4151 Camino Coyote
Las Cruces, NM 88011
Phone (575) 522-0484
Fax (575) 522-0483

Las Cruces Comprehensive REHABILITATION Home Care and Hospice

E-mail: _____

Last Name: _____ First Name: _____ Middle Initial: ___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Age: _____

Social Security # _____ Date of Birth: ___/___/_____ Gender: □ Male □ Female

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

Employer _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: ___ _____

Are you receiving nursing or therapy in your home currently? _____

Referring Physician: _____

Primary Care Physician: _____

I agree that if I cancel AND/OR no show 3 times during my treatment I will be discharged.

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 other insurance claims. I understand that I am responsible for any amount not covered by insurance. I authorize Las Cruces Comprehensive Rehabilitation to release medical information to any of the following: Hospital, Provider, and Attorney.

Patient/Authorized Signature: _____ Date: _____

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Health History

Patient Name _____ Date _____

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

Name _____ Phone _____ Relationship _____

Are you presently working? ☐ Yes ☐ No Date of Next Physician 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 ☐ Re-occurrence 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
   If yes, 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 ☐ Pacemaker

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

☐ Diabetes (circle one) Type 1 juvenile Type 2 adult onset Do you take insulin? ☐ Yes ☐ No

Are you on blood thinners? ☐ Yes ☐ No

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

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

☐ Hernia ☐ Kidney Problems ☐ Special diet guidelines ☐ Osteoarthritis ☐ Thyroid Condition

☐ Bowel/Bladder abnormalities ☐ Liver/Gallbladder problems ☐ Allergies ☐ AIDS/HIV

☐ Parkinson's Disease ☐ Spine Issues ☐ Osteoporosis ☐ Recent Fractures ☐ Recent Surgery

☐ Metal Implants ☐ Rheumatoid arthritis ☐ Skin abnormalities ☐ Nausea/Vomiting

☐ Other _____

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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 know about?

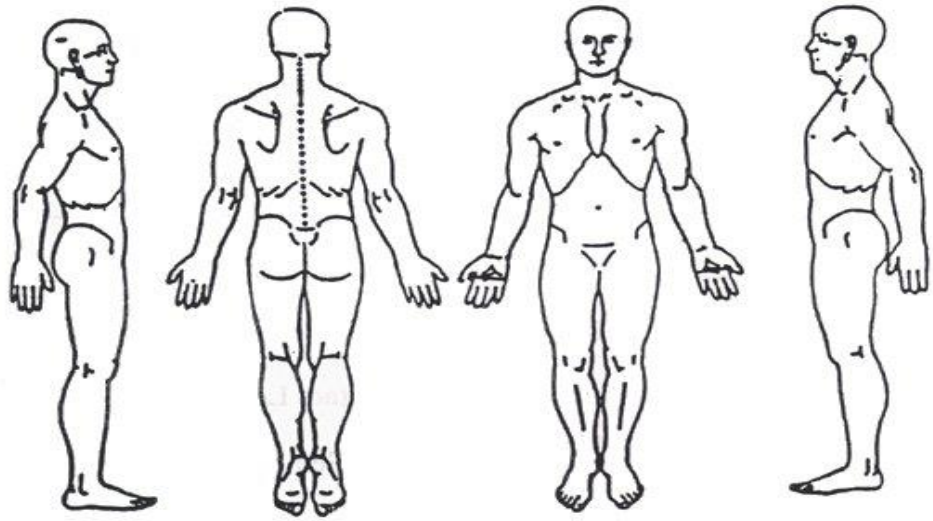
_____
_____
_____

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

☐ Yes ☐ No If yes, please list

_____
_____
_____

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

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GENERAL CONDITIONS OF TREATMENT

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 all injury or illness. I further understand that there exists the possibility of some risks associated with the services that are intended to improve my wellbeing 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.

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

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 state below, this consent shall automatically expire one year from date signed.

ADVANCED DIRECTIVES:

If you have Advanced Directives, Living Will or Durable Power of Attorney and would like to provide LCCR 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 its terms.

_____ _____

Patient/Legal Representative/Authorized Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS 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 care 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 that may identify you and your pas, 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 and others outside 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 oversite 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 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 TPO. 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 than your home.

You have the right to obtain a paper copy of this notice from us upon requested 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 Las Cruces Comprehensive Rehab. 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 that are described in this notice. If you have any questions or complaints, please contact out HPFC Privacy Officer at:

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_____ _____

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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, prospect participant or staff member who has a 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 this 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 Service 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 may be appropriated 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 in an additional 14 days resolve the grievance. The grievance will be notified in writing of he 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/Legal Representative/Authorized Signature Date