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

Certified Nurse Practitioner
Nicole McPhee, NP

NEW MEXICO
BONE & JOINT INSTITUTE
ALAMOGORDO · RUIDOSO · LAS CRUCES

Foot & Ankle Surgery/Reconstruction
John Anderson, DPM FACFAS
Loren Spencer, DPM

General Podiatry
Troy Shepherd, DPM

Interventional Pain Management
Daniel Bonis, MD

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. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

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

26130 Hwy. 70
Ruidoso, NM
Phone: 575-378-8001
Fax: 575-378-8003

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

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? YES☐ If yes please explain: _____

NO☐ _____

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

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:

_____ _____

Patient/Guardian Signature Date

Acknowledgement of Privacy Notice

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

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

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 Information

Name of PERSON who carries Insurance policy: _____

Social Security Number of Policyholder: _____

Date of Birth of Policyholder: _____

Relationship to Patient: _____

_____ _____

Signature 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: If your injury claim is being handled by an attorney, 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: New Mexico Bone & Joint Institute agrees to accept the Medicare allowable amount as the full charge. I am responsible for the deductible, coinsurance and non-covered services. My signature below represents authorization to bill Medicare for services rendered to me.

(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_____