St Francis Health Center, LLC
1494 S. St Francis Drive
Santa Fe: N.M. 87505
Phone: 505-983-7276 Fax: 505-983-5017

CONFIDENTIAL PERSONAL INFORMATION

Today's Date: _____

Patients Name (Last, First, Middle): _____

Preferred Name: _____ Age: _____ Date Of Birth: _____ Sex at Birth: _____ Gender: _____

Parent Name (If patient is a minor): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address if different from Home address: _____

City: _____ State: _____ Zip code: _____

Telephone (Cell, Home): _____ Work Telephone: _____

Email Address: _____

Occupation: _____ Employer's Name: _____

Emergency Contact Name: _____ Relationship: _____

Telephone Number: _____

Financial Information:

Insurance Company: _____ Subscriber's Name: _____

Insurance ID Number: _____ Group Number: _____

Credit Card Information Required: We ONLY accept VISA and MASTER CARD.

Type of CC: _____ Credit Card Number: _____

Expiration Date: _____ CVC: _____ Zip Code: _____

Printed Name: _____

Signature: _____ Today's date: _____

By signing, I verify that the above information is correct and true to the best of my knowledge.

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Name: _____ DOB: _____ Date: _____

Health History Questionnaire

What are the concerns for which you are seeking care?

1.) _____ Date of onset: _____
2.) _____ Date of onset: _____
3.) _____ Date of onset: _____
4.) _____ Date of onset: _____

Who is your primary care physician? _____

For what concern did you last receive health or medical care? _____

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc, are you currently taking?

_____
_____
_____
_____
_____

Check each of the following that you currently use:

☐ Laxative ☐ Pain Relievers ☐ Antacids ☐ Cortisone ☐ Antibiotics
☐ Heart/Blood Medication ☐ Allergy Medication ☐ Thyroid Medication
☐ Sleeping Pills ☐ Anti-Depressants ☐ Birth Control Pills ☐ Hormones

Do you have any known contagious diseases at this time? Yes/No _____
If Yes, what? _____
_____

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Name: DOB: Date:

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current Health							
Age of Death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer: Diabetes: Epilepsy:

Heart Disease: High Blood Pressure: Stroke:

Anemia Kidney Disease Glaucoma

Allergies: Asthma: Mental Illness:

Arthritis: Tuberculosis: Alzheimer's Dz:

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Notice of Privacy Practices

This Notice explains how our office may issue and disclose your protected health information and your rights. We reserve the right to change the terms of this notice and our privacy policy at any time, if you may have inquiries, please let us know.

Uses and Disclosures:

We may use and disclose your health information for different reasons:

- Treatment: To assist on your diagnosis and treatment.
- Payment in order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plant to get reimbursement for services.
- Health Care Operations: For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing board, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose when required by law for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about a victim of a crime or other lawful process.
- **National security and Intelligence.** As required by military officials for security and military purposes.
- **Public Health activities.** To public health agencies for reasons such as preventing or controlling disease, injury and disability.
- **Victims of abuse, neglect or domestic violence**. To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers compensation law.

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Authorization:

Any use or disclosures other than those described above will be made with your prior written consent, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Printed Name: _____

Signature: _____

Date: _____

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Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to St. Francis Health Center. Upon receiving your request we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email then by regular mail. To verify or modify where or how you would like communication sent contact. St. Francis Health Center. Unless requested otherwise, we will direct mailings and telephone messages to the address/ telephone number we have on record.

Right to inspect and copy: Includes the right to see and get copies of your information that we maintain. Submit your request in writing to St. Francis Health Center and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to St. Frances Health Center. We will respond within 60 days of receiving written request. We may deny your request in writing if your information is not 1.) Correct and complete, 2.) Not created by us, 3.) Not allowed to be disclosed, or 4.) Not part of the information. Upon approval we will make the changes, inform you when the changes are complete and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures: This will not include uses or disclosure make for treatment, payment or health care operations, disclosure made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving your written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom the information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you in advance.

Right to get a paper copy of this Notice: At any time even if you previously agreed to receive electronic copy.

Right to file a complaint: If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact St. Frances Health Center to file a complaint. You also have the right to file a complaint with the Secretary of

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the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with is or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please Print):

Patient/ Guardian Signature: Date:

Relationship to Patient (if other than self):

Note: If this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

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Name: DOB: Date:

Review of Systems

Have you had any of these childhood illnesses? (Check if yes)

Scarlet Fever: Diphtheria Rheumatic Fever: Mumps:
Measles: German measles:

Have you had any immunizations? Yes/ No Negative reactions?

Hospitalization, surgery, x-rays and special studies:

What hospitalizations, surgeries, x-ray, or special studies have you had?

Year: Year:
Year: Year:

Allergies:

Are you hypersensitive or allergic to?

Environmental Substances:

Foods:

Drugs:

Weight: lbs. Height: Weight 1yr ago:
lbs.

Maximum (not pregnant) Weight: lbs. When:

Review of Symptoms:

Answer questions or check any of the following you have or have had in the past 6 months.

Lifestyle Habit

Main Interests and hobbies:

Exercise, what kind?

How often do you exercise?

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Answer Yes or No to the following:

Have a religious/spiritual practice? _____

Average 6-8 hrs. of sleep? _____

Have a supportive relationship? _____

History of abuse? _____

Major Trauma? _____

Use recreational drugs? _____

Treated for drug dependence? _____

Drink Coffee/Drink black or green tea: _____

Drink cola or other sodas? _____

Add salt to your food? _____

Eat refined sugar? _____

Enjoy work? _____

Take vacations? _____

Spend time outside? _____

Watch TV? How often? _____

Use alcoholic beverages? # Per week _____

Treated for alcoholism? _____

Use tobacco currently? _____

Used tobacco in the past? How many years? How many a day? _____

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Name:_____ DOB:_____ Date:_____

Check any of the following you have had in the past 6 months:

Skin:
- ____ Rashes
- ____ Eczema, Hives
- ____ Acne, Boils
- ____ Itching
- ____ Fungal Infections
- ____ Color Change
- ____ Hair loss
- ____ Dry skin
- ____ Lumps
- ____ Night sweats
- ____ Slow healing ulcerations
- ____ Flushing or hot flashes

Nose and Sinuses:
- ____ Frequent colds
- ____ Nose bleeds
- ____ Stuffiness
- ____ Hay Fever
- ____ Sinus Problems
- ____ Loss of smell

Eyes and Ears:
- ____ Itchy eyes
- ____ Watery eyes
- ____ Dry Eyes
- ____ Swollen/ Painful eyes
- ____ Red Eyes
- ____ Impaired vision/ Blurriness
- ____ Floaters Vision
- ____ Glaucoma
- ____ Hearing difficulty
- ____ Ringing
- ____ Earaches/Infection

Mouth and Throat:
- ____ Sore Throat
- ____ Copious Saliva
- ____ Teeth Grinding
- ____ Sore Tongue/Lips
- ____ Gum problems Hoarseness
- ____ Gagging/choking
- ____ Difficulty swallowing

Head/Neck:
- ____ Headache/migraine
- ____ Faintness
- ____ Dizziness
- ____ Jaw Pain
- ____ Swollen Glands
- ____ Goiter
- ____ Pain or stiffness
- ____ TMJ

Respiratory:
- ____ Chest congestion
- ____ Wheezing
- ____ Asthma
- ____ Bronchitis/Pneumonia
- ____ Emphysema
- ____ Difficulty/Pain breathing
- ____ Shortness of breath
- ____ Tuberculosis
- ____ Cough ____ Wet ____or Dry
- ____ Coughing blood

Cardiovascular:
- ____ Heart disease
- ____ Angina/Chest pain
- ____ High/Low Blood Pressure
- ____ Murmurs
- ____ Blood clots
- ____ Irregular heart beat
- ____ Palpitations/Fluttering
- ____ Swelling in ankles

Circulation:
- ____ Easy bleeding or bruises
- ____ Anemia
- ____ Deep leg pain
- ____ Varicose Veins
- ____ Cold hands/feet

Endocrine:
- ____ Hypothyroid
- ____ Heat or cold intolerance
- ____ Hypoglycemia
- ____ Diabetes
- ____ Excessive thirst
- ____ Excessive hunger
- ____ Fatigue
- ____ Seasonal depression

Immune:
- ____ Chronic Fatigue Syndrome
- ____ Chronic Infections
- ____ Chronically swollen glands
- Slow wound healing

Muscles/Joints:
- ____ Joint pain
- ____ Muscle spasm/ cramps
- ____ Restless leg syndrome
- ____ Sciatica
- ____ Osteoporosis

Neurologic:
- ____ Seizures
- ____ Paralysis
- ____ Muscle weakness
- ____ Numbness or tingling
- ____ Easily stressed
- ____ Vertigo or dizziness
- ____ Loss of balance

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Name: _____ DOB: _____ Date: _____

___ Tics

Digestion:
___ Trouble swallowing
___ Heartburn/Acid Reflux
___ Change in thirst/appetite
___ Ulcer
___ Nausea/ Vomiting
___ Gas/ Bloating
___ Belching or passing gas
___ Diarrhea
___ Constipation
___ Pain or cramps
___ Mucous in stool
___ Black/Bloody stool
___ Hemorrhoids
___ Itchy/Burning Anus
___ Rectal Pain
___ Liver/Gall Bladder trouble
___ Jaundice (Yellow Skin)
Bowel Movements are how often? ____
Has this changed? ____
___ Stools ___ Hard
___ Firm ___ Soft ___ Loose

Urinary:
___ Pain on Urination
___ Increased Frequency
___ Frequency at night
___ Frequent infections
___ Inability to hold Urine
___ Kidney Stones
___ Blood In Urine

Mental/ Emotional:
___ Mood swings
___ Anxiety or nervousness
___ Considered/ Attempted
___ Suicide
___ Depression
___ Poor Concentration
___ Poor Memory
___ Other: ___

General:
___ Poor Sleep/Insomnia
___ Dream disturbed sleep
___ Fatigue/Low energy
___ General feel Hot
___ General Feel Cold
___ Chills
___ Fevers
___ Poor Appetite
___ Constant Hunger
___ Cravings
___ Particular taste in mouth
___ Low Libido
___ Experience High Stress

Genitourinary:
___ Hernias
___ Testicular masses
___ Testicular Pain
___ Prostate disease

Uterine/Ovarian/Vaginal:
___ Irregular Cycles
___ Bleeding Between cycles
___ Pain during intercourse
___ Clotting
___ Heavy or excessive flow
___ PMS
___ Endometriosis
___ Painful Menses
___ Vaginal discharge?
___ Color?
___ Vaginal odor
___ Ovarian Cysts
___ Menopausal Symptoms

Age at which menses began? _____
Age of last menses (If menopausal) _____
Length of cycle? _____
Duration of Flow _____
Date of last period _____

Sexual Health:
Sexually Transmitted Diseases _____
Last STD testing? _____
Are you sexually active? Y/N
Sexual Orientation _____
Sexual dysfunction/erectile dysfunction _____
Birth Control? Type? _____

Pap History:
Date of last PAP _____
History of abnormal PAP: _____

Gestational History:
Number of pregnancies? ____
Number of live births? ____
Number of miscarriages? ___
Number of abortions? ____
Could you be pregnant? Y/N
Difficulty conceiving ____

Breast:
___ Breast pain/Tenderness
___ Nipple discharge
___ Breast Lump
Do you breast self-exam? Y/N
Date of last mammogram? _____

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Name: _____ DOB: _____ Date: _____

Motor Vehicle Accident:

Date of MVA: _____
State MVA occurred: _____
Claim #: _____
Insurance Co. _____
Claim Submitted? _____
Adjuster: _____
Phone: _____
Attorney Name: _____
Phone: _____
PIP Coverage: _____

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St. Francis Health Center Financial Policies

Please have your insurance card ready for our staff to photocopy and verify your insurance.

We are contracted with the following Insurance companies:

- BCBS PPO & Centennial
- United Health Care
- Presbyterian PPO & Centennial
- True Health

We do not take Medicare or any Medicare Advantage Plans.

For those patients without health insurance: Full payment for service is expected at the time of service.

1.) Each patient has a contract for an insurance policy; this contract is between the patient and their insurance carrier.** It is the patients responsibility to review their insurance policy in order to understand their financial obligations**
2.) SFHC maintains a contract to provide health care services; this contract is between SFHC and the insurance carrier.
    - As part of this contract, SFHC is obligated to bill your primary insurance company.
    - As part of this contract, SFHC is obligated to bill your insurance company using a series of codes that describe both the diagnosis of any clinical issues (ICD 10codes) and the services provided (CPT code).
    - As part of this contract, SFHC has agreed to collect patient-due amounts that include co-pays, deductibles, and co-insurance. (These amounts are subject to the patient's insurance policy.)
    - Also as part of this contract, SFHC may directly charge the patient for any non-covered services.
    - **Please Note/ Annual Exams:** Annual Exams cover Medical History, Measurement of Height and Weight, Measurement of Blood Pressure, Performance of a breast exam, performance of a PAP Test with HPV probe (if applicable), contraception refills and HRT refills. Your insurance carrier will consider any medical, behavioral or symptomatic issues discussed

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within a preventative visit as an additional visit (new or pre-existing problems, if any new or old issues are addressed in the process of performing an annual exam it will require additional time. In addition appointments that run longer than 60 minutes will be billed as prolonged services; therefore the patient will be 100% responsible for the full payment of any fees that these charges may incur.

3.) ***Please Note: it is your responsibility to notify SFHC if your insurance plans changes or is terminated.***

- If you do not have a copy of your current insurance card on the day of your appointment you will be considered a "non-insured patient" and have to pay the full amount for the cost of your appointment.

St Francis Health Center **Balance Due and Collections Policy:**

It is the patient's responsibility to review their benefits, and understand the out of pocket amounts that may be incurred.

Do not ignore your bill: if you are having trouble paying your bill please contact our billing office. We are happy to make payment arrangements. If you do not call we cannot help. Please call our billing department to make payment arrangements:

HCMS: 707-255-8825

Past Due Account: Accounts greater than 90 days past due will be sent to collection agency and the patient will be dismissed form the practice. There will be a $25.00 late fee per month after 90 days of no payment.

Return check policy: All returned checks will be charged and NSF of $40.00. If the check plus the fee is not paid in full within 10 business days the debt, it will be turned over to the collection agency.

SFHC's Cancellation/ No show/Rescheduling policy: Failure to keep scheduled appointment is extremely costly to our clinic to and to other patients. Patients who are not able to keep their scheduled appointment are required to give our office 24 business hours cancellation notice, if the patient fails to do so, there will be a **$100 fee** (leaving cancellation voicemails after business hours for a next or same day appointment are not accepted).This FEE is not covered by your insurance. Office hours are MONDAY-Thursday 9:00 AM -5:00 PM Friday 9:00AM-1:00 PM. It is the responsibility of the

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a courtesy appointment reminder 1 day in advance, though this does not constitute as a confirmation or fulfillment of the appointment, and it is required that the patient shows up to avoid the fee. It is also the patient's responsibility to ensure we have a valid phone number and the capability to leave a voice mail if there is no answer at the patient number provided.

SFHC requires a credit card or debit card to keep on file. In the event that an appointment is not cancelled within the required 24 hour notice: you authorize to our office to charge $100 in full to this card:

Card Type: _____ Card #: _____

Exp: _____ CVC: _____

I authorize direct payment to be made to SFHC for all medical/ preventative services rendered. I understand that if any services or charges are not covered by my insurance that I am responsible for all charges incurred for services/products rendered.

I have read the above information and understand my financial responsibility as a patient of SFHC. I agree to adhere to all SFHC policies:

Printed Name: _____

Signature: _____ Date: _____

St. Francis Health Center Policies

Please Initial next to every statement in acknowledgment.

_____ We require a complete 24 business hour cancelation notice for any appointment. There will be a $100 fee for no call or no show appointments.

_____ 3 missed appointment/ late cancellations may result in dismissal from practice.

_____ All products are final sale. We do not accept returns.

_____ We require 72 hour turnaround time for all RX refills, lab/mammogram orders, referrals, and copy request that you make.

_____ Copy fee is $1 per page.

_____ There will be a fee of $35 + TAX for any prescription refills without an appointment, letters of medical necessity (i.e. airline travel, camp immunizations, etc.) or lost requisitions/medical orders.

_____ Controlled substance refills require and appointment. NO EXCEPTIONS.

_____ We require an appointment for all new prescriptions, imaging and physical therapy requests. No exceptions.

_____ Labs and third party reports are not released to patients and or alternative provider until they have been reviewed and signed off by your PCP.

_____**We require a valid credit card to keep on file. All charges listed above will be automatically billed to this credit card if the patient is not on premises for appointment or service provided.**

_____****We have a zero tolerance policy for abusive patients. SFHC reserves the right to dismiss any patient who exhibits rude/inappropriate behavior.****

By signing here I agree that I have read and initialed all of the statements above and acknowledge SFHC policies.

SIGNATURE: _____

DATE: _____