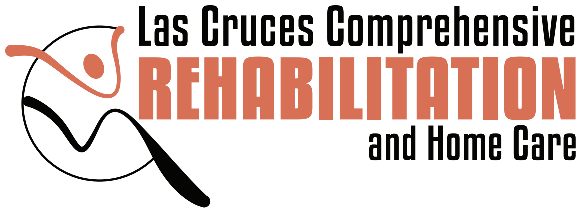

2540 S. Telshor Blvd. Suite B
Las Cruces, NM 88011
Office (575) 522-0484
Fax (575) 522-0483

Personal Information

Last Name:__________________First Name:__________________Middle Initial:__________________

Address:______________________ City:__________________State:_____________Zip:_____________

Home Phone:________________________Cell Phone:__________________________Age:__________

Social Security#______________________Birth Date:______________________Sex: ☐Male ☐Female

Marital Status: (circle one) Single Married Widowed Widowed Divorced Separated

Employer________________________________ Occupation:________________________________

Employer Address:____________________City:_________________ State:_________Zip:_________

Referring Physician:______________________Primary Care Physician:__________________________

Emergency Contact:________________________Phone:______________Relationship:_____________

Primary Insurance Company:____

Phone:______________________ ID/Policy #______________________Group #__________________

Secondary Insurance Company:____

Phone:______________________ID/Policy #_______________________Group #__________________

Is this illness/injury due to a Work related accident/condition? ☐Yes ☐No

If yes, please complete information below.

Workman's Comp. Insurance Company:____

Address:_____________________ City:____________________State:______________ Zip:__________

Employer:____________________Claim#____________________ Date of Injury:__________________

Claims Adjuster:________________________ Phone:____________________

Is this illness/injury due to Non-Work related accident/condition? ☐Yes ☐No

Attorney? ☐Yes ☐No

If yes to either question, Please complete information below.

Name of Attorney of Accident Insurance Company (Non-Work Related Only):___________________

Address:_______________________City:___________________ State_____________ Zip:_________

Phone:________________________Claim #_____________________ Date of Injury:______________

Claims Adjuster or Contact Person______________________________________

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: (please read and sign)

I hereby authorize payment of medical benefits to Las Cruces Comprehensive Rehabilitation for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance. I Authorize LCCR to release Medical information to any of the following: Hospital, Provider, and Attorney

Patient/Authorized Signature:_________________________________Date:_____________________

Las Cruces Comprehensive Rehabilitation

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GENERAL CONDITIONS OF TREATMENT

(Please read and sign)

1. PATIENT INFORMED CONSENT :

I hereby indicate my wish to be a participant in the rehabilitation program offered by LCCR.
I understand that the purpose of this program is to enhance my recovery from an injury or illness.
I further understand that there exists the possibility of some risks associated with the services that are intended to improve my well being and functionality. I have been informed of the risk and benefits of these procedures. I have also been informed of the methods of treatment that will be administered and understand what is required of me as a patient. I verify that my participation is voluntary and that I may withdraw from treatment at any time. I understand that the facility administrator maintains an open door policy and encourages patients to participate in their health care plan. For any grievance of any kind, I can refer to the Grievance Procedures posted in the clinic lobby.

2. PATIENT RIGHTS:

We are committed to serving you with compassion, care, skill and respect.
As one of our patients:

You have the RIGHT	You have the RESPONSIBILITY
To be treated with dignity and respect	To seek medical attention promptly
To know the names and professional status of people serving you	To be honest about your medical history
To privacy	To ask about anything you do not understand
To confidentiality of your records	To follow health advice and medical instructions
To receive accurate information about your health related concerns	To report any significant changes in symptoms or failure to improve
To know the effectiveness, possible side effects and problems of all forms of treatment	To respect clinic policies
To participate in choosing a form of treatment	To keep appointments or cancel in advance
To receive education and counselling	To seek non-emergency care during regular business hours
To consent to, or refuse any care treatment	To provide useful feedback about services and policies
To select and/or change your health care provider	
To review your medical records with a clinician	
To know information about services and any related costs	

3. AUTHORIZATION TO RELEASE INFORMATION :

I Authorize LCCR to release medical information to any of the following:
Hospital, Provider, Attorney and Family Member.
I understand that this Consent to Release of Information is subject to revocation by the undersigned at any time, except to the extent that action has already been taken in reliance thereon.
Unless otherwise stated below, this consent shall automatically expire one year from date signed.

4. ADVANCE DIRECTIVES:

If you have Advance Directives, Living Will or Durable Power of Attorney and would like to provide LCCR Healthcare a copy, please notify our Office Manager, and a copy will be placed in your file.
I have read and understand the patient information provided. I have had an opportunity to ask questions and accept the responsibility of it's terms.

Patient/Legal Representative/Authorized Agent **Date**

Health History

Patient Name__________________________________ **Date**______________________

In the rare instance of an emergency who should we contact?

Name _________________________Phone _____________________

Are you presently working? ☐ Yes ☐ No Date of next Physicians visit _________________

1. Date of injury/onset ________________________
2. Have you ever had these symptoms before ☐ Yes ☐ No
3. Check all that apply to your symptoms:

☐ Work related injury ☐ Reoccurrence of previous injury ☐ Motor vehicle accident

☐ Injury related to lifting ☐ Athletic or recreational injury ☐ Cause unknown

☐ Other____

Have you had a related surgery? ☐ Yes ☐ No When:______________________________

Do you currently have or have had in the past any of the following?

☐ Heart Attack ☐ Heart Disease ☐ Heart Palpitations ☐ Chest Pain Angina

☐ High Blood Pressure Are you on blood thinners ☐ Yes ☐ No ☐ Pacemaker ☐ Yes ☐ No

☐ Diabetes ☐ Type 1 juvenile ☐ Type 2 Adult onset ☐ Do you take insulin?

☐ Asthma/Breathing Difficulties Do you use a rescue inhaler ☐ yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

☐ Headaches ☐ Dizziness/Fainting ☐ Ringing in your ears ☐ Seizures ☐ Stroke

☐ Kidney Problems ☐ Cancer ☐ Hernia ☐ Special diet guidelines ☐ Osteoarthritis

☐ Bowel/ Bladder abnormalities ☐ Live/Gallbladder problems ☐ Thyroid condition

☐ Allergies ☐ AIDS/ HIV ☐ Parkinson's Disease ☐ Spine Issues ☐ Osteoporosis

☐ Recent Fractures ☐ Recent Surgery ☐ Metal Implants ☐ Rheumatoid arthritis

☐ Skin abnormalities ☐ Nausea/Vomiting ☐ Other____

Las Cruces Comprehensive REHABILITATION

Patient Name:____ Date:________________________________

If you answered yes to any of the previous questions – please explain and give approximate date:

____
____
____

Is there any other information regarding your past medical history we should now about?

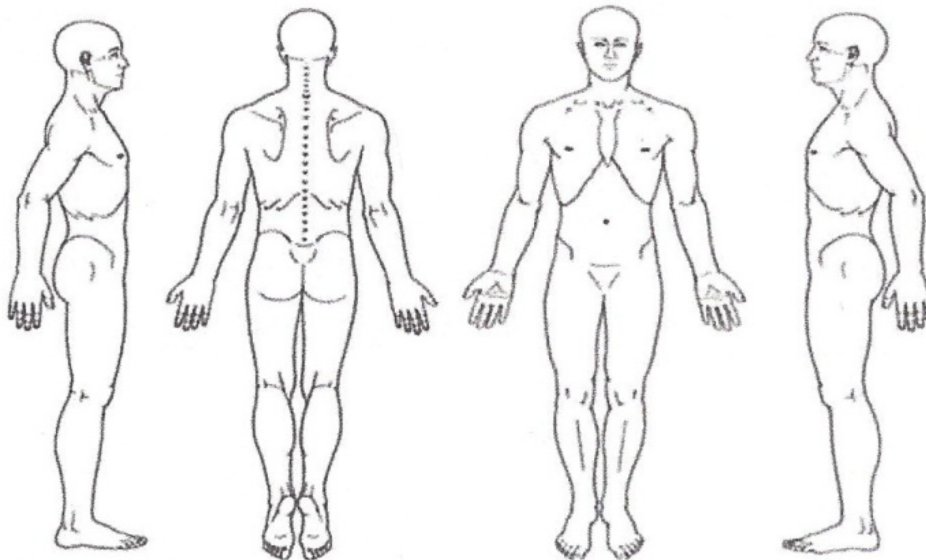
____
____
____

Are you currently taking any medications? (over-the –counter and prescribed)

☐ Yes ☐ No If so – please list below receipt

____
____
____

Please place an "X" to indicate current areas of pain on the body chart below:



What is the intensity of your pain on a scale of 1 to 10. With 0 being no pain and 10 being the worst (circle your choice)

Best?	0	1	2	3	4	5	6	7	8	9	10
Worst?	0	1	2	3	4	5	6	7	8	9	10
Currently?	0	1	2	3	4	5	6	7	8	9	10
	No Pain			Moderate Pain					Very Painful		

501g Grievance Procedure

Section 504 of the Rehabilitation Act prohibits discrimination based on handicap. In accordance with Section 504 Regulation, any program participant, participant representative, prospective participant or staff member who has reason to believe that he or she has been mistreated, denied services, or discriminated against in any aspect of services or employment because of handicap may file a grievance. In order to implement his policy, this facility has adopted an internal grievance procedure providing for prompt and equitable resolution of complaint alleging any action prohibited by the U.S. Department of Health & Human Services regulations (45 CFR Part 84) implementing Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Section 504 states, in part that "no otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance". The law and regulations may be examined in the office of the Administrator.

Established Procedure for Grievance

1. **A grievance must be in writing, contain the name and address of the person filing it, and briefly describe the action alleged to be prohibited by the regulations.**

2. **A grievance must be filed in the office of the Section 504 Coordinator within 7 days after the person filing the grievance becomes aware of the action alleged to be prohibited by the regulations. The time frame may be waived by the Coordinator in extenuating circumstances.**

3. **The Coordinator, or his designee, shall conduct such investigation of a grievance as many be appropriate to determine its validity. These rules contemplate thorough investigations, affording all interested persons and their representatives, if any an opportunity to submit evidence relevant to the grievance. Under Section 504 of the Rehabilitation Act, 45 CFR 84.7(b), the facility need not process complaints from applicants for employment.**

4. **The Section 504 Coordinator shall issue a written decision determining the validity of the grievance no later than 21 days after its filing.**

5. **If the Grievance has not been resolved at this point, the Section 504 Coordinator should forward it to the Facility Administrator, who shall an additional 14 days to resolve the grievance. The grievant will be notified in writing of the decision and the list of the evidence on which the decision is based.**

6. **If the complaint is still unresolved, the grievant may request, in writing, that the Administrator submit the grievance to the Administrative Board. Who shall have 14 days to resolve the grievance. If the grievance is then unresolved, the grievant will be advised in writing of the right to file a complaint with appropriate local, state and federal civil rights office, and will be provided the names and addresses of such office.**

Patient Signature____**Date**____________________

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

This Notice of Privacy Practices describes how Las Cruces Comprehensive Rehabilitation may use and share your medical information with others to carry out Treatment, Payment of health car operation (TPO) and for other purposes that are permitted or required by law. IT also describes your rights to see your protected Health Information (PHI). Protected Health Information is information about you and services that you have received. This would include information such as your name, address, date of birth, diagnosis, treatment, or other information that may identify you and your past, present or future physical or mental health or treatment you receive.

Uses and Disclosures of Your Medical Information:
Your PHI may be used and shared by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of Las Cruces Comprehensive Rehabilitation, and any other uses permitted or required by law.

Treatment:
We will use and share your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (e.g. sending PHI about you to a specialist as part of a referral).

Payment:
Your PHI will be used, as needed to receive payment for your healthcare services. For example, getting approval for a hospital stay may require that your PHI be shared with the health plan to obtain approval for the hospital admission. Or for example, sending billing information to your insurance company, Medicaid or Medicare.

Health Care Operations:
We may use or disclose, as needed, your PHI in order to support the business activities of Las Cruces Comprehensive Rehabilitation. These activities, training of medical students, licensing, health oversight audits or inspections, marketing and fundraising activities, and conducting or arranging for other business activities. We may contact you to remind you of your appointments by phone or email.

We may use or disclose your PHI in several other situations without your authorization. We also disclose PHI when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to a valid judicial or administrative
Order.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke your authorization at any time, in writing.

You have the right to inspect and request a copy of your PHI. Federal law, however, does create some exceptions to the right and exempts the following records: psychotherapy notes, information gathered to be used in a civil, criminal, or administrative action or proceeding.
You have the right to request a restriction of your PHI. This means you may ask us not to use or share any part of your PHI for the purpose of Treatments, Payment of Healthcare Operations. You may also request that any part of your PHI not be disclosed to family members, friends, or other individuals who may be involved in your care. While Las Cruces Comprehensive Rehabilitation will consider any reasonable request for restrictions, we are not required to agree to your request.

You have the right to request that PHI about you be communicated to you in a confidential manner, such as sending mail to an address other that your home or by other means.
You have the right to obtain a paper copy of this notice from us upon request at any time.
You have the right to request that HPFC amend your PHI. If we deny your request for an amendment you have the right to file a statement of disagreement with us and we may prepare an answer to your statement and will provide you with a copy of any such answer.
You have the right to receive an accounting of certain disclosures, of any, of your PHI.
You have the right to complain to HPFC or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Paragon Healthcare. You may file a complaint with us by notifying our HIPAA Privacy Office at the address or phone number below. Filling a complaint will not affect your health care services in any way.
In order to exercise any of the above rights, you may ask any staff member in the Las Cruces Comprehensive Rehabilitation office for the proper forms and instructions.

We reserve the right to change the terms of this notice for all records and will inform you by posting the revised notice in the waiting area.

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices and follow the information practices that are described in this notice. If you have any questions or complaints, please contact our HPFC Privacy Officer at

Las Cruces Comprehensive Rehabilitation
2450 S. Telshor Blvd Suite B
Las Cruces, NM 88011
(575) 522-0484

______________________________ ______________________

Patient's Signature: Date: