SOUTHWEST
CENTER ON AGING

1106 CENTRE COURT | LAS CRUCES, NM 88011 | (575) 532-5455 | FAX (575) 532-5641

Dear Patient,

Welcome to the Patient-Centered Medical Home (PCMH) initiative, a new way of managing your health care! PCMH is a model of care designed to improve the coordination of your health care with an emphasis on your all-around well-being.

I invite you to continue working with me in this new model of care. I will work with other health care providers to take care of you. As your care team, we will involve you in decisions about your health and health care, and thus be able to develop a stronger relationship with you.

The practice is concerned about the range of the patient's whole health, including behavioral health. We are responsible for coordinating care across the healthcare setting.

I look forward to working with you on the path to a healthier you!

Sincerely,

J. Roberto Duran, III, M.D.
Southwest Center on Aging

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We serve the populations of people of age 55 and older
Our Mission is to make healthy aging a reality through excellence in clinical care.

Office Hours

Monday–Thursday	8:00 am – 5:00 pm
Friday	8:00 am – 1:00 pm

1st Monday of the month, extended hours from 5:00pm – 7:00 pm by appointment only
Walk in hours are Monday-Friday 12:00pm-12:30pm (existing patients only)

To schedule an appointment or speak with a clinician, please call our office at 575-532-5455
After hours, please call the above office number. The answering service will answer your phone call and notify the on-call physician if necessary.
In case of an Emergency, call 9-1-1 immediately.

Southwest Center on Aging (SWCOA) offers a unique, comprehensive assessment of older persons in an outpatient setting. SWCOA uses multiple resources to look at the individual from medical, functional, and emotional perspectives. Our goal is to work with the patient's family to address strengths and weaknesses found during the assessment process. This assessment is valuable on a consultation basis or as a first step to ongoing primary care with us.

SWCOA treats residents in a variety of assisted living and long-term settings.

SWCOA provides state of the art in home care for geriatric and homebound patients through our house call program.

SWCOA coordinated medical, social, and hospice services for patients and families facing terminal illnesses. Assistance is provided in establishing Advance Directives, selecting resuscitation status and designing a Durable Power of Attorney. Care plans are individualized to the need of the patient and family, and focus on maximizing quality of life and comfort.

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Patient Portal Consent Form

Patient Portal is a secure online secure online source of confidential medical information for patients. This gives patients a convenient 24-hour access to personal health information, from anywhere with an Internet connection. Using a secure username and password, patients can:

- Access personal health information
- Request refills for prescriptions
- Revie results for Labs/Tests
- Correspond with our staff and providers regarding your care

I agree to the following:

1. I will abide by all terms and conditions of Southwest Center on Aging Patient Portal.
2. Southwest Center on Aging is not responsible for any breach of information caused by patient misuse.
3. I understand that my activities within the Patient Portal will become part of my medical record.

I understand the following:

1. For medical emergencies, dial 911. The Patient Portal is NOT to be used for urgent needs.
2. All communication is sent to the nursing staff, not directly to the provider. You will receive a response within 24-48 hours.
3. The Patient Portal is NOT a substitute for office visits with your provider and prescription requests for medications not currently being prescribed will NOT be honored.

I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal.

☐ I DECLINE access to the Patient Portal ☐ I would like access to the Patient Portal

Patient Name: _____ DOB: _____/_____/_____

Secure Email Address: _____

Patient Signature: _____ Date: _____

Relationship if representative: _____

For office use only

Portal invitation emailed by _____on _____
Initials Date

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Patient Centered Medical Home Patient Contract

Thank you for choosing Southwest Center on Aging as your Patient Centered Medical Home. Our staff is committed to providing the best health care possible for you

As your Primary Care Provider (PCP), my responsibilities are:

- Explain diseases, treatment, and results in an easy to understand way. Listen to your feelings and questions which will help us make decisions about your care.
- Keep your treatments, discussions, and records confidential.
- Provide same day appointments whenever possible.
- Provide instructions on how to meet your health care needs, when our office is not open, through our After Hours Answering Service which provides 24 hour access to medical care.
- Give you clear directions about medicine and other treatments.
- Send you to a trusted specialist, if needed.
  Each visit will end making sure you have clear instructions and expectations, treatment goals, and future plans.

As our Patient, your responsibilities are:

- Asking questions, sharing your feelings, and taking an active part in your care.
- Being honest about your history, symptoms, and other important information, including any of care possible changes in your health and any care you may be receiving from other health professionals.
- Taking all medication as directed. Inform us when there is a problem with your medication.
- Making healthy decisions about your daily habits and lifestyle.
- Keeping your scheduled appointments or reschedule in advance if possible.
- Calling our office FIRST with your health concerns, unless it is an emergency.
- Being sure you leave our office with a clear understanding of our expectations, treatment goals and future plan**.**

I have read and understand my responsibilities as a patient of this practice. I understand that it is imperative that I meet these responsibilities so that my primary care provider can provide optimal care for me.

_____

Patient's Name

Patient's Signature Date

As your Primary Care Provider, I understand my responsibilities to you as a patient of this practice. I will do my best to provide you with the highest quality of care possible.

"Making health aging a reality through excellence in clinical care"

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HIPAA Compliance Patient Consent Form

Our notice of privacy practices (on the back) provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Your rights:

- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. SWCOA offers a 50% discount for uninsured patients and this is payment is required at the time service is rendered.

We may charge an upfront **$35.00 administrative fee** for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a **25% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a **$35.00 service fee** in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. SWCOA also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current **no-show fee is $25.00** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

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By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **PCMH Initiative Letter**
- **Patient Rights Regarding Medical Records**
- **HIPPA Policy and Responsibilities**
- **Patient Financial Responsibility including collections, no-show policy**

This consent was signed by: _____
Please PRINT Name

Signature: _____ Date: _____

Witness: _____ Date: _____

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Patient Authorization for the Release of Medical Records

_____
Name (Please Print) Date of Birth

_____
Address City State Zip Ph #:

I hereby authorize:
_____
_____
_____

Release to:
_____
_____
_____

Records requested are as follows:
___ Lab Reports, X-Rays, EKG Reports
___ History and Physical, Echocardiograms
___ Nuclear/ Regular Stress Test
___ Holter Monitors
___ Cath/ PTCA/ Stent Reports
___ All Records
___Other: _____
_____

I specifically authorize the release of information relating to:
___ Substance abuse (including alcohol/drug abuse)
___ STD related information (HIV and AIDS related testing)
___ Mental health (including psychotherapy notes)

_____
Signature of patient or Legal Guardian

I understand that I have the right to revoke this authorization at anytime. I also understand that I must do so in writing and present my written revocation to Southwest Center on Aging at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

_____ _____ _____
Signature of the Patient or Legally Authorized Representative Date Relationship to Patient

_____ _____
Witness- Printed Name and Signature Date

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Release of Medical Information

I, _____ hereby give authority to _____
(Patient's name) (Other than Physician)

_____, to have access to the medical information below, effective
(Relationship to patient)

_____
Date

____ *Procedures*

____ *Medications*

____ *Appointment times and cancellations*

____ *Patient history*

____ *All medical information may be released to the above mentioned person(s).*

I understand that I may request to cancel this release of information in writing for whatever reason, at anytime and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Southwest Center on Aging cannot be held liable for any misuse of information obtained by the person mentioned above.

_____ _____
Patient's Signature Date

_____ _____
Witness Date

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PLEASE NOTE THE FOLLOWING CHANGES AND CHARGES THAT WILL TAKE EFFECT JUNE 6, 2017

MEDICAL APPOINTMENT CANCELATION POLICY

Initial_____ If a patient misses or reschedules a confirmed appointment without contacting the office 24 hours in advance, this is considered a missed appointment (no call, no show). A fee of **$25.00** will be charged to you for a missed appointment. (**YOUR INSURANCE WILL NOT COVER THIS FEE**)

REQUEST FOR PHISICIAN LETTER

Initial_____ Any letter such as disability, competency, diagnosis etc.--**$25.00**

Initial_____ Jury Duty excuse **-- $20.00**

Initial_____ Handicap parking placard form fill out**-- $15.00**

Initial_____ Family Medical Leave Act form --**$30.00**

MEDICAL RECORDS CHARGE

Initial_____ The following fee will apply for copying medical records: If you request a copy of your medical records, there will be a **$30.00** charge. The fee includes preparing electronic records exported on a CD, cost of labor and supplies. If a new physician requests your medical records, you will not be charged.

_____ _____

Patient/POA Signature Date

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General Information

Name:_____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip code: _____ Date of Birth: _____

Employer: _____ Social Security #: _____

Marital Status: _____ Spouse/ Partner: _____

Age/ Sex: _____ Language: _____

Race: _____ Ethnicity: _____

Preferred Provider

☐ **Dr. Duran** ☐ **Tyson Kay, MSPAS, PA-C**

*In the event that preferred provider is not available, to avoid a delay in care, you agree to see an alternate provider. Schedules are subject to change.

E-mail address:

_____

In Case of Emergency (other than spouse)

Name: _____ Relationship: _____

Home Phone#: _____Work Phone#: _____

Insurance Information

1st Insurance: _____ 2nd Insurance: _____

Policy #:_____ Policy #: _____

Group #: _____ Group #: _____

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Medical Questionnaire

Name: _____ Date: _____

Home Address: _____

Phone: _____ D.O.B: _____ Age: _____ SS#: _____

Circle the highest year of education: 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 1 2 3 4
Elementary High College Post-Grad

What is your marital status? Single Married Divorced Widowed

Reason for visit: _____

Are you under a health care provider's care for any condition? YES ___ NO ___

If yes, what is the health care provider's name: _____

Last date seen by provider: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR GENERAL HEALTH:

How would you rate your general health: Excellent___ Good___ Fair___ Poor___

PAST MAJOR ILLNESSES:

Lung Disease	Date: _____	Migraine / Headaches	Date: _____
Heart Disease	Date: _____	Neurological Problems	Date: _____
Kidney Disease	Date: _____	Gallbladder Disease	Date: _____
Tuberculosis	Date: _____	Epilepsy / Seizures	Date: _____
Blood Disorder	Date: _____	Migraine / Headaches	Date: _____
Diabetes	Date: _____	Blood Transfusion	Date: _____
Stroke / TIA	Date: _____	Anxiety / Depression	Date: _____
Swelling	Date: _____	High Blood Pressure	Date: _____
Glaucoma	Date: _____	Parkinson's Disease	Date: _____
Cataracts	Date: _____	Colitis / Bowel Disease	Date: _____
Gallbladder Disease	Date: _____	Seasonal allergies	Date: _____
Epilepsy / Seizures	Date: _____	Loss of Consciousness	Date: _____
Thyroid Problems	Date: _____		

SURGERIES:

Appendectomy	YES___	NO___	DATE_____
Cholecystectomy	YES___	NO___	DATE_____
Hysterectomy	YES___	NO___	DATE_____
Cataract Surgery	YES___	NO___	DATE_____
Heart Surgery	YES___	NO___	DATE_____
Heart Catheterization	YES___	NO___	DATE_____
Hip surgery	YES___	NO___	DATE_____

Other Surgeries not mentioned above:

_____

_____

Broken Bones:

_____

_____

Hospitalizations:

_____

_____

FAMILY HISTORY:

Parents: Mother living ___deceased___ age and cause of death _____

Father living ___deceased___ age and cause of death _____

Siblings: Number living ___ Number Deceased___

Children: Number living ___ Number Deceased___

Do you have family in the local area? YES___ NO___

Any family history of the following:

Cancer If so, who _____

Depression If so, who _____

Diabetes If so, who _____

Heart Disease If so, who _____

Stroke If so, who _____

Dementia/Senility If so, who _____

Have any of your friends or relatives pass away recently?

If so, who and when _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY:

Who would assist you in an emergency? _____

Are you Retired? YES___ NO___ YEAR_____

Do you have a living will or a Medical Power of Attorney ? YES___ NO___

What type of work have you done? _____

What kind of activities are you involved in now? _____

Do you live by yourself? YES___ NO___

If not, who do you live with? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR RECENT HEALTH STATUS:

When was your last Mammogram? YEAR____ Not applicable__

When was your last pelvic exam or Pap Smear? YEAR____ Not applicable__

When was your last Prostate exam? YEAR____ Not applicable__

When was your last hearing exam? YEAR____ Not applicable__

When was your last bone density exam? YEAR____ Not applicable__

When was your last eye exam? YEAR____

When was your last dental exam and cleaning? YEAR____

When was your last Colonoscopy? YEAR____

When was your last Pneumococcal Immunization? YES___ NO___ Date_____

Have you had a flu shot this season? YES___ NO___ Date_____

Have you had a Tetanus Immunization? YES___ NO___ Date_____

Do you exercise regularly? YES___ NO___

Do you smoke or have you ever smoked? YES___ NO___

If so, how many years? _____ How many packs a day? _____

Do you still smoke? _____ When did you quit? _____

Do you drink alcohol? YES___ NO___

- Social_____
- Occasional_____
- Daily_____ How many glasses a day? ____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ACTIVIES OF DAILY LIVING:

Can you handle your own personal care (Toileting, Eating, Walking, Dressing, Bathing)?
YES___ NO___ SOME___

Do you do your own cooking? YES___ NO___

Do you do your own cleaning? YES___ NO___

Do you do your own shopping? YES___ No___

Do you handle your own finances? YES___ NO___

Do you handle your own medications? YES___ NO___

If you answered no to any of these questions, who does these things for you?

_____

Do you use the phone to call family, friends or for emergencies? YES___ NO___

Do you drive? YES___ NO___

If so, have you had any accidents or near accidents in the last two years? YES___ NO___

Have you ever gotten lost? YES___ NO___

PLEASE INDICATE IF YOUR ARE HAVING PROBLEMS WITH ANY OF THE FOLLOWING:

Dizziness YES___NO___ Comments _____

Blurred Vision YES___NO___ Comments _____

Headaches YES___NO___ Comments _____

Swelling YES___NO___ Comments _____

Chest Pain YES___NO___ Comments _____

Insomnia YES___NO___ Comments _____

Sexual Function YES___NO___ Comments _____

Memory Loss YES___NO___ Comments _____

Easily Fatigued YES___NO___ Comments _____

Recent Fall YES___NO___ Comments _____

Painful/Burning Urination YES___NO___ Comments _____

Diarrhea/Constipation YES___NO___ Comments _____

Indigestion/Heartburn YES___NO___ Comments _____

Weight loss/ Weight gain YES___NO___ Comments _____

Muscle or Joint Pain YES___NO___ Comments _____

Anxiety/ Depression YES___NO___ Comments _____

Recent appetite change YES___NO___ Comments _____

Shortness of Breath YES___NO___ Comments _____

Cough YES___NO___ Comments _____