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

Interventional Pain Management
John V. Watkins, MD

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

Foot, Ankle & Lower Leg Reconstructive Surgery
John Anderson, DPM, FACFAS
Loren Spencer, DPM, FACFAS
Stephanie Campbell, DPM
Joseph Fleck, DPM

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

www.newmexortho.com

Date: ___________________

Patient Name:____________________________________ **DOB:** ________________

Preferred pharmacy: ____________________ Location: ____________________________

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

Medications	Strength/Dosage	Taken How Often

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

26130 Hwy 70
Ruidoso, NM
Phone: 575-434-0639
Fax: 575-434-4148

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

PATIENT REGISTRATION FORM

Today's Date _____/_____/_______

PATIENT INFORMATION

Patient Name Last First Middle		□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?	Birthdate / /	Age Sex □ M □ F □ T
Street or Mailing Address (circle one) City State Zip Code			Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address		Social Security - -
Occupation	Employer	Employer Phone Number	

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other ___________

Pharmacy: **City:** **Body Part Being Treated:**

Is Patient a Minor: □ YES □ NO
If YES, Name of Parent/Guardian:

Referring Physician: Phone #

Primary Physician: Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name		Address	Home Phone Number ( )
Birth Date / /		E-Mail Address	
Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ MOTOR VEHICLE ACCIDENT (MVA) □ **ACCIDENT/INJURY DATE:**

Does the patient have healthcare coverage? □ YES □ NO **Insurance Name**

Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other ___________

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other ___________

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

______________________________ ______________________

Patient/ Guardian Signature Date

New Mexico Bone & Joint Institute Financial Policy:

-Ultimately you are responsible for knowing and understanding your benefits and paying the balance of your account.
-You are responsible for getting referrals (Medicaid Patients) and Authorizations (Tricare Prime Patients)
-Co-Payments are due at time of service.
-Workers' Comp: If the Workers' Compensation payer denies your claim, you will be 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.

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. **(MARK YES OR NO AS APPLICABLE AND INITIAL)**

(____) 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 in regards to any co-pays, deductibles or balances.

I have read all the information 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. 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

Privacy Acknowledgement Notice-pursuant to 45 CFR S164.520(c)(ii), Health Insurance Privacy and Accountability Act of 1996

This acknowledgement, which allows "the Practice" (New Mexico Bone & Joint Institute) to use and/or disclose personally identifiable health information for treatment, payment, or healthcare operations. **Please read the following carefully:**

I understand and acknowledge the following:
1. I am consenting to the use and/or disclosure of personally identifiable health information for the purpose of treating me and is necessary in order to carry out any healthcare operations permitted in the Privacy Regulations.
2. In its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as necessary.
3. I have the right to request that the Practice restrict how my information is used or disclosed.
4. 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 The Practice 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, Guardian or Responsible Party Print Patient Name 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.

______________________________ ____________
Signature of Patient/Parent/Guardian Date

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.

I AGREE to take the medication(s) exactly as directed 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 AGREE to never sell any of my medication(s), and **I AGREE** to never share my medication(s) with anyone, including 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 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 it is my responsibility to inform the prescribing provider if I experience any other side effects of the medication(s).*

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

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,

I HAVE FULLY READ AND UNDERSTAND THE ABOVE STATEMENTS. By signing below you agree to all the above:

____

Patient Signature **Date**

NMBJI Provider Disclosure & Acknowledgment Statement (Please initial each statement)

______I understand the doctor(s) may have ownership in this facility and Southern New Mexico Surgery Center (SNMSC) and I am aware that I may have surgery performed at any facility where my surgeon has privileges. Ownership can change at any time. They may also have stock or ownership in devices and/or procedure patents. Surgeons do not receive any financial gain based on any amount, type or brand of implant used.

______I understand that our doctors are instructors and teachers at many hospital(s) and medical school(s). Medical students/residents/fellows may be assisting during my Evaluation and Care. If physicians are out of the office my care may require me to receive some of my treatment from another provider as necessary I understand that I have the right to decline or exclude participation of any person or provider from my care.

______I understand that I may go to any facility I wish for labs and imaging. I may seek a second opinion and will notify the NMBJI staff with any questions or concerns that I may have. If a provider cannot return a call in reasonable time or in case of an emergency I will go to ER or call 911.

______I understand that before, during, and after my procedure that NMBJI surgeons may use my surgery/images/photos to teach other surgeons, residents, medical students, to improve procedures. I understand that no personal or private information will be disclosed at any time. I understand I have the right to decline any use of my surgery/clinical case to be used for the improvement of healthcare. If I do not agree with this, I will alert the provider or staff immediately.

______ I understand that forms, information, insurance, health histories, medication lists, referrals and data are necessary for medical care, such as authorizations for medications, therapy, as well as surgeries and procedures. We don't like paperwork either, but it is necessary for all healthcare.

______ I understand that I should expect NMBJI to be kind, courteous, friendly, helpful, compassionate, knowledgeable and have my best care in mind. I, in turn, promise to be respectful, exercise patience, ask questions if concerned or unsure, follow care plans and instructions of the provider, and treat all other patients, staff, and our employees the way I wish to be treated. *We will do our best to treat you like a member of our own family!*

____

Patient Signature **Date**