Orthopedic Surgery & Sports Medicine
Douglas Dodson, DO, FICS
Eric Freeh, DO, FAOAO

Interventional Pain Management
John V. Watkins, MD
Foot, Ankle & Lower Leg Reconstructive Surgery
John Anderson, DPM, FACFAS
Loren Spencer, DPM, FACFAS
Anthony Chesser, DPM

Podiatry, Podiatric Surgery & Wound Care
Troy Shepherd, DPM, AACFAS

www.newmexortho.com

Patient Name:__________________________________ **DOB:**____________________

Please list your medications below. Include the strength and how often you take them.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____

2301 Indian Wells, Alamogordo, NM
Phone: 575-434-0639
Fax: 575-434-4148

2951 N Roadrunner Pkwy, Las Cruces, NM
Phone: 575-434-0639
Fax: 575-434-4148

26130 Hwy 70, Ruidoso, NM
Phone: 575-434-0639
Fax: 575-257-7647

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13. ____

14. ____

15. ____

16. ____

17. ____

18. ____

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New Mexico Bone & Joint Institute
Welcome to our office!

Patient's Name: ______________________ Sex: Male☐ Female☐

Date of Birth: ______________ Age: ______________ SSN ______________

Mailing Address: ______________ City: ______________ State: ______ Zip Code: ______

Physical Address ______________ City: ______________ State: ______ Zip Code: ______

Primary Phone: ______________ Cell Phone: ______________

Employer: ______________ Work Phone: ______________

E-Mail Address: ______________________

Emergency Contact: ______________ Emergency Contact's Phone: ______________

Referring Physician: ______________ Primary Care Physician ______________

How did you hear about our office? ______________________

Is your injury work related? YES☐ NO☐ Date of injury: ______________

Is your injury related to a motor vehicle accident? YES☐ NO☐ Date of accident: ______________ State: ______

Is there a third party liability? NO☐ ______________________

YES☐ If yes please explain: ______________________

____

______________________ ______________

Signature of Patient/Parent/Guardian That the Above Information is Accurate Date

<u>PARENT/GUARDIAN'S INFORMATION (IF PATIENT IS UNDER THE AGE OF 18)</u>

Parent/Guardian's Name: ______________ Relationship to Patient: ______________

Date of Birth: ______________ Social Security Number: ______________

Mailing Address: ______________ City: ______________ State: ______ Zip Code: ______

Physical Address: ______________ City: ______________ State: ______ Zip Code: ______

Home Phone: ______________ Work: ______________ Cell: ______________

Employer: ______________ Employer's Phone: ______________

? Medical Power of Attorney ? Guardianship Other ______________________

______________________ ______________

Signature of Patient/Parent/Guardian Date

24 Hour Cancellation Policy

It is the policy of New Mexico Bone & Joint Institute that a 24 hour cancellation notice is required for all scheduled appointments. Any patient not giving a minimum of 24 hour notice of cancellation will be charged a $25.00 fee for the reserved appointment time. This charge is not covered by your insurance company and will be billed directly to you. If you have excessive no shows New Mexico Bone & Joint Institute reserves the right to discharge you from our practice. Thank you for your cooperation and understanding. Please do not hesitate to call our office at (575) 434-0639 with any questions or concerns. We are here to assist you. I have read and fully understand this policy:

______________________ ______________

Signature of Patient/Parent/Guardian Date

New Mexico Bone & Joint Institute
Welcome to our office!

In order for us to bill your Health Insurance, we will need the following information for all services rendered.

Primary Insurance

Name of Insurance: ______________________

Insurance Policy #: ______________________

Name of PERSON who carries the Insurance Policy ______________________

Address of PERSON who carries Insurance: ______________________

Relationship to Patient: ______________________

Social Security Number of Policyholder: ______________________

Date of Birth of Policyholder: ______________________

Employer: ______________________

Patient's Name: ______________________

Secondary Insurance

Name of Insurance: ______________________

Insurance Policy #: ______________________

Name of PERSON who carries the Insurance policy: ______________________

Address of PERSON who carries Insurance: ______________________

Relationship to Patient: ______________________

Social Security Number of Policyholder: ______________________

Date of Birth of Policyholder: ______________________

Employer: ______________________

Patient's Name: ______________________

New Mexico Bone & Joint Institute
Welcome to our office!

____ _______________
Signature of Patient/Parent/Guardian **Date**

New Mexico Bone & Joint Institute Financial Policy

Insurance claims (Primary and Secondary) are filed as a courtesy to our patients. Ultimately you are responsible for knowing and understanding your benefits and paying the balance of your account.

Co-Payments are due at time of service as indicated by your insurance company. If you owe towards your deductible we may collect $100.00 per visit until this is met. You are responsible for the balance of your account.

Medicare: All covered services will be billed by our office directly to Medicare. If you have a secondary or supplemental coverage, and you have provided us the necessary information, it will also be billed after Medicare has paid. If you don't have a secondary payer and your deductible has not been met, we may collect $100.00 at time of service. Once the deductible has been met we will collect the Medicare 20% co-insurance at time of service. You are responsible for the balance of your account.

Medicaid: All covered services will be billed by our office directly to the appropriate Medicaid carrier. If payment denies for reasons of expired eligibility, payment in full will be due immediately. A current Medicaid card and appropriate prior authorization/referral from your primary care physician is due at time of service.

Workers' Comp: Verification of your work-related injury will be obtained by our office prior to your appointment.
Claims are filed directly with your employer's insurance carrier. If the Workers' Compensation payer denies your claim, you will be responsible for the balance of your account.

Private/Self Pay: If you have no insurance coverage, or we are unable to verify medical benefits, payment is due in full at time of service. We will collect $200.00 per visit at check in as a **DEPOSIT** towards your account. The remaining balance will be due when you check out from your visit. You are responsible for the balance of your account.

Third party Liability: New Mexico Bone & Joint Institute does ***not*** get involved in **Third Party** billing, payment is due in full at time of service. We will collect $200 per visit at check in as a **DEPOSIT** towards your account. **The remaining balance will be collected when you *check out* from your visit**. You are responsible for the balance of your account.

Assignment of Insurance Benefits: I authorize my insurance company to make payment directly to New Mexico Bone & Joint Institute for services rendered to me or my insured dependent.

(circle one) Yes _____ No ____________ Initials

Medicare Assignment: I authorize New Mexico Bone & Joint Institute to bill Medicare and receive payment for services rendered to me. I am responsible for the deductible, coinsurance and non-covered services.

(circle one) Yes _____No _____________Initials

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account with New Mexico Bone and Joint Institute. I have read all the information on both sheets and have completed all answers. I certify this information is true and correct to the best of my knowledge. I agree to notify this office of any changes in my insurance status or the information given this date. I understand that failure to provide updated insurance information may result in denial of payment and will become my financial responsibility. NEW MEXICO BONE AND JOINT INSTITUTE WILL NOT ASSUME FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED THAT MAY REQUIRE PRIOR APPROVAL / AUTHORIZATIONS FROM PATIENT'S INSURANCE.

____ ______________
Signature of Patient, Guardian or Responsible Party Date

NMBJI representative___________________________________ Date_______________________

New Mexico Bone & Joint Institute
Welcome to our office!

CONTROLLED SUBSTANCE TREATMENT AGREEMENT & IMPORTANT CONTROLLED SUBSTANCE INFORMATION

"Controlled Substances" are drugs that are illegal to have unless they are prescribed by a licensed provider for medical purposes. These medications include common pain medications (opioids or narcotics), tranquilizers that are often used for sleep or anxiety (benzodiazepines), and stimulants that are used for attention or arousal problems (amphetamines). Please be aware that if you use these controlled substances improperly (if you use them in ways other than how they are prescribed by your provider), they may cause serious medical problems. Also, if you do not keep these medications secure or if you allow them to be used for recreational or other nonmedical purposes, this is likely to contribute to crime and addiction problems in our community. The purpose of the Treatment Agreement below is to make sure that you understand how to use these medication(s) safely and appropriately. Please understand that your prescribing provider is likely to stop prescribing any controlled substance medication(s) for you if you fail to follow the guidelines in the Agreement very strictly and exactly.

Medication(s) Covered by this Agreement: Any Opioids, Muscle relaxants, Benzodiazepine, neuroleptic medications.

I AGREE to receive the medication(s) listed above only from the prescribing providers listed above. The prescribing providers will delegate an alternate provider to cover his/her practice and write prescriptions in his/her absence.

I AGREE to take the medication(s) exactly as directed by the prescribing provider.

I AGREE that I will **NOT** increase my medication(s) without first getting clear directions from the prescribing provider.

I AGREE not to go to walk-in clinics, urgent care centers, or emergency rooms for treatment of the ongoing problems for which the medication(s) is/are prescribed unless it is absolutely necessary. I realize that if I do visit a walk-in clinic or emergency room for the ongoing problem, especially if I am seeking additional medication, the prescribing provider may consider this a reason to stop prescribing the medication(s) for me.

I AGREE to attend all scheduled appointments, tests, visits with other providers, and additional treatments recommended by the prescribing provider.

I AGREE to give a urine or blood sample as directed by the prescribing provider, for any purpose, including testing for drugs in my system.

I UNDERSTAND that the medication(s) may cause harm or even death to a person who has not had the medication(s) prescribed to them, and the medication(s) is/are particularly dangerous to a child. Therefore, I AGREE to carefully protect my supply of medication(s) and my prescriptions, using a locking safe or locking box or similar highly secure method, to make sure that they cannot be stolen, lost or misused by anyone.

I AGREE to never sell any of my medication(s), and **I AGREE** to never share my medication(s) with anyone, even family members.

I AGREE to never use any prescription medication(s) that I might get from a friend, family member, or anyone else other than a licensed prescriber.

I UNDERSTAND that my prescribing provider will not replace medication(s) that are lost, stolen, taken incorrectly, or destroyed or damaged in any manner.

I UNDERSTAND that I can get refills on my medication(s) ONLY during normal business hours (weekdays 8:00 a.m. to 4:00 p.m.); the medication(s) cannot be prescribed after hours, on weekends, or on holidays.

I UNDERSTAND that it is my responsibility to contact the prescribing provider at least 3 business days before I am due for a new prescription in order to allow time for processing.

I UNDERSTAND that I may become physically dependent on the medication(s). Therefore, unless instructed by the prescribing provider, I will not suddenly stop taking my medication(s) because this could cause drug withdrawal symptoms that could make me very sick.

I UNDERSTAND that I may experience side effects from the medication(s); these may include: **Opiates**: constipation, drowsiness, dizziness, constipation, fatigue, anxiety, itching, breathing difficulty, respiratory arrest, death and a number of other problems that are listed in the information provided with the prescriptions at the pharmacy. **Amphetamines**: agitation, irritability, anxiety, insomnia, hallucinations or delusional thoughts, not thinking clearly, rapid heartbeat, high blood pressure, and a number of other problems that are listed in the information provided with the prescriptions at the pharmacy. **Benzodiazepines**: drowsiness, dizziness, blurred vision, confusion, depression, impaired coordination and a number of other problems that are listed in the information provided with the prescriptions at the pharmacy. These effects of the medication may interfere with my ability to concentrate or think clearly, especially when I am first started on a new drug or a new dosage.

I UNDERSTAND *that it is my responsibility to inform the prescribing provider of any of these or any other side effects of the medication(s).*

FOR WOMEN OF CHILDBEARING AGE ONLY: I realize that the medication(s) may have negative side effects on the developing fetus and on the newborn child or may adversely affect the potency of some forms of contraception. **I THEREFORE AGREE** to inform the prescribing provider

New Mexico Bone & Joint Institute
Welcome to our office!

BEFORE becoming pregnant if I am considering it or if there is a chance that I may become pregnant. **I AGREE** that if I believe that I may have become pregnant at any time, I will inform the prescribing provider immediately.

I UNDERSTAND THAT IF I DO NOT FOR ANY REASON FOLLOW THESE GUIDELINES VERY STRICTLY AND EXACTLY, THE PRESCRIBING PROVIDER WILL LIKELY DECIDE TO NO LONGER PRESCRIBE ANY CONTROLLED SUBSTANCES FOR ME, EVEN IF SOMEONE ELSE MAY BE PARTIALLY TO BLAME FOR MY INABILITY TO FOLLOW THESE GUIDELINES.

I UNDERSTAND that my prescribing provider will continue to evaluate the possible benefit of the medication(s) for me and the side effects or problems that the medication(s) may be causing me. If at any time the prescribing provider determines that the risks to my health or the side effects of the medication(s) outweigh the benefits, I UNDERSTAND that the prescribing provider may decide to stop prescribing the medication(s) for me, even if I have followed the Treatment Agreement, and even if I am not in agreement with the provider's judgment.

I UNDERSTAND that my provider will monitor my controlled substance prescription(s) use by reviewing the reports issued by NM Board of Pharmacy controlled substance monitoring program.

I UNDERSTAND that this Treatment Agreement replaces any previous Treatment Agreement that I may have had for using controlled substances.

I have had an opportunity to ask all questions I may have had.

____

Patient Signature & Date

____

Witness Signature & Date

Acknowledgement of Privacy Notice

New Mexico Bone & Joint Institute
Welcome to our office!

Purpose of this Acknowledgement
This acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment, or, healthcare operations, is pursuant to the requirements of 45 CFR S164.520(c)(ii), part of federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by New Mexico Bone & Joint Institute, P.C. (the "Practice") for the purpose of treating me and necessary in order to carry out any healthcare operations permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types, uses, and disclosures that the Practice is permitted to make under the Privacy Regulations.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it seems fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Policy to the office of the Practice at the following address: 2301 Indian Wells Rd., Suite A, Alamogordo NM 88310, Attention: Practice Compliance Director.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment, or, healthcare operations. I understand and acknowledge that the Practice is not required to agree to restriction requested by me, but, if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information
(Leave blank if no restrictions):____
I understand the foregoing provisions and wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment and healthcare operations.
BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

___________________________ ____________
Signature of Patient or Representative Date

____
Patient Name (Print)

____
Social Security Number

____
Name of Personal Representative (if Applicable)
Relationship to Patient

To Be Completed By Practice	The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:
_____Accepted	_____Denied
_____Not Applicable	____Other (explain)
____ NMBJI Representative & Date	