# Pecos Valley Physician Group

## New Patient Information

Patient (Legal) Name: _____ Patient Address: _____

City: _____State: _____Zip: _____ Home/Cell: (____) _____/ (____) _____

Patient Soc Sec No: _____ Patient DOB: _____ Sex: Male / Female

Martial Status: _____ Race (optional): _____ Pharmacy: _____

Email address: _____ Primary/Referring Doctor: _____

***Emergency Contact (Outside of Household)***

Emergency Contact Name: _____ Phone: _____

Address: _____City: _____State: _____Zip: _____

***Guarantor Information (Person Responsible for the Bill)***

Guarantor Name: _____ Phone: _____

Address: _____City: _____State: _____Zip: _____

Relationship to patient: _____

***Primary Insurance*** ***Secondary Insurance***

Name of Insurance: _____ Name of Insurance: _____

Policy Holder: _____ Policy Holder: _____

ID Number: _____ ID Number: _____

Group Number: _____DOB:_____ Group Number: _____DOB: _____

Policy Holder Soc Sec No: _____ Policy Holder Soc Sec No: _____

***Employment***

Employer Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Additional Phone: _____

***Authorization for Treatment – Parent/Guardian***

I hereby give permission to Pecos Valley of New Mexico to provide medical care and treatment for myself and/or child.

_____
Signature Date

In the event that my spouse or I are unavailable, I give permission to Pecos Valley of New Mexico to provide medical care as they deem necessary while my child is under the supervision of:

Name: _____ Relationship to Patient: _____

_____
Signature Date

***Assignment of Benefits and Release of Information:***

I hereby authorize payment benefit directly to Pecos Valley of New Mexico. I also authorize release of any medical record information for insurance purposes.

_____
Signature Date

***Privacy Practice Notice Receipt***

I have received the Notice of Privacy Practice Notices. Your signature indicates you understand and have received a copy of our notice. The notice is yours to keep.

If you have any questions regarding the information set forth in our Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at 575-492-5094.

_____
Signature Date

***Financial Policy***

Your insurance policy is a contract between you and the insurance company. It is your responsibility to know what type of coverage you have. We will bill your insurance carrier, but cannot guarantee benefits or amounts covered. **YOU ARE RESPONSIBLE FOR THE BALANCE OF PAYMENT**, which is due within 30 days or as per arrangements with our billing department.

Insurance deductibles and co-payments are due at the time of service. Adults accompanying a minor are responsible for the payment of the service.

Questions regarding this policy statement or payment method may be directed to our office manager

_____
Signature Date

# Pecos Valley Physician Group

*Consent for Special Disclosure of Protected Health Information and Advance Directive Notification.*

I have an Advance Directive (Living Will) in place.
_____ yes _____ no

Since I do not have an Advance Directive in place, I would like information.
_____ yes _____ no

Would you like automated reminder calls about future appointments?
_____ yes _____ no

Would you like to participate in Patient Satisfaction survey calls?
_____ yes _____ no

I consent to Pecos Valley Employees identifying themselves and leaving messages on my answering machine or with other individuals answering my phone, for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call.
_____ yes _____ no

I consent to Pecos Valley Employees contacting me at work, if applicable, for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call.
_____ yes _____ no

I consent to Pecos Valley Employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.
_____ yes _____ no

*If yes, please designate the person(s) to whom such information may be disclosed:

Name: _____

Relationship: _____

Phone: _____

(If more than one person, please list additional names on back)

Patient Signature: _____ Date: _____

**Patient Consent for E-Prescribing (Electronic Prescribing)**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

| | | |
|---|---|---|
| Parent, Patient's Signature or Authorized Representative | Date | Time |
| Relationship to Patient | Interpreter, if utilized | |
| Witness' Signature | | |