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/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.

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

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:

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

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? _____
_____

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

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.

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

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: _____

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

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

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

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.

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

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?

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

Name: DOB: Date:

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?

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

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

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

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

Male Only:
___ Hemias
___ Testicular masses
___ Testicular Pain
___ Prostate disease
___ Sexually transmitted disease
___ Discharge or sores
___ Sexual dysfunction
___ Are you sexually active? Y/N
___ Sexual Orientation? _____
___ Birth Control? Type? _____

Female Only:
___ Irregular Cycles
___ Bleeding Between cycles
___ Pain during intercourses
___ Clotting
___ Heavy or excessive flow
___ PMS
___ Endometriosis
___ Difficult conceiving
___ Painful Menses
___ Vaginal discharge? Color? _____
___ Vaginal odor
___ Ovarian Cysts
___ Menopausal Symptoms
___ Abnormal PAP
___ Sexually transmitted disease
___ Breast pain/Tenderness
___ Nipple discharge
___ Breast Lump
___ Age at which menses began?
___ Age of last menses (If menopausal)
Length of cycle? _____
Duration of Flow _____
Date of last period _____
Are you sexually active? Y/N
Sexual Orientation _____
Birth Control? Type? _____
Number of pregnancies? _____
Number of live births? _____
Number of miscarriages? _____
Number of abortions? _____
Difficult of premature births? _____
Do you breast self-exam? Y/N
Date of last PAP? _____
Date of las mammogram? _____
Could you be pregnant? Y/N

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

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

Name: DOB: Date:

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

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

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

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 (MBS Billing Office #: 505-983-1533).

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.

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 patient to keep track of their scheduled appointment with our office. Our office provides a courtesy appointment reminder 1 day in advance, though this does not constitute as a

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

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 flat fee of $35 for any letters of medical necessity (i.e. airline travel, camp immunizations, etc.)

_____ 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 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: _____