Experienced Concierge Care In Albuquerque

(PLEASE PRINT CLEARLY)

Last Name: ____________________ First Name: ____________________

Middle Initial: __________ Male:_____ Female: _____ Date of Birth:__________

Soc Sec Number: ____________________

Address: ____

City: ____________________ State: _________ Zip: ______________

Mailing Address (if different): ________________________________

City: ____________________ State: _________ Zip: ______________

Phone: ______________ Cell: ______________ Work: ______________

Email: ____

Employer: ____

Marital Status: Married: _____ Divorced: _____ Widowed: _____ Single: ____ Domestic Partner: _____

Primary Insurance Cardholder:

Last Name: ____________________ First Name: ______________ MI: _______

Male: _____ Female: _____ Cellphone: ______________ SSN: ______________

Date of Birth: __________ Employer: ____________________

Emergency Contact: ____________________ Phone: ______________

Relationship: ____

Please present your insurance card to the receptionist at check in. Your co-payment is due at time of service. I certify that the information above is correct. I request that ABQ Integrative Family Medicine file claims on my behalf to the insurance company (companies) listed above for any services furnished to me now, and in the future, ABQ Integrative Family Medicine to release the insurance company and its agents any information needed to determine those benefits payable for the related services. Non-Medicare insurance: I acknowledge that I am personally responsible for any portion of the bill not paid for by my insurance. I understand it is my responsibility to resolve any disputes with my insurance company. Medicare: I request that payment of authorized Medicare benefits be made on my behalf to ABQ Integrative family medicine for any services provided to me. If ABQ Family Medicine believes that Medicare would not pay for any part or all the requested service, I will be asked to sign an advanced beneficiary notice signifying that I understand Medicare may not pay and that I am personally responsible for the charges. I have agreed to be responsible for any portion of the deductibles and co-pays not covered by Medicare or other insurance.

Signature: ________________________________ Date: ______________

04/2024

ABQ INTEGRATIVE FAMILY MEDICINE

Experienced Concierge Care In Albuquerque

Patient: ______________________________ Date of Birth: ____________

Medication Allergies/ Sensitivities and Reaction:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Medications:

Name Dose Frequency

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________

Supplements:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________

04/2024

Financial Policy

Financial Responsibility

All professional services rendered are charged to the agreed-upon payer and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments. All copay and payments are due at the time of service.

Assignment of Benefits

I hereby assign all medical, dental and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers, including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to **ABQ Integrative Family Medicine** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I may be responsible for any amount not covered by insurance. All copay and payments are due at the time of service.

Authorization to Release Information

I hereby authorize **ABQ Integrative Family Medicine** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **ABQ Integrative Family Medicine** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately up presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour was not given. There will be a fee of $30.00.

I understand that there will be a $25.00 fee for all returned Checks.

____
Print Name of Patient (or Responsible Party):

______________________________ ______________
Signature of Patient (or Responsible Party) Date:

Only if needed:

______________________________ ______________
Guardian Signature: Relationship:

______________ ______________ ______________
Witness Name: Signature: Date:

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ABQ INTEGRATIVE FAMILY MEDICINE

Experienced Concierge Care In Albuquerque

HIPAA Policy

IF YOU WOULD LIKE TO HAVE ANY PAPERWORK MAILED TO YOU, PLEASE BRING IN A SELF-ADDRESSED, STAMPED ENVELOPES(S) THAT WE WILL KEEP IN YOUR CHART FOR THIS PURPOSE.

I,______________________________, acknowledge that I have received a copy of the **HIPAA** Patient Consent Form.

Signature: ____ Date: ________________

PLEASE INITIAL ALL THAT YOU AGREE TO:

1.______ I give permission for ABQ Integrative Family Medicine to leave a detailed health information message on my telephone. I prefer that these messages to be left on (Please write your number on which one applies)

Home Number: _________________________________ Cell Number: ____

or ______ Either.

2.______ I give permission for staff or physicians of ABQ Integrative Family Medicine to speak to:

____ (relationship) _______________________,

their number: ____or speak to:

____ (relationship) _______________________,

their number: ____ regarding my medical treatment.

3.______ I realize that using personal email is **NOT** HIPAA compliant, but I give permission to ABQ Integrative Family Medicine to communicate with me about my medical information through email.

My email address is ____

IF YOU WOULD LIKE TO HAVE ANY PAPERWORK MAILED TO YOU, PLEASE BRING IN A SELF-ADDRESSED, STAMPED ENVELOPES(S) THAT WE WILL KEEP IN YOUR CHART FOR THIS PURPOSE.

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ABQ INTEGRATIVE FAMILY MEDICINE

Experienced Concierge Care In Albuquerque

(PLEASE PRINT CLEARLY)

Name: ______________________________

Date of Birth: ______________________ Today's Date: ______________________

MEDICAL HISTORY

Please list any current medical conditions that you have and specialists if applicable
(For example: asthma, diabetes, epilepsy...)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Females- Please Complete

Menstrual Flow:

- ☐ Regular
- ☐ Irregular
- ☐ Pain/cramps
- ☐ Menopausal
- ☐ Hysterectomy

Days of flow ______

Length of cycle ______

First day of last period: ______

- ☐ Pregnant
- ☐ Planning Pregnancy

Pregnancies ______

Abortions ______

Miscarriages ______

Live Births ______

☐ Children—Years of birth/names:

______

☐ Birth Control Method
(If pill, provide name):

______

Date of last PAP: ______

☐ History of abnormal?

Date of abnormal: ______

Date of last Mammogram: ______

☐ History of abnormal?

Date of abnormal: ______

Date of last DEXA: ______

☐ History of abnormal?

Date of abnormal: ______

04/2024

SOCIAL HISTORY/HABITS

☐ Alcohol
Types: ____________ *Amount per week:* ____________

☐ Caffeine
Types: ____________ *Amount per week:* ____________

☐ Nicotine

☐ Cigarettes- *Packs daily:* ____________ *How Long:* ____________

☐ Chewing Tobacco
Frequency: ____________

☐ Pipe
Pouches per week: ____________

☐ Cigars-
Frequency: ____________

☐ Vape *(please bring packaging to appointment)*-

Mg/mL: ____________ *Cartridges per week:* ____________

☐ Cannabis: edibles flower wax vape *(circle all that apply)*

Types: ____________ *Frequency:* ____________

☐ Other recreational drugs-

Types: ____________ *Frequency:* ____________

☐ Diet *(including dietary restrictions)*
Type: ____________

☐ Exercise
Routine: ____________

Frequency: ____________

☐ Occupation/Prior Occupations/Volunteering

Who lives at home? ____________

Comments: ____________

04/2024

FAMILY HISTORY

MOTHER:
Serious Medical Conditions

____
____
____
____
____

D.O.B or if deceased list cause and age at death-

____

FATHER:
Serious Medical Conditions-

____
____
____
____
____

____

CHILDREN:
Serious Medical Conditions

____
____
____
____
____

D.O.B or if deceased list cause and age at death-

____
____
____

SIBLINGS:
Serious Medical Conditions-

____
____
____
____
____

____
____
____

GENERAL FAMILY HISTORY OF ISSUES:

____
____
____
____

04/2024

SURGICAL HISTORY

Surgery	Date
☐ Colonoscopy	
☐ EGD (Upper Endoscopy)	
OTHER	

Comments: (Any repeat surgeries?) ______________________________

VACCINES

Vaccine	Date
☐ Tdap ☐ Td	
☐ Pneumovax-13	
☐ Pneumovax-23	
☐ Shingrix-1	
☐ Shingrix-2	
☐ Flu shot- most recent	
OTHER	

Current Concerns to address: ______________________________