Memorial Cancer Center

Welcome to the Cancer Center – Medical Oncology & Hematology:

As with anything new, we want to make sure that you are aware of clinic rules. These rules help us take care of you and all the other patients we serve.

If you have any questions, we would be happy to answer them.

- The Medical Oncology office is a SCENT FREE ZONE. Please avoid wearing anything that has a fragrance. Smells can cause patients to have nausea.
- All prescriptions require a 72 hour turn-around time. Please plan accordingly.
- We are not a walk-in clinic, therefore, appointments are required.
- The physicians in this clinic do not complete medical cannabis paperwork.
- This clinic and the hospital (as well as the grounds) are completely smoke free. If you have a strong smell of tobacco or marijuana, you may not been seen.
- No weapons are permitted.
- ALL paperwork requires FIVE working days to complete before pick up.
- You must keep your appointments and notify the office if you need to reschedule. More than two missed appointments, without notice, may lead to termination as a patient in this clinic.
- Nurses are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. You will receive a call back (almost always) the same day. Please only call once. If you feel it is an emergency, please notify us that you are going to the Emergency Room.
- If you are admitted to the hospital, please let the hospital physician know to call us.
- If you arrive more than 15 minutes late for your appointment, you may be rescheduled.
- Arriving too early for your appointment does not mean you will be seen any sooner than your scheduled appointment time.
- Patients on oxygen are asked to bring their own tank, allowing enough oxygen for approximately 2 hours. Your oxygen carrier may also deliver to our office.
- Please notify the Front Desk of any change in insurance, address or phone numbers.
- All VA and/or Triwest patients: Please verify that you have a current authorization.
- Please minimize cell phone use when seeing the Physician.

Sincerely,

Lynn Fletcher, RN, BSN, MBA, CPPS
Director of the Cancer Program
Clinic Phone Number: 575-521-1554

Consult or Initial Visit History and Review of Systems: Memorial Cancer Center

Interpreter required? No☐ Yes☐ If yes, what language: _____
Learning barriers? No☐ Yes☐ Describe: _____

List your current Primary Physician/NP/PA, surgeon, subspecialists (examples: heart, kidney, GI, cancer, blood, lung, thyroid):
_____
_____

Do you want information about advanced directives/end of life care/ life support if you stop breathing or your heart stops? No☐ Yes☐
If yes, notify social worker.

Are you interested in learning about research studies that may offer you a new treatment for your disease? Yes☐ No ☐

Allergies to medications? food? environment? If yes, please list and state what the reaction is: _____
_____

Medications? List all prescription, over the counter, vitamins, and herbal or alternative remedies (or attach list)_____
_____
_____

Surgeries? If yes, what was done? when was it done? where was it done? List all: _____
_____

Medical History: (examples: diabetes, high blood pressure, heart, liver, kidney, or thyroid disease, stroke, arthritis, chronic pain, COPD, asthma, etc)
_____
_____
_____
_____
_____
_____

Lifestyle Habits:

Have you smoked tobacco? Yes ☐ No ☐
How many packs per day? ___and for how many years?___
If you quit smoking, when was your last puff? _____
Have you chewed tobacco? Yes ☐ No ☐ Still? Yes ☐ No ☐
Have you vaped? Yes ☐ No ☐ Still? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐
How many beers, mixed drinks, and/or wine do you have in one day?____ one week?___ one month___?
If you drink alcohol, have you ever:
felt the need to cut down? Yes ☐ No ☐
felt annoyed by criticism of your drinking? Yes ☐ No ☐
felt guilty about drinking? Yes ☐ No ☐
drink a morning "eye-opener"? Yes ☐ No ☐
If you quit alcohol, when was your last drink? _____

What harmful environmental substances have you been exposed to? (examples: asbestos, agent orange, insecticides)
_____

What drugs do you use or have you tried? (examples: cocaine, heroin, meth, marijuana) _____
When was the last time?_____

Exercise/Physical Activities:

What activities?_____

How many times per week and how many minutes per day?
_____

Healthcare Maintenance:

Last colonoscopy: _____Results:_____ Next due:_____
Ever had an EGD? Results:_____ Next due:_____
Last skin check by PCP or dermatologist? _____
Ever had a breast biopsy? Yes ☐ No ☐
Results: _____
Ever had a prostate exam? Yes ☐ No ☐
Results: _____ Last PSA? _____
Are you or your partner using birth control? Yes ☐ No ☐
What type of birth control? _____

Family History: (indicate alive or deceased; current age: age at cancer diagnosis and cancer type for each, if appropriate)

Father _____ Mother _____ Total Brothers/Sisters__/__
Brother(s)_____Sister(s)_____
_____

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

Consult or Initial Visit History and Review of Systems: Memorial Cancer Center

Support:

Marital Status:(*circle one*)
Single Married Divorced Widowed Partnered
Do you live alone? Yes ☐ No ☐
If no, list who lives with you:_____
Who do you rely on for support or help? _____
Do you have transportation? Yes ☐ No ☐
Do you have a place to stay in Las Cruces? Yes ☐ No ☐
Are you currently working? Yes ☐ No ☐
What type of work do you or did you do?
Do you have living children? Yes ☐ No ☐
How many? _____
Who is your decision maker if you can't speak for yourself?_____

For WOMEN:

Last PAP/GYN exam:_____ Results:____ Next due:_____
Last mammogram:_____Results: ____ Next due:_____
Are you or might you be pregnant? Yes ☐ No ☐
Date of last menstrual period: _____Length of period:_____
Age at first menses: _____ Number of pregnancies: _____
Number of live births: _____Age at first birth:_____
Number of living children: _____
Do you or have you ever taken
Hormone pills: Yes ☐ No ☐
Birth Control pills: Yes ☐ No ☐
Are you planning to have children Yes ☐ No ☐

General: None ☐

Fever Yes ☐
Recent loss of weight Yes ☐
If yes, how much? _____
Over what period of time? _____
Drenching night sweats Yes ☐
Fatigue or decrease in energy level Yes ☐
If yes describe: _____

Pain:

Experiencing pain **right now**? None ☐

If yes, rate on a scale of 1 to 10 with 10 being the worst pain you can imagine? ___/10

Where is pain located? _____
What does it feel like? Sharp? Dull? Constant?
_____
Does it travel or stay in one place? _____
If travels, to what part of body? _____
What makes it worse? _____
What makes it better? _____
Change in position ☐ Food ☐ Pain meds ☐
Other _____

Gastrointestinal: None ☐

Nausea/Vomiting Yes ☐
Heartburn Yes ☐
Trouble swallowing Yes ☐
Constipation Yes ☐
Diarrhea (how many stools/day?)____ Yes ☐
Bloating Yes ☐
Abdominal Pain Yes ☐

Psychological: None ☐

Depression Yes ☐
Anxiety Yes ☐
Thoughts/feelings of hurting yourself Yes ☐

Neurologic: None ☐

Pins and needles sensation Yes ☐
Seizures Yes ☐
Muscle weakness Yes ☐
Headaches Yes ☐
Dizziness Yes ☐
Lightheadedness Yes ☐
Falls Yes ☐

Hematologic/Endocrine None ☐

Bleeding/easy bruising Yes ☐
Diabetes control Yes ☐
Sensation to hot or cold Yes ☐

Eyes/Mouth/Ears: None ☐

Double vision or loss of vision Yes ☐
Mouth sores Yes ☐
Toothache Yes ☐
Hearing Loss Yes ☐
Ringing in Ears Yes ☐
Sinus congestion Yes ☐

Respiratory: None ☐

Shortness of breath Yes ☐
When moving? Yes ☐
At rest? Yes ☐
Chest pain Yes ☐
Cough Yes ☐
Dry Yes ☐
Productive Yes ☐
Color of Sputum _____
Breathing troubles Yes ☐

Musculoskeletal: None ☐

Muscle aches Yes ☐
Joint swelling or stiffness Yes ☐
Bone pain Yes ☐
If yes, where? _____

Cardiovascular: None ☐

Chest tightness Yes ☐
Chest pressure Yes ☐
Extra heart beats or palpitations Yes ☐
High blood pressure Yes ☐
Chest pain Yes ☐
Leg swelling Yes ☐

Genitourinary: None ☐

Urination problems Yes ☐
Bleeding Yes ☐
Burning Yes ☐
Change in color Yes ☐
Urgency Yes ☐
Hesitancy Yes ☐
Weak stream Yes ☐
Incontinence Yes ☐
Frequency Yes ☐

Skin: None ☐

Loss of hair Yes ☐
Change in skin color or rash Yes ☐
Lumps, bumps, thickening Yes ☐

Sexuality:

Gender preference? _____
Changes in sexual function? Yes ☐
Sexually active? Yes ☐
Birth control? Yes ☐
Type of birth control _____
Breast problems Yes ☐

For Women:

Pregnant? Yes ☐
Last menstrual period date _____
Length of period? _____
Any non menstrual bleeding Yes ☐

Patient (or caregiver) signature_____Date_____Time_____

Provider signature_____ Date_____ Time_____

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

Memorial Cancer Center

Medical Oncology & Hematology Patient Screening and Intake Form

Today's Date: _____

Name: _____

Do you have another name that you go by: _____

Diagnosis: _____

Social Security Number: _____ Date of Birth: _____

Gender: Date of Birth: _____ ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____

Email Address: _____@ _____

Contact Next of Kin: Name: _____

Relationship: _____ Phone: _____

Address: _____

City/State/Zip Code: _____

Insurance PRIMARY: (please have card available at check in): _____

Policy Holder's Name: _____ Date of Birth: _____

Insurance SECONDAR: (please have card available at check in): _____

Policy Holder's Name: _____ Date of Birth: _____

Reason for Referral: ☐ Cancer ☐ Hematology ☐ Other

Physician Information (full name, address and phone number)

Primary care physician: _____

Address: _____

Phone Number: _____

Previous Cancer Physician: _____

Address: _____

Phone: _____

Thank you and have a great day!

Memorial Cancer Center

Medical Oncology & Hematology

PHARMACY OF CHOICE

PLEASE SELECT (WRITE IN) ONE

• ___ FAMILY PHARMACY	1205 S. SOLANO
• ___ CVS PHARMACY	940 N Main St
• ___ CVS PHARMACY	3011 N. MAIN ST.
• ___ SAM'S CLUB	2711 N. TELSHOR
• ___ SAV-ON PHARMACY	1285 EL PASEO
• ___ SAV-ON PHARMACY	2551 E. LOHMAN AVE.
• ___ SAV-ON PHARMACY	2501 N. MAIN
• ___ WALMART	3331 RINCONADA BLVD
• ___ WALMART	1550 S. VALLEY
• ___ WALMART	571 S. WALTON BLVD.
• ___ WALGREENS	3990 E. LOHMAN (NEAR ROADRUNNER)
• ___ WALGREENS	3100 N. MAIN
• ___ WALGREENS	2300 E. LOHMAN (NEAR WALMART)
• ___ WALGREENS	1250 EL PASEO
• ___ WALGREENS	3490 NORTHRISE (NEAR WALMART)
• ___ OTHER: _____	

Memorial Cancer Center

Medical Oncology & Hematology
2530 S. Telshor Blvd, Suite 107
Las Cruces NM 88077-5076
Phone: 575-521-1554 Fax: 575-556-1754

AUTHORIZATION TO OBTAIN INFORMATION FROM OTHER PROVIDERS

NAME_____

DOB_____

SOC SEC#_____

This authorization is to OBTAIN medical records from another provider. Please fill in ALL the information requested: leave NO Blanks. Print full name and address of individual or institution from whom records are to be requested.

Records Requested From: _____

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

The purpose of this disclosure is: _____

Please specify the extent of information you wish released.

A. Records of inpatient, outpatient, or emergency service for the following condition or injury:
_____

B. Records of the period from_____ to _____

C. Specific records needed are:

- ☐ Admission face sheet
- ☐ Discharge summary
- ☐ History/physical exam
- ☐ Operative report
- ☐ Pathology report
- ☐ Consultation report
- ☐ Orders/progress notes
- ☐ Laboratory report
- ☐ X-ray report
- ☐ Electrocardiogram report
- ☐ Emergency dept report
- ☐ Entire chart
- ☐ Other:_____

D. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness, I understand that I have a right to examine and get a copy any information disclosed under the terms of this release (N.M. Stat. Ann 43-1-19.) (If the patient is a minor, the patient and legal representative must sign here and below. At least one signature is needed in this section in ALL cases.)

Signature:_____Date: _____ Signature:_____Date: _____

This authorization shall be considered invalid after 6 months (60 days for drug/alcohol abuse records), from the date of signing. Medical information gathered by you after the date of authorization signing is not to be released. The authorizing party may revoke this authorization at any time by notifying the individual/institution from which records were requested. I agree that my individual/institution from which records were requested received my written notice to revoke this authorization. I understand that I can receive treatment at Memorial Medical Center even thought I have not signed an authorization to obtain my medical records from other providers.

I hereby authorize you to provide the above medical information to Memorial Medical Center. In furtherance of this authorization, I do hereby waive all provisions of law related to the disclosure hereby authorized.

Patient Signature_____ Date_____

If the patient unable to sign, give reason _____

Signature of legally authorized representative _____ Date _____

Relationship to patient _____ Witness Signature _____ Date _____

PLEASE ADDRESS REPLIES TO THE ATTENTION OF: **MEMORIAL CANCER CENTER**
MEDICAL ONCOLOGY & HEMATOLOGY
2530 S. TELSHOR BLVD, SUITE 107
LAS CRUCES, NM 88077-5076

Memorial Cancer Center

Medical Oncology & Hematology
2530 S. Telshor Blvd, Suite 107
Las Cruces NM 88077-5076

575 521-1554 Fax 575 556-1754

AUTHORIZATION FOR RELEASING INFORMATION FROM MEDICAL RECORDS

NAME_____

DATE OF BIRTH_____

SOC. SEC. #_____

PT. ACCT. #_____

This authorization is to RELEASE MEMORIAL MEDICAL CENTER MEDICAL RECORDS. Please fill in **ALL** the information requested; leave **NO** blanks. This authorization will not be considered valid if all the information is not provided.

Send To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Memorial Medical Center to provide the above-named person(s) or company access to my medical records for the purpose of review, examination, and provision of such copies as may be requested.

The purpose of this disclosure is: _____
Please specify the extent of information you wish released.

A. Records of Inpatient, Outpatient, or Emergency Services whether such records were generated at Memorial Medical Center or were obtained from a previous provider, which relate to my care and treatment, except (specify what kind of information you do NOT want released):_____

_____

B. Records of the period from _____ to _____

C. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness I understand that I have a right to examine and copy any information disclosed under the terms of this release (N.M. Stat. Ann. § 43-1-19). If the patient is a minor, the patient and the legal representative must sign here and below. At least one signature is needed in this section in **ALL** cases.

Signature _____ Date_____ Signature _____ Date_____

This authorization shall be considered invalid after 6 months or 60 days for drug and alcohol abuse records, from the date of signing. Medical information gathered after the date of authorization signing will not be released. The authorizing party may revoke this authorization at any time by notifying MMC in writing. Send revocation to: Health Information Management Director, Memorial Medical Center, 2450 S. Telshor Blvd., Las Cruces, NM 88011-5076. I agree that my revoking the authorization will not have any effect on any information which MMC has already released before they received my written notice to revoke this authorization.

I understand that I can receive treatment at Memorial Medical Center even though I have not signed an authorization for release of my medical records.

In furtherance of this authorization, I do hereby waive all provisions of law relating to the disclosures hereby authorized.

Patient Signature _____ Date_____

If patient unable to sign, give reason _____

Signature of legally authorized representative _____ Date_____

Relationship to patient _____ Witness' Signature_____ Date_____

ANY REDISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED

Authorization For Releasing Information
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ROIAUTH

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

Memorial Cancer Center

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

Memorial Cancer Center

Medical Oncology & Hematology

CONSENT FOR FAMILY MEMBERS

Date: _____

I, _____, understand my rights as a patient and the role my providers take to ensure my privacy.

This letter is to inform the staff of Memorial Radiation Oncology permission to allow the following individuals access to my medical information.

I assign primary responsibility to the first person listed because I understand it is difficult for the staff at Memorial Radiation Oncology to speak to multiple family members.

	NAME	PHONE #	RELATIONSHIP
1			
2			
3			
4			

This list can be reviewed at any time.

Printed Name:_____

Signature:_____

Date:_____

EMERGENCY CONTACTS

Primary Contact:_____

Relationship:_____

Phone Number (s):_____

Secondary Contact: _____

Relationship:_____

Phone Number(s):_____

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

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9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS. HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital if, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS AND OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PA's), Nurse Practitioners (NP's), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that I may ask my Health Care Provider to verify if they are a Hospital employee or an independent contractor.

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.
    I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT ADMISSION, TRANSFER, OR DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

12. **ELECTION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S):** I hereby authorize Hospital to provide a copy of my medical record or portions thereof to any health information exchange or network with which Hospital participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which Hospital participates may be found in the Notice of Privacy Practices, which is available on the Hospital website, and this list may be updated from time to time if and when Hospital participates with new health information exchanges or networks. Hospital participates in the LifePoint health information exchange, which is operated by business associates of Hospital identified in the Notice of Privacy Practices, including LifePoint Corporate Services General Partnership. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

13. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

14. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

15. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

16. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

17. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.

18. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

    ☐ I have executed an Advance Directive
    ☐ I have not executed an Advance Directive
    ☐ I would like to formulate an Advance Directive and receive additional information

19. **OTHER ACKNOWLEDGEMENTS:**

    a. Personal Valuables: I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices. I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables; however, except as required by law, the hospital is not liable for any loss or damage to property that is secured in the safe.

    b. Smoke Free Facility Policy: The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

    c. Weapons / Explosives / Drugs: I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found, the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

20. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

21. **AGREEMENT AS TO FORUM SELECTION (where lawsuits shall be filed):** The patient or patient's representative, and Memorial Medical Center, including employees and agents Memorial Medical Center, rendering or providing medical care, health care, or safety, professional or administrative services in any way related to health care to patient (all of the above referred to as "health care"), agree: in the event of a dispute or claim, any lawsuit, which in any way relates to health care provided to the patient shall only be brought in the Third Judicial District Court, Dona Ana County, Las Cruces, New Mexico, and in no event will any such lawsuit ever be brought in any other place. The provisions of this paragraph, as to where suit shall be brought, are mandatory.

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient or Legal Representative for Health Care Hospital Services if Other Than Patient

Date and Time

Relationship to Patient

Reason patient is Unable to sign

Signature of Witness

Date and Time

USE LABEL OR PRINT PATIENT ID HERE