Los Alamos Medical Care Clinic, Ltd.

Allergy/Immunology, Dermatology, Internal Medicine, & Family Practice

3917 West Road Suite 150, Los Alamos, New Mexico 87544
Telephone 505-662-4351 Fax 505-662-2932

Richard W. Honsinger MD, MACP
J. Monique Beyerle, PA-C
Galina Batygina, PA-C
James J Ziomek MD, FACP
G. Elisa Lange, MD
Lori Whitley, MD, FAAD
Monica Snowden, MD

Please Print. All information will be confidential

Date_____

PATIENT INFORMATION

Name_____,_____ Birth Date_____/____/_____ Gender M F
Last First
Social Security # _____-_____-_____
Address_____City_____State_____ Zip_____
Home Phone ( )_____Work Phone ( )_____ Cell ( )_____
Name of Employer_____Occupation_____
Race_____Ethnicity_____
Preferred Language_____Preferred Pharmacy_____
E-mail address_____ Web Enable Yes No

GENERAL INFORMATION

Referred to medical practice by _____
Patient's Primary Care Physician_____

In Case of Emergency Contact: Name _____
Relationship_____
Address_____
Daytime Phone ( )_____ Eve Phone ( )_____

FILL OUT IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name_____ Work Phone ( )_____
Mother's Name_____ Work Phone( )_____
Responsible Party_____ Work Phone( )_____
Relationship_____

INSURANCE INFORMATION / RESPONSIBLE PARTY

Please bring your insurance card(s) with you to your appointment to be copied by receptionist

Primary Insurance Plan Name_____
Plan Phone ( ) _____Policy ID# _____Group#_____
Effective Date _____Expiration Date_____

Secondary Insurance Plan Name_____
Plan Phone ( )_____Policy ID#_____ Group #_____
Effective Date _____ Expiration Date_____
**If Policyholder's address is different from patient's please list:

_____
Address City State Zip Code

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DOCUMENTATION OF GOOD FAITH EFFORTS

PATIENT NAME_____DOB_____

I Acknowledge receipt of Los Alamos Medical Care Clinic's Notice of Privacy Practices
On_____

_____
(Patient Signature) **(Date)**

To be filled out only if patient refuses to sign for Notice of Privacy Practices

The patient was provided with a copy of the practice's Notice of Privacy practices on
_____. The Practice made a good faith effort to obtain a written
(Date)
acknowledgment of receipt of the Notice. The practice was unable to obtain an acknowledgment because:

⁞ Patient refused to sign
⁞ Patient was unable to sign (explain reason):
_____
_____

⁞ There was a medical emergency (another attempt to obtain an acknowledgment will be made at the next available opportunity).
⁞ Other (give reason)
_____
_____
_____
_____

Signature of Practice Employee Completing Form:
_____ Date: _____
(Employee Signature)

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Patient History

Date_____

Name_____ Age _____ Birth Date_____

Birth Place_____ Places Lived_____

Marital Status S M W D (circle one) Religious Preference_____

Family History Age if living Age at death Cause of death Present disease or disability
Father_____
Mother_____
Brother (No.)_____
Sisters (No.)_____
Children (No.)_____

1. Have any of the above had any of the following:

Strokes	Diabetes	Emphysema	Hives
Heart disease	High blood pressure	Asthma	Suicide
Cancer	Gallbladder	Hay fever	Mental illness
Tuberculosis	Migraine headaches	Kidney stones	Kidney disease

2. How much do you smoke? _____
3. How much alcohol do you use? _____
4. Highest education level attained? _____
5. Do you exercise regularly? _____
6. Are you a veteran? _____
7. Hospitalization: _____

Year	Hospital	City	Diagnosis, injury, operation

8. List any medication you take regularly or frequently:

   _____

9. List all medications you are allergic to:

   _____

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CHILDHOOD DISEASES
Measles
Mumps
Chicken Pox
Scarlet Fever
Diphtheria
Whooping Cough

ALLERGY
Hay Fever
Asthma
Food Allergies
Drug Allergies or
Drug Reactions
Allergy to Bee Stings

ENDOCRINE
Thyroid Disease
Diabetes

SKIN
Hives Acne
Eczema
Boils or Abscesses
Fungus Infection
Psoriasis
Mole (changing)

HEART
Rheumatic Fever
Coronary Disease
Angina
Chest Pain
Congenital Heart Disease
High Blood Pressure
Edema
Heart Failure
Irregular Heart Rate

NERVOUS
Epilepsy
Meningitis
Encephalitis
Poliomyelitis
Nervous Breakdown
Fainting Spells
Tension Headaches

BLOOD
Anemia
Malaria
Blood Transfusions
AIDS
Easy Bruising

ENT
Earaches
Hearing Loss
Dizziness
Ringing Ears
Eye Injury
Wear Glasses
Wear Contacts
Glaucoma
Nasal Polyps
Sinusitis
Nosebleeds
Dentures

PULMONARY
Tuberculosis
Asthma
Bronchitis
Pneumonia
Emphysema
Shortness of Breath
Coughing or spitting up blood
Chronic Cough

MUSCULOSKELETAL
Hernia
Muscular Dystrophy
Fracture of Bones
Spine Injury
Arthritis/Rheumatism
Back Pain

WOMEN ONLY
Breast Lumps
Irregular Periods
Severe Cramps with Period
Stillbirth
Miscarriages
Ovarian Disease
Last Period_____

DIGESTIVE
Difficulty in Swallowing
Vomiting of Blood
Gallbladder Disease
Pancreatitis
Intestinal Parasites
Intestinal Obstruction
Spastic Bowel
Constipation
Hemorrhoids
Anal Fistula
Pilonidal Cyst
Hepatitis
Liver Disease

KIDNEY AND BLADDER
Nephritis
Kidney Stones
Cystitis
Uremia
Venereal Disease
Nighttime Urination
Blood in Urine
Painful Urination
Frequent Urination
Bedwetting
Urinary Retention
Prostatitis

VASCULAR
Phlebitis
Thrombophlebitis
Varicose Veins

OTHER SERIOUS DISEASE
_____
_____
_____

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FINANCIAL POLICY / CONSENT TO TREATMENT

Thank you for choosing Los Alamos Medical Care Clinic to provide your healthcare needs. Because we are committed to providing you with the best possible care and service, we would like to make you aware of our financial policy. We require that you read and sign this document prior to receiving medical treatment.

Co-payments, Deductibles, and Fees: Your insurance carrier requires that we collect your co-pay at the time of service. Fees for services not covered by your insurance are also due at the time service is rendered. We accept cash, checks, and most major credit cards. A $7.50 fee will be assessed to your account if a check is returned for nonsufficient funds.

Insurance: You must present a current insurance card at each visit. If you do not present a current insurance card, you will be responsible for payment in full at the time of service. Your medical insurance is a contract between you and your insurance company. You agree that Los Alamos Medical Care Clinic may bill these payors and that these payors may make payments directly to Los Alamos Medical Care Clinic, but you are primarily responsible for any charges incurred while you are a patient. If your insurance carrier is not one we participate with; you are responsible for payment at the time of service. We offer a 35% discount for visits paid in full at the time of service. The discount is not applicable to cosmetic services or immunizations. You have a responsibility to provide timely information to our office so a claim can be properly submitted. If you receive services without a referral from your primary care physician or services that are not a covered benefit, you will be responsible for payment in full.

Missed Appointments: We may charge up to a $150.00 "no show" fee if you fail to keep a scheduled appointment or fail to cancel an appointment with at least 24-hour notice. This fee is not covered by your insurance plan and is your responsibility. Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice.

Prompt Payment: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you do not have medical insurance, have a financial hardship, or if you are unable to pay your bill in its entirety please contact our billing department prior to your appointment to discuss payment options. We reserve the right to turn any account over to a collection agency if the account is not paid within 90 days.

Patient Financial Responsibility: I acknowledge full financial responsibility for services rendered by Los Alamos Medical Care Clinic, Ltd. I understand that I am financially responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of co-pays and any prior balance I may owe is due at the time of service unless a payment agreement is on file.

Consent to Treatment: Care will be provided according to your attending physician's orders. For major procedures, such as surgery, you will be asked to sign a separate consent form. By agreeing to receive care, you are consenting generally to other medical treatments such as x-ray examinations, laboratory tests, and minor procedures that your physician may order. Your right to information about or refusal of any test or procedure is not altered by this agreement.

Patient Name: _____ Date of Birth_____

Patient/Legal Guardian Signature_____

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Galina Batygina, PA-C

To Whom It May Concern:

We have you scheduled on_____ with_____ at_____ in our Los Alamos office. Please bring completed paper work to your appointment.

Below is an abbreviated list of insurance companies we are currently contracted with:

Presbyterian
Medicaid **We take *all* Medicaid Plans**
ACA/Marketplace Plans **Blue Cross, NM Health Connections, and Christus St. Vincents**
(we do not accept Molina ACA/Marketplace)
Great West
United Health Care
Blue Cross
Medicare
Cigna
Aetna **(We are not contracted with all Aetna Plans, call your plan for confirmation)**
Humana
Medicare Advantage Plans **(We are not contracted with Amerigroup or Molina)**
We are not contracted with Multiplan or PHCS Networks
No insurance (we offer a 35% discount if paid in full same day or payment plans may be set up)

No Pain Management Provided.

We are not contracted with Tricare.

Copays are due at the time of service.

If your insurance company is NOT listed please contact our office to obtain more information.

In order to avoid a $50.00 no show fee, you must cancel/reschedule

24 hours prior to your scheduled appointment.

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If you wish to share your personal health information with another person, please fill out the Medical Release Form on the next page.

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AUTHORIZATION TO RELEASE INFORMATION

IF RECORDS ARE BEING RELEASED TO PATIENT THERE IS A PRINTING FEE OF $2.00 PER PAGE FOR THE FIRST 10 PAGES AND $.20 PER PAGE AFTER. CD'S ARE $6.50 FLAT RATE

PLEASE PRINT CLEARLY

PATIENT'S NAME_____
(LAST) (FIRST) (INITIAL)

ADDRESS_____
(STREET) (CITY) (STATE)

PHONE (_____)_____ BIRTHDATE_____

*** MEDICAL RECORD SENT BY:**

I AUTHORIZE _____ ADDRESS_____
(DOCTORS FULL NAME AND ADDRESS)

PHONE_____ TO RELEASE MEDICAL INFORMATION FROM MY MEDICAL RECORD

*** MEDICAL RECORD SENT TO**:

NAME OF DOCTOR, HOSPITAL, ETC _____
ADDRESS _____
CITY / STATE / ZIP CODE _____

FOR THE PURPOSE OF REVIEW / EXAMINATION, I FURTHER AUTHORIZE YOU TO PROVIDE SUCH COPIES THEREOF AS MAY BE REQUESTED. THE FOREGOING IS SUBJECT TO SUCH LIMITATION AS INDICATED BELOW:

*** PROPORTION OF RECORD SENT:**

ENTIRE RECORD _____
SPECIFIC INFORMATION_____
OLD RECORDS FROM PREVIOUS PHYSICIANS _____

I GIVE SPECIAL PERMISSION TO RELEASE ANY INFORMATION REGARDING: (INITIAL ON APPLICABLE LINE (S) BELOW)
_____ SUBSTANCE ABUSE
_____ PHYCHIATRIC / MENTAL HEALTH INFORMATION
_____ HIV INFORMATION

*** REASON FOR REQUEST:** _____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. OTHERWISE, THIS AUTHORIZATION IS GOOD UNTIL IT IS REVOKED.

***SIGNED**_____ *** DATE**_____
(IF NOT PATIENT, STATE RELATIONSHIP)

WITNESS_____DATE_____

FOR OFFICE USE ONLY

NAME_____
RECEIVED_____COMPLETED BY_____
COMPLETED_____FEE PAID_____
AMOUNT BILLED_____AMOUNT DUE_____
DISCLOSURE CONSISTED_____