ASPEN MEDICAL CENTER
URGENT CARE & PRIMARY CARE

PATIENT INFORMATION

Last name: First: Middle initial:			❑ Mr. ❑ Mrs. ❑ Ms.	Marital status (circle one) Single Married Widowed	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Date of birth: ___ / ___ / ___	Age:	Sex: ❑ M ❑ F
Street address:		Social Security #:	Home phone #: ( )		
P.O. Box (if applicable):	City:	State:	ZIP Code:		
Occupation:	Employer:	Contact Phone #: ( )			

Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Co. ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Please provide us your email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for payment:	Date of birth: ___ / ___ / ___	Address (if different from above):	Home phone #: ( ) Cell phone #: ( )
Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Are you covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance: ❑ Medicare ❑ BC/BS ❑ United Healthcare ❑ Presbyterian ❑ Tricare ❑ Aetna ❑ Humana ❑ Cigna PPO ❑ Lovelace Health Plan ❑ Lovelace Senior Plan ❑ Other

Policy Holder's Name:	Policy Holder's Social Security #:	Date of birth: ___ / ___ / ___	Group #:	Policy #:

Patient's relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Type of secondary insurance (if applicable):	Secondary insurance Policy Holder's Name:	Policy Holder's Social Security #:
Date of birth: ___ / ___ / ___	Group #:	Policy #:

Patient's relationship to Policy Holder: ❑ 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 to be paid directly to the physician. I understand that I am financially responsible for any balance due. I also authorize Aspen Medical Center or my health insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

ASPEN MEDICAL CENTER
URGENT CARE & PRIMARY CARE

PRIVACY NOTICE

Notice of Privacy Practices: This notice describes how health information about you (as a patient of Aspen Medical Center) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our medical center is dedicated to maintaining the confidentiality of your health information as required by law. Please note the following important information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect such information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will make disclosures only to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans), and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our clinic communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your medical treatment, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Aspen Medical Center, 3450 Zafarano Drive, Suite C, Santa Fe, New Mexico 87507
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Aspen Medical Center, Medical Records, 3450 Zafarano Drive, Suite C, Santa Fe, NM 87507. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may request a copy of this Notice at any time by contacting our front desk receptionist.
6. If you believe your privacy rights have been violated by Aspen Medical Center, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact: Aspen Medical Center, Medical Records, 3450 Zafarano Drive, Suite C, Santa Fe, NM 87507. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I have read this Privacy Notice and understand my rights contained herein. I authorize Aspen Medical Group, LLC, to use and disclose my protected health care information for purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Release of Medical Information:
If you would like us to be able to give medical information to someone other than yourself, please complete the following authorization:

I authorize the physicians and staff of Aspen Medical Group, LLC, to communicate with the following persons regarding my medical care:

Printed Names of Family Member/Legal Representative/Other Specified Person:_____

Relationship (Spouse/Significant Other/Parent/Other Specified Person):_____
If a name is not provided, medical information will not be released. I understand this authorization will be valid until revoked in writing.

I authorize Aspen Medical Group, LLC, to leave the following information on my voice messaging service, or via email as provided (check all that apply):
❑ Scheduling of Appointments/Procedures ❑ Medical Information ❑ Billing Information

Patient Name (please print): _____

Patient Signature: _____ Date: _____

ASPEN MEDICAL CENTER
URGENT CARE & PRIMARY CARE

INSURANCE/CASH ASSIGNMENT POLICY

Dear Patient:
If you have selected "**INSURANCE**" or "**CASH**" as a method of choice to take care of your financial obligation with Aspen Medical Center, please read the following:

- You are considered a cash patient until you bring your insurance information and this clinic qualifies and accepts your coverage.
- You are ultimately responsible for full payment of any and all services rendered, regardless of your insurance coverage. There is a $30 charge for returned checks.
- You are responsible for payments of any unsatisfied deductible.
- Co-payment must be paid at the time of service.
- If your insurance carrier has not paid a claim within 60 days of submission, you are responsible for taking an active part in the recovery of your claim.
- In the event you discontinue your program of care prior to the doctor's consent, you are responsible for payment in full of any outstanding balance.
- In the event this account goes to a collection agency, you are responsible for paying all agency fees in addition to any outstanding balance with this clinic andany legal fees pertaining to collection services.
- All cancelled, missed, and rescheduled appointments without 24-hour notice are billable to you, the patient, at $20 per incident.
- X-rays provided by **Santa Fe Imaging Center** and lab draws provided by **Tricore Reference Lab** will be billed directly to your insurance. Any outstanding balances from these services will be billed directly to the patient.
- The charge for office visits is $100. Additional services (e.g., urinalysis, EKG, PAP smear, strep test, etc.) will be charged at 50% of full amount if paid at time of visit.

Please sign below as acknowledgment that our policy has been explained to you and that you understand and agree.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Medicare Authorization:
I request that payment of authorized Medicare benefits be made on my behalf to Aspen Medical Group, LLC, for services provided to me by the clinic. I authorize any holder of medical information about me to release to Medicare and its agent any information needed to determine these benefits payable for related services. I permit a copy of this to be used in place of the original.

Assignment of Benefits:
I hereby authorize payment of medical benefits to Aspen Medical Group, LLC, for services rendered to myself and/or dependents. The signature below shall suffice for all insurance forms on a continuing basis.

Primary Care Physician Designation:
I understand that I am responsible for complying with the rules and regulations of my insurance company regarding the requirements for designating a provider from Aspen Medical Group, LLC, as my Primary Care Physician and that failure to do so may result in a higher out-of-pocket expense to me.

Signed: _____ Date: _____

I have an Advance Medical Directive (pre-written instructions regarding future health care wishes in the event I am not able to make an informed decision about my health care): ____YES ____NO Please provide a copy for your chart.

ASPEN MEDICAL CENTER
URGENT CARE & PRIMARY CARE

WELCOME TO OUR OFFICE

We sincerely appreciate you as a patient! We are committed to providing you the best care and are pleased to discuss our professional fees with you anytime. All Aspen Medical Center patients receive the same level of attention and care. We trust you will be happy with our efforts, as we do our utmost to provide quality medical treatment and services.

Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures. Payment is due when services are rendered. We gladly accept all credit cards and cash. Thank you once again for allowing our office to help you ensure a better quality of life!

- ❑ **PRESCRIPTION REFILL:** We request a minimum of a 72-hour turnaround of all prescription refills. It is always a good habit to call these refills in early so there is no risk to you and your health. Please contact your pharmacy to fax a request to our office prior to calling the office. Fax: 505-466-5886.

- ❑ **REFERRALS:** We require a 24-hour turnaround for all non-urgent referrals. All urgent referrals, lab work, and x-rays will be flagged by our doctors and completed within 24 hours of checkout or at the earliest possible availability. Urgent requests by physicians only are accommodated within 8 hours. We thank you for your understanding and patience as we prioritize life-and-death issues before regular medical requests. Every request will receive our best attention.

- ❑ **RECORD REQUESTS:** We require a minimum 7-day turnaround for all record requests. If you know you will need records for an appointment with a specialist, for insurance purposes, or for any other reason, please sign a records release at our office or your other doctor's office and get it to us as soon as possible. We provide one free copy per patient. If additional copies are needed, there is a $40 charge for the first 15 pages and 25¢ per page thereafter. This charge does not include continuation-of-care requests or referral supporting records.

- ❑ **COLLECTION/ATTORNEY FEES**: In the event that we need to hire a collection agency to collect an overdue balance for your medical services, you will be required to pay all the costs of the agency, plus any agency percentage, in addition to your unpaid balance and any attorney's fees or other costs deemed reasonable by a judicial court.

- ❑ **LATE APPOINTMENTS, CANCELLATIONS, and MISSED APPOINTMENTS:** In order to accommodate all patients and keep the schedule on time, we ask that all patients arrive at their check-in time: 15 minutes prior to their appointment time. Anyone arriving more than 10 minutes late for their appointment *will* be rescheduled. There are *no exceptions* to this policy. Also, 24-hour notice is required for all cancellations or rescheduled appointments. Our doctors reserve personal time to accommodate each patient; when changes happen on the same day of service, there is no way for them to accommodate others in need. Please be advised: Patients will be charged $20 for *any* missed appointments or late cancellations. In accordance with New Mexico State law, we reserve the right to dismiss any patient who fails to follow this policy.

_____ _____

Patient/Guardian signature *Date*

FOR OFFICE USE ONLY

Print Patient Name:	Account #:

Special Arrangements:

ASPEN MEDICAL CENTER • 3450 ZAFARANO DRIVE, SUITE C • SANTA FE, NEW MEXICO 87507
PHONE: 505-466-5885 • FAX: 505-466-5886