDICAL SERVICES

CONSENT FOR SERVICES: I hereby grant permission to the De Baca Family Practice team of licensed Physicians, Nurse Practitioners, Physician Assistants and other Physician designees to render any medical treatment, surgical care or diagnostic procedures that they deem necessary for my health and well being. I acknowledge that no guarantees have been made as the result of treatments or examination in the facility.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize De Baca Family Practice Clinic to release any and all medical and other patient information that may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records and/or electronic medical records. The information may be released to third party payers, including the third party payer's agent and/or representatives.

ASSIGNMENT OF BENEFITS: I authorize payment of benefits, including insurance benefits, otherwise payable with respect to the patient, to De Baca Family Practice Clinic or its designee (such as Radiologists and Pathologists).

MEDICARE AUTHORIZATION: I certify the information given by me in applying for payment under the Social Security Act is correct. I authorize the release of my medical and patient information to the Social Security Administration and Health Care Financing Administration, its intermediaries or carriers as may be needed for a related medical claim. I authorize payment of benefits otherwise payable with respect to the patient, to De Baca Family Practice Clinic or its designee.

FINANCIAL RESPONSIBILTY: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of De Baca Family Practice Clinic. I assign and authorize payments to De Baca Family Practice Clinic. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

I have been informed that any supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care will be charged to me and understand such charges.

De Baca Family Practice Clinic is **NOT** responsible for personal property.

The undersigned certifies the foregoing statements and consents have been read and understood.

The undersigned is the patient or duly authorized as the patient's representative to execute and accept its terms.

_____ _____

Patient Signature **Legal Representative (if not patient)**

_____ _____

Date **Witness**

Revised 03/28/2018

DE BACA FAMILY PRACTICE CLINIC

Our family caring for yours.

ACKNOWLEDGEMENT OF RECEIPT

- ☐ Notice of Privacy Practices, 2020 July
- ☐ Reporting of Abuse, Neglect or Misappropriation of Property, 2017 June
- ☐ Information about Authorization
- ☐ Principles of Medical Home, 2019 April
- ☐ Patient Information and Responsibilities (Patient Compact) 2017 April
- ☐ Sliding Fee Information Sheet, 2020 April
- ☐ No Show Policy and Appendix A, 2019 April

Patient's Signature or Printed Name of Minor: _____ Date: _____

Patient/Legal guardian's Signature: _____ Date: _____

DBFPC Staff Signature: _____ Date: _____

To be scanned into Patients EHR Chart

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Our family caring for yours.

APPENDIX A

Patient No Show Policy

In order to provide the best quality service and access to care for all of our patients we have instituted the following No Show Policy:

Our staff works hard to offer you an appointment that is convenient for both you and your family. If circumstances prevent you from keeping your appointment, please call the office **575-355-2414** *at least 24 hours in advance* to reschedule your appointment. The following represents the steps that will be taken should you not show up for your appointments and incur three no shows over a twelve (12) month time period:

1. In the event that you neglect to notify us and miss your scheduled appointment, the staff will call to remind you of our cancellation policy and offer you an opportunity to reschedule.
2. If you miss a second scheduled appointment and do not notify the office as requested, you again will receive a call to remind you of our cancellation policy and offer you an opportunity to reschedule.
3. If you miss a third scheduled appointment without proper notification, we will send you a letter by registered mail. In that letter, it will notify you that if you miss another scheduled appointment, and do not notify the office as requested, we will request a meeting with you to discuss the behavior to see if there is a way to improve it.
4. If the patient is unwilling to meet with Risk Management Staff, the patient will be placed on the providers schedule on "walk in" status and will be worked into the Providers schedule, which could result in extended wait times.

Please understand that our policy is in place to assure that we maintain a superior standard of care for all of our patients. If you or your family miss multiple appointments, we cannot provide you with the level of care that we would expect for our own families or ourselves. In addition, unexpected missed appointments prevent us from caring for other patients that may need our services at that time.

Policy for Late Patients

It is the policy of DBFPC to provide the best quality service to our patients. As such, all patients are expected to arrive at the Clinic fifteen (15) minutes prior to their scheduled appointment time. In the event that you are late for your appointment, we will try to accommodate you during the same session if your provider's schedule has an opening. This may, however, require that you wait until all the patients with scheduled appointments have been seen. You may also need to see an alternative provider if the provider you were scheduled to see does not have an opening in the schedule.

If we cannot accommodate you into the schedule, we will ask that you reschedule for a time that is convenient for you and your child.

Policy for Early Patients

We appreciate your diligence in arriving to your appointment early. *Please understand that traditionally patients are seen in the order of their scheduled appointment times, rather than on their time of arrival.* In the event that you are more than 20 minutes early for your appointment, we will try to accommodate you as soon as possible. In the spirit of fairness, please be aware, however, that patients who are scheduled before you and arrive on time for their scheduled appointment will be seen first, even if they arrive after you. In the event that multiple providers are working, patients will be taken back according to their provider's schedule. If patients are seeing different providers, it may appear that later arriving patients are being taken back ahead of earlier arrivers.

I have read the above policies and been offered a chance to ask questions about them. I agree that I will adhere to these policies as long as I/my child is a patient at De Baca Family Practice Clinic (DBFPC). This applies to all DBFPC locations.

_____ _____

Patient, Parent, or Guardian Date

CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

Name: _____ Date: _____

1. I authorize De Baca Family Practice Clinic (DBFPC) to allow me/the patient to participate in a telehealth (videoconferencing) service.

2. The type of service to be provided via telehealth is family practice.

3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telehealth provider.

4. My/the patient's provider has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telehealth session, as well as possible alternatives to the proposed sessions, including visits with a provider in-person. The attendant risks of not using telehealth sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

5. I understand that there are potential risks to the use of the technology, including, but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telehealth service if we believe that the videoconferencing connections are not adequate for the situation.

6. I understand that the telehealth session will not be audio or video recorded at any time.

7. I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider to be present during my/the patient's telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.

8. I acknowledge that I have the right to request the following:
    a. Omission of specific details of my/the patient's medical history/physical examination that are personally sensitive, or
    b. Asking non-medical personnel to leave the telehealth room at any time if not mandated for safety concerns, or
    c. Termination of the service at any time.

9. When the telehealth service is being used during an emergency, I understand that it is the responsibility of the telehealth provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.

10. It is the responsibility of the telehealth provider to conclude the service upon termination of the videoconference connection.

11. I/the patient understand(s) that my/the patient's insurance will be billed by the local healthcare provider for telehealth services. I/the patient understand(s) that if my insurance does not cover telehealth services I/the patient will be billed directly by the local healthcare provider for the provision of telehealth services.

12. My/the patient's consent to participate in this telehealth service shall remain in effect for the direction of the specific service identified above, or until I revoke my consent in writing.

13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.

14. I/the patient acknowledge the telehealth program's no-show policy which states that I/the patient will be discharged from the telehealth program if I/the patient no-show for 2 consecutive telehealth appointments, without prior contact to the scheduled staff at DBFPC.

15. I confirm that I have read and fully understand the above. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

_____	_____
Patient/Relative/Guardian Signature*	Print Name
_____	_____
Relationship to Patient (if required)	Date
_____	_____
Witness	Date
_____	_____
Interpreter (if required)	Date

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) to the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____	_____
Provider's Signature	Date