EASTERN NEW MEXICO
FOOT & ANKLE

ASSOCIATIONS

Pharmacy: ______________________________

Primary Care Doctor: ______________________

How did you hear about us?: ________________

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PATIENT INFORMATION

Prefix: Mr. Mrs. Ms. First: ______________ MI: ___ Last: ______________ Suffix (Jr./Sr./III): _____

Gender: M ❐ F ❐ DOB: ______________ SSN: ______________

Address: __________________________ City,State,Zip: __________________________

Home phone: __________________________ Cell phone: __________________________

E-mail: ______________________________ Employer: __________________________

Primary Language: English ❐ Spanish ❐ Other ❐ ______________________________

Race: ______________________________ Ethnicity: ______________________________

EMERGENCY CONTACT INFORMATION

First: __________________________ Last: __________________________

Relationship to patient: ______________________

Home phone: ______________________ Cell phone: ________________________

PRIMARY INSURANCE

Insurance: ______________________

Policy Holder's Name

❐ Self (skip the following if "self")

Gender: M ❐ F ❐

First: ____________________ MI: ___

Last: __________________________

DOB: __________ SSN: ____________

Relationship to patient: ______________

SECONDARY INSURANCE

Insurance: ______________________

Policy Holder's Name

❐ Self (skip the following if "self")

Gender: M ❐ F ❐

First: ____________________ MI: ___

Last: __________________________

DOB: __________ SSN: ____________

Relationship to patient: ______________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES ☐ NO ☐

May we leave a message on your answering machine at home or on your cell phone? YES ☐ NO ☐

May we discuss your medical condition with any member of your family? YES ☐ NO ☐

If YES, please name the members allowed:

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_______________________ Patient/Guardian Signature

_______________________ Patient/Guardian Print Name

_______________ Date

Eastern New Mexico Foot & Ankle of Clovis N.M (hereinafter collectively referred to as "ENMFA") **Notification of Office Policies and Procedures**

1 **Reading the following policies and procedures annually will keep you informed about our office.**
2 **Appointments:** Physicians are available by appointment during posted hours. During a medical emergency, patients should seek care at the nearest emergency room or call 911.
3 **Refills and Medication:** Refills are completed via a pharmacy request. Contact your plan regarding your drug coverage.
4 **Messages:** Phone messages received before 3PM are usually returned daily.
5 **Benefits:** ENMFA will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre- operative appointment.
6 **Payments:** ENMFA accepts Debit Cards, Credit Cards, Health Savings Account Cards, Cash and Checks.
7 **Insurance Claims:** ENMFA files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. ENMFA only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers.
8 **Multiple Policies:** When multiple policies exist, it is the policy holder's responsibility to inform ENMFA of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
9 **Insurance Networks:** ENMFA only files claims whom we have a contractual relationship; our in-network list is available upon request.
10 **Liability Claims:** ENMFA does not accept personal injury protection, letters of protection or other liability claims. These types of claims are to be paid in full by the patient.
11 **Non-Covered Services:** ENMFA will not submit claims for non-covered items including, but not limited to cosmetic services and other over the counter convenience items (OTC eg. Biofreeze, Coban, Lyncos, Mycomist, etc...)
12 **Referrals:** ENMFA may refer patients to other providers, facilities and labs. ENMFA is not responsible for these entities. The patient should contact these non-ENMFA providers, facilities, or labs directly regarding any billing questions. The policyholder is also responsible for all insurance prior authorizations and/or managed care referrals necessary for payment to ENMFA.
13 **Appointment Hold:** Regarding repetitive missed appointments, non-compliance, hostile behavior, and/or financially deficient relationship, 30 days advance notice will be given should the situation result in transfer of the patient care.
14 **Account Balance:** If you have multiple unpaid claims, you may be required to pay 25% of your total account balance before your next appointment to remain in good standings.
15 **Patient Balance Statement:** ENMFA will send a reminder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be accessed a $10 rebilling fee for each month that it is reissued.
16 **Delinquent Accounts:** Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient/ guarantor's responsibility in addition to the balance due the office.
17 **Return Checks:** A $25.00 fee will be assessed on all returned checks. Any NSF or Closed Accounts will result in future services on a pre-pay cash credit basis. The District Attorney's Office will prosecute unresolved checks.
18 **Refunds:** ENMFA issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, as long as the other outstanding accounts have been resolved.
19 **Returns:** Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs: custom items are non-returnable, non-refundable.
20 **Medical Records:** The cost for copied medical records and x-rays for personal records will be charged to the patient and collected prior to replicating. The fees for services regulated by HIPAA and New Mexico Health and Safety Code.

The undersigned certifies that he/she has read and understands the forgoing 1-19 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

________________________ ________________________
Patient/Guardian Signature Patient/Guardian Print Name

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Date

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are 100% responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.

I agree to be 100% responsible for the payment of all unpaid services rendered on my behalf or my dependents, including fees for collection services, court costs, etc.

Durable Medical Equipment/Supplies Waiver

Certain medical conditions may, or may not, require the use of durable medical equipment/supplies, which include any of the following: prefabricated and custom-fabricated casts, splints, braces, dressings, slings, cushions, etc.

Although these are considered to be "medically necessary" by your physician, many insurance carriers will deny payment of such items.

If you are covered by private insurance, it is our policy to bill your insurance carrier(s) for certain items (please note: many private insurance companies consider prefabricated or "off the shelf" splints to be non-covered items). In the event that these claims are denied by your insurance carrier(s), you will be held responsible for paying any outstanding bills regarding such items issued. For non-covered items, payment is due when the item is dispensed.

Consent to Obtain Prescription History

This consent form authorizes Eastern New Mexico Foot and Ankle to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Eastern New Mexico Foot and Ankle can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes. Understanding all of the above, I hereby provide informed consent to Eastern New Mexico Foot and Ankle to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I understand that by signing below, I am agreeing with the individual financial agreement, the DME/supply waiver and the prescription history obtainment.

______________________________ Patient/Guardian Signature

______________________________ Patient/Guardian Print Name

______________ Date