**Central Medical Services of Southern New Mexico**

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Please answer EVERY question***

**First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Last:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Sex:** M F **Age:** \_\_\_\_\_\_\_\_\_\_

**Marital Status:** Single Married Divorced Widowed Separated **SSN** \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Apt/Sp#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Contact: 🞏** Residence  **🞏** Cell  **🞏** Phone **🞏** Work Phone **🞏** Email  **🞏** Letter

**Will you allow the office to leave messages on answering machine:** 🞏 YES 🞏 NO

**Home Ph:** (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Ph:** (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Ph:** (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you like a text reminder for appointments? 🞏** Yes  **🞏** No **Do you have an advance directive?** **🞏** Yes  **🞏** No

**Emergency Contact Information:**

**Emergency Contact Name(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Ph**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse/Parent(s)/Legal Guardian(s) Information:**

**Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_**

**Home Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wk #(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Language:** 🞏 English 🞏 Spanish 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:** White African American Asian American Indian **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnic Group:** Hispanic/Latino Unknown **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nationality:** US Citizen Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drivers License #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_

**I give the provider permission to access my medication history:** 🞏 YES 🞏 NO

**Preferred PHARMACY/LOCATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ALL OTHER PHYSICIANS PATIENT HAS SEEN:**

 **Type Name Reason**

**Example Cardiologist Dr. Heart Pain in chest**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***PRIMARY* Insurance Information**

**Type: 🞏 Medicaid 🞏 Medicare 🞏 Commercial/Group 🞏 Self Pay 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Co-Pay Amt $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: Self Spouse Parent Legal Guardian Life Partner Employer Other**

**INSURED INFORMATION:**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: M F Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

***SECONDARY* Insurance Information**

**Type: 🞏 Medicaid 🞏 Medicare 🞏 Commercial/Group 🞏 Self Pay 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Co-Pay Amt $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: Self Spouse Parent Legal Guardian Life Partner Employer Other**

**INSURED INFORMATION:**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: M F Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT OR GUARDIAN CONSENT FOR TREATMENT:**

**I AUTHORIZE THE PROVIDERS OF CENTERAL MEDICAL SERVICES OF SOUTHERN NM TO EXAMINE, DIAGNOSE, AND RECOMMEND TREATMENT TO ME OR PERSONS UNDER MY CARE. I AGREE TO BE THE RESPONSIBLE PARTY FOR THE PAYMENT OF ALL SERVICES PERFORMED AT THE CLINIC THAT ARE NOT COVERED BY MY INSURANCE.**

**FINANCIAL POLICY**

**Thank you for choosing Central Medical Services of Southern NM as your health care provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our Patient Information form prior to seeing the physician. Payment for service is due at the time services are rendered. We accept cash check, Visa, Discover and MasterCard. We will be happy to help your process your insurance claim for your reimbursement.**

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges. Secondary insurance, and “usual and customary” charges. We are however, contracted with certain managed care, and preferred provider plans; we will follow the guides for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. **All charges your responsibility whether your insurance company pays or does not pay.** Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.**
4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment.  **You will be responsible for any unpaid claims.**
5. If your insurance company does not pay in full within 45 days, we require you to pay the balance **by cash, check, Visa, MasterCard, and Discover.**
6. **Lab Billing-** Please remember, you lab billing is separate from our physician’s billing and you may receive a separate itemized bill from the laboratory, for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.
7. Returned checks and balances older than 45 days may be subject to collection placement and collection fees.
8. FMLA/Disability Forms charge is due at time of request. Charge is determined on individual form.

*Please note, that if you must cancel or reschedule your appointment, all cancellations must be made at least 24 hours in advance. Thank you for choosing Central Medical Services of Southern NM as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.*

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**