San Juan Health and Wellness Center

1009 Ridgeway Place | Farmington, NM 87401
505-327-0002 phone | 505-325-9443 fax

Patient Information Form

Patient Information

Name_____Date of Birth: _____

SSN#_____Sex___M___F___ single married divorced widowed separated

Mailing
Address:_____

City_____State_____Zip_____

Home Phone:_____Cell Phone:_____Email: _____

Responsible Party Information ***(must be completed for all patients under the age of 18)***

Name_____Date of Birth: _____

SSN#_____Sex___M___F___ single married divorced widowed separated

Mailing
Address:_____

City_____State_____Zip_____

Home Phone:_____Cell Phone:_____Email:_____

Relationship to Patient: _____

Emergency Contact:

Name:_____Phone:_____

Relationship to Patient: _____

Primary Care Provider:

Name:_____Phone: _____

Allergies:_____

_____

Preferred Pharmacy: _____

Current Medications: (include prescriptions, over the counter, supplements, vitamins, and herbs

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

By signing below, I acknowledge that the information I have provided above is accurate.

Signature:_____ Date:_____

If person signing this document is not the patient being seen, please complete the following:

Print Name: _____

Relationship to patient:_____

San Juan Health and Wellness Center

1009 Ridgeway Place | Farmington, NM 87401
505-327-0002 phone | 505-325-9443 fax

Insurance Information:

Please note: In order to bill insurance and/or to obtain prior authorizations for services we must have a copy of the insurance card and complete policy holder information. If this information is not provided, patient will be considered a self-pay. Payments are due at the time of service.

Insurance Information

Primary Insurance_____

ID #_____ Group #_____

Subscriber's Name_____ Subscriber's Employer_____

Subscriber's Date of Birth_____ Subscriber's SSN_____

Secondary Insurance_____

ID #_____ Group #_____

Subscriber's Name_____ Subscriber's Employer_____

Subscriber's Date of Birth_____ Subscriber's SSN_____

Financial Agreement:

As a patient, it is important that you understand the benefits and limitations of your insurance coverage. Before your appointment, we will verify your basic insurance coverage as the first step. There may be additional research you want to do to ensure you understand your financial responsibility under your plan.

Please read the following for additional information regarding what you may be responsible for:

INFORMATION SECURITY:

We recognize that many patients are concerned about the sensitive nature of their information we collect and we assure you that we take every precaution to keep your personal information secure and use this information only to assist us in providing the services, filing claims and for identification/communication purposes as it relates to healthcare operations. We are required to obtain complete demographic information which includes your social security number to support billing for the services. Refusal to provide this information may constitute a refusal of service.

FINANCIAL RESPONSIBILITY:

As a courtesy, we will send statements each month for any balance that you may owe for services. You are responsible for any balance due regardless of insurance coverage. If at any point an account becomes past due, we reserve the right to collect on these balances prior to scheduling any future appointments. Collection of past due amounts may involve a collection agency.

We reserve the right to limit, reschedule or refuse treatment to anyone who cannot pay at the time of service.

ACKNOWLDGEMENT:

By signing this document, I hereby:

- **Authorize the Assignment of Benefits:** Assign all medical benefits under my coverage to us for services provided to me. Furthermore, my signature authorizes and directs my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan to issue payment directly to us for servicesrendered.
- **Agree to my Financial Responsibility:** Acknowledge and understand that my insurance co-payments are due at time of service and that I am responsible for any amounts that are not covered by my insurance, which may include co-insurances, deductibles or claims denied due to contracting.
- I have received, understand and agree to abide by the above as it relates to my financial obligations as a patient.

Patient or Legal Guardian Signature: _____ **Date:** _____

Patient name (pleaseprint): _____

Legal Guardian name (pleaseprint): _____

San Juan Health and Wellness Center

1009 Ridgeway Place | Farmington, NM 87401
505-327-0002 phone | 505-325-9443 fax

Acknowledgment of Receipt of Notice of Privacy Practices

Patient name:_____ Date of Birth: _____

I acknowledge that I have been given the opportunity to review a copy of the Notice of Privacy Practices of San Juan Health and Wellness Center effective January 1, 2018.

Signature (patient or authorized representative): _____

Date:_____

FOR OFFICE USE ONLY

San Juan Health and Wellness Center attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ Other (Please Specify)_____

San Juan Health and Wellness Center

1009 Ridgeway Place | Farmington, NM 87401
505-327-0002 phone | 505-325-9443 fax

No Show/Late Cancellation Policy

The appointment times we have to offer you are limited and in high demand. Due to this, San Juan Health and Wellness Center has established the following no show/late cancellation policy:

- Appointments that are cancelled or rescheduled with less than a 24-hour notice will be considered a ***late cancellation***.
- If you do not keep your appointment and do not notify the office, you will be considered a ***no show***.
- If you arrive without enough time for your appointment to be completed (50% of your appointment time or less), you will be marked a ***no show***. And you will need to reschedule your appointment.
- If you have three (3) ***late cancellations*** and/or ***no shows*** within any six-month period, we reserve the right to terminate the provider patient relationship and discharge you from our practice.

By signing below, I acknowledge that I have read , understand and agree to all the above statements.

Signature:_____ Date:_____

Patient Name: _____

Printed Name (if signer is not the patient): _____

San Juan
Health and Wellness Center

1009 Ridgeway Place | Farmington, NM 87401
505-327-0002 phone | 505-325-9443 fax

Informed Consent for Treatment

I_____(print name of patient), agree and consent to participate in behavioral health care services offered and provided at San Juan Health and Wellness Center.

My care team provider(s) are (select all that apply):

_____Mark Braunstein, D.O.
_____Janet Thelen, PMHNP-BC
_____Valerie Burgelin, FNP
_____Joanna Dominick, FNP
_____Eva Morales, LCSW
_____Thomas McColloch, LCSW

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within:

(1) the scope of the provider's license, certification, and training; or
(2) the scope of license, certification, and training of the behavioral healthcare providers directly supervising the services received by the patient.

Please note the following about treatment:
Our staff will depend on statements made by the patient, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment.

Some services may be provided with telemedicine equipment and involve interaction with providers who are not physically in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not: videotaped, routed through the Internet, or saved in any way. However, relevant information from your visit will be documented in

your medical records, just as it would be if the provider had been physically present.

Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

If the patient is under age 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____Date_____

Printed name (if not signed by patient):_____

San Juan Health and Wellness Center

Presbyterian Health Plan (Magellan Behavioral Health) Member Rights and Responsibilities*

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand, and free of charge.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Staff Signature Date

***Claims sent to Presbyterian Health Plan for services at San Juan Health and Wellness Center will be processed by Magellan Behavioral Health.**

San Juan Health and Wellness Center
1009 Ridgeway Place | Farmington, NM 87401
(505) 327-0002 phone | (505) 325-9443 fax

Authorization to Request / Release Information

Client Info	Name:_____ Address:_____ DoB:_____ SS#_____ Phone:_____		
Release and/or Receive Information From	I authorize: Facility:_____ Address: _____ _____ Phone#_____ Fax#_____	**Release and/or receive Information To**	I authorize: Facility:_____ Address: _____ _____ Phone#_____ Fax#_____
Information to be released	❑ Medical information ❑ Psychiatric diagnosis and treatment ❑ Mental health diagnosis and treatment ❑ Substance use disorder diagnosis and treatment ❑ Other (specify) _____		
Purpose of Release	❑ Continuation of Care ❑ Insurance ❑ Legal ❑ Personal/other (specify)	**Time Span**	Release: ❑ All of my records ❑ Progress notes and problem list ❑ Records limited to: From:_____ To: _____
Authorization	If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that Federal Law 42 CFR Part 2 protects the confidentiality of the information. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. I certify that this request has been made voluntarily. I understand this consent will expire upon_____, or if left blank, in one (1) year. I hereby release the provider/agency from any liability that may result from furnishing the information requested as authorized in the release. I understand that I may revoke this authorization at any time (except to the extent that the action has been taken to comply with it); I must do so in writing to the facility Privacy Officer or his/her designee. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected by the HIPAA Privacy Rule. I MAY REFUSE TO SIGN THIS AUTHORIZATION. A copy of this authorization is to be considered as valid as the original. I understand that the information released may include a diagnosis or reference to the following condition (s): behavioral health services/psychiatric care; acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or drug and/or alcohol abuse.		
Signature	By signing the Authorization, I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization. _____ Relationship:_____ Date:_____ Client, (Parent or Guardian if client is a minor). _____ Date:_____ Witness		