ESPERANZA
MEDICAL AND WELLNESS

4420 Sonoma Ranch Blvd. Ste B.
Las Cruces, NM 88012
Phone: (575) 532-1334
Fax: (575) 532-1173

## Patient Information:

| | | |
|---|---|---|
| Patient Name: (Last, First, MI) | DOB: | Sex: ☐ Male ☐ Female |
| Race: ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Black/African American | | |
| Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic or Latino | | |
| Address: | Social Security #: | Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed |
| City, State, ZIP: | Primary Phone: | Secondary Phone: |
| Email: | Occupation: | Account Type: ☐ Personal Injury ☐ Work Comp ☐ Other |
| Date of Injury: | Date of Initial Treatment: | Injured Body Area(s): |
| Police Report/Number | Property Loss (Amt $): | ☐ Employment Related ☐ Auto Related ☐ Other Accident |

## Employer:

| | | |
|---|---|---|
| Employer Name: | Employer Address: | Employer City, State, ZIP: |
| Employer Phone: | Injury Verified by: | Supervisor/Contact Person: |
| Email: | | |

## Insurance / Attorney

| | |
|---|---|
| Insurance Provider / Law Firm | Relationship: ☐ Self ☐ Child ☐ Spouse ☐ Other |
| Policy Number: | Group Number: |
| Subscriber Name (If NOT Self): | Effective Date: |
| Subscriber DOB: | Termination Date: |
| Subscriber Address: | Plan Name: |
| Subscriber City, State, ZIP: | Reference ID Number: |

## Accident Information:

| | |
|---|---|
| Type of Accident: ☐ Home Accident ☐ Motor Vehicle Collision ☐ Workplace Accident | |
| Date of Accident: | Time of Accident ☐ AM ☐ PM |
| Describe the Accident: | |

## Accident Information:

**Type Of Vehicle That Hit You:**

**Type Of Vehicle You Were In:**

**Did your vehicle hit another structure?:** ☐ Yes ☐ No

**If Yes, Describe Structure:**

**Were You The:** ☐ Driver ☐ Pedestrian ☐ Back Passenger ☐ Front Passenger

**How did you feel immediately after the accident?**

**Did you lose consciousness?:** ☐ Yes ☐ No

**If Yes, for how long?:**

**Did you go to a hospital/clinic?:** ☐ Yes ☐ No

**If Yes, when did you go?:** ☐ Immediately after Accident ☐ Next Day ☐ Two Days or More After Accident

**How did you get to the hospital/clinic?** ☐ Ambulance ☐ Private Transportation

**Name of hospital/clinic:**

**Name Of Doctor:**

**Diagnosis:**

**Treatment Received:**

**X-Rays/Imaging/Body Part(s):**

## Symptoms:

**Location of pain:**

☐ Chest ☐ Neck ☐ Lower Back ☐ Upper Back

☐ Left Shoulder ☐ Left Hand ☐ Left Lower Leg
☐ Left Arm ☐ Left Hip ☐ Left Ankle
☐ Left Elbow ☐ Left Thigh ☐ Left Foot
☐ Left Wrist ☐ Left Knee

☐ Right Shoulder ☐ Right Hand ☐ Right Lower Leg
☐ Right Arm ☐ Right Hip ☐ Right Ankle
☐ Right Elbow ☐ Right Thigh ☐ Right Foot
☐ Right Wrist ☐ Right Knee

**Severity of Pain:**

No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable

**Type of Pain:**

☐ Sharp ☐ Cramps ☐ Shooting ☐ Throbbing ☐ Swelling ☐ Tingling
☐ Aching ☐ Dull ☐ Stiffness ☐ Burning ☐ Numbness ☐ Other

**Radiates Into:**

☐ Left Shoulder ☐ Left Hand ☐ Left Lower Leg
☐ Left Arm ☐ Left Hip ☐ Left Ankle
☐ Left Elbow ☐ Left Thigh ☐ Left Foot
☐ Left Wrist ☐ Left Knee

☐ Right Shoulder ☐ Right Hand ☐ Right Lower Leg
☐ Right Arm ☐ Right Hip ☐ Right Ankle
☐ Right Elbow ☐ Right Thigh ☐ Right Foot
☐ Right Wrist ☐ Right Knee

**Frequency of Pain:** ☐ Constant ☐ Hourly ☐ Daily ☐ Several Times a Day ☐ Weekly ☐ Several Times a Week

**Worse With:**

☐ Activity ☐ Bending ☐ Nothing ☐ Weather ☐ Work
☐ Heat ☐ Ice ☐ Cold ☐ Everything
☐ Movement ☐ Sitting ☐ Laying Down ☐ Lifting
☐ Twisting ☐ Walking ☐ Sleeping ☐ Standing

**Better With:**

☐ Bending ☐ Changing Position ☐ Heat ☐ Ice
☐ Laying Down ☐ Massage ☐ Medications ☐ Resting
☐ Sitting ☐ Sleeping ☐ Standing ☐ Therapy
☐ Walking ☐ Other ☐ Nothing

**Interferes With:**

☐ Bending ☐ Sleeping ☐ Turning Head
☐ Sitting ☐ Lifting ☐ Other
☐ Walking ☐ Standing
☐ Laying Down ☐ Performing Household Chores

**Have you had any of the following symptoms since your injury:**

☐ Arm/Shoulder Pain ☐ Dizziness ☐ Feet/Toe Numbness ☐ Jaw Problems ☐ Neck Pain ☐ Stomach Upset
☐ Back Pain ☐ Ear Buzzing ☐ Hand/Finger Numbness ☐ Leg Pain ☐ Neck Stiff ☐ Tension
☐ Back Stiffness ☐ Ear Ringing ☐ Headaches ☐ Memory Loss ☐ Shortness of Breath ☐ Vision Blurred
☐ Chest Pain ☐ Fatigue ☐ Irritability ☐ Nausea ☐ Sleep Difficulty ☐ Change In Vision

## Past Medical History

**Patient reports a past history of:**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Stroke | ☐ Parkinson's Disease | ☐ High Cholesterol | ☐ Gout |
| ☐ Anorexia | ☐ Tuberculosis | ☐ Prostate Problem | ☐ Migraine Headaches | ☐ Herniated Disk |
| ☐ Bleeding Disorders | ☐ Vaginal Infections | ☐ Rheumatoid Arthritis | ☐ Mumps | ☐ Kidney Disease |
| ☐ Cancer | ☐ Alcoholism | ☐ Suicide Attempt | ☐ Pinched Nerve | ☐ Miscarriage |
| ☐ Diabetes | ☐ Appendicitis | ☐ Tumors / Growths | ☐ Prosthesis | ☐ Osteoporosis |
| ☐ Glaucoma | ☐ Breast Lump | ☐ Whooping Cough | ☐ Scarlet Fever | ☐ Pneumonia |
| ☐ Heart Disease | ☐ Cataracts | ☐ Allergies | ☐ Thyroid Problems | ☐ Psychiatric Care |
| ☐ Herpes | ☐ Emphysema | ☐ Arthritis | ☐ Typhoid Fever | ☐ Sexually Transmitted Disease |
| ☐ Liver Disease | ☐ Goiter | ☐ Bronchitis | ☐ Anemia | ☐ Tonsillitis |
| ☐ Mononucleosis | ☐ Hepatitis | ☐ Chemical Dependency | ☐ Asthma | ☐ Ulcers |
| ☐ Pacemaker | ☐ High Blood Pressure | ☐ Epilepsy | ☐ Bulimia | |
| ☐ Polio | ☐ Measles | ☐ Gonorrhea | ☐ Chicken Pox | |
| ☐ Rheumatic Fever | ☐ Multiple Sclerosis | ☐ Hernia | ☐ Fractures | |

**Other:**

## Family History:

**Mother:** ☐ Living ☐ Deceased ☐ Unkown

**Conditions:** ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ High Blood Pressure ☐ Other

**If Deceased, what was the cause of Death?**

**Father:** ☐ Living ☐ Deceased ☐ Unkown

**Conditions:** ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ High Blood Pressure ☐ Other

**If Deceased, what was the cause of Death?**

**Other Details you would like the Doctor to Know:**

## Social History:

**Tobacco:** ☐ Currently Smokes ☐ Has never smoked ☐ Quit Smoking

**If you smoke, How many packs _____ and how often?**

**Alcohol:** ☐ Currently drinks alcohol ☐ Has never drank alcohol ☐ Quit Drinking Alcohol

**If you drink, How many drinks _____ and how often?**

**Exercise:** ☐ Daily ☐ 2-3 Times per week ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Doesn't exercise

## Referral Source

**Where did you hear about Esperanza Medical & Wellness?**

I consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation. I acknowledge that no guarantees have been given to me as to the outcome of any examination and all results of any examination and/or treatment are kept confidential.

**Patient Signature:** _____ **Date:** _____

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**Insurance Company Notice of Assignment and Contractual Lien**
**VIA FAX AND CMRRR**

Dear Sir/Madam:
It is our understanding that your insurance company may elect or be obligated to pay or provide certain proceeds or benefits to the above referenced patient for medical conditions and treatment related to an incident. For your file, I have enclosed a copy of the signed and notarized Assignment of Proceeds and Contractual Lien that the patient has executed. That document legally assigns to our clinic 'all claims, causes of action, and right to any proceeds and/or benefits' of the patient. Please take note that the patient gives the following instruction:

**'PAY DIRECTLY AND EXCLUSIVELY TO ESPERANZA MEDICAL AND WELLNESS** such sums as may be outstanding and owed to said Provider for charges incurred by me at the office relating to my condition, with such payment **TO BE MADE BY SEPARATE CHECK AND PAYABLE EXCLUSIVELY IN THE NAME OF ESPERANZA MEDICAL AND WELLNESS** and deliver such payment to 4420 N. Sonoma Ranch Blvd. Ste. B, Las Cruces, NM 88011.

I have also enclosed for your file a separate letter signed by the patient with the same instructions.

This document is legally enforceable and it is our office policy that if a company does not honor our Assignment, Contractual Lien, and patient instructions, and the account is not satisfied by the patient, we pursue all available legal collection efforts against any responsible entity, **including direct action against the insurance company.** We expect that your company will honor this valid Assignment, Contractual Lien, and written payment instructions from the patient. If you do not believe that the Assignment is valid and legal, or that for some reason you are not required to honor them, please contact our office immediately and put the basis for such decision in writing to us.

Thank you for your anticipated cooperation.

Sincerely,

*Esperanza Medical & Wellness*

Esperanza Medical & Wellness

_____
Date

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MEDICAL AND WELLNESS

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**Las Cruces, NM 88012**
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**Fax: (575) 532-1173**

**Insurance Company Request for Payments**
**VIA FAX AND CMRRR**

Dear Sir/Madam:

When any settlement agreement or any payment is made for this case, please issue a separate check payable to **ESPERANZA MEDICAL AND WELLNESS** for the amount of my outstanding balance with their office and deliver such payment to **4420 N. Sonoma Ranch Blvd. Ste. B, Las Cruces, NM 88011.** I have previously agreed to this in writing and signed an irrevocable Assignment of Benefits and Contractual Lien when I began treatment with **ESPERANZA MEDICAL & WELLNESS**.

Sincerely,

X_____
Signature of patient and/or responsible parties

_____
Date

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MEDICAL AND WELLNESS

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# HIPPA NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**PLEASE REVIEW IT CAREFULLY.**

if you have any questions about the above notice, please contact our Office at (575) 532-1334

**Our Obligations:**
We are required by law to:
- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect

**How We May Use and Disclose Health Information:**
Described as follows are the ways we may use and disclose health information that identifies you ('Health Information'). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, and insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may also share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services**. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

**Special Situations**
**As required by law.** We will disclose Health Information when required to do so by international, federal, state, or local law. **To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.**

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

**Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
may

**Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.
necessary,

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the president, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

**Your Rights**
You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request and accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You obtain a copy of this notice by contacting our office.
may

**Changes to This Notice**
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page in the top right hand corner.

**Complaints**
If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with your office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

X_____ _____
Patient Signature Date

ESPERANZA
MEDICAL AND WELLNESS

**4420 Sonoma Ranch Blvd. Ste B.**
**Las Cruces, NM 88012**
**Phone: (575) 532-1334**
**Fax: (575) 532-1173**

## ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

In consideration for deferred billing and the services rendered and/ or to be rendered, I, the undersigned patient and/or responsible patty, hereby irrevocably and exclusively assign and transfer to ESPERANZA MEDICAL AND WELLNESS (herein after 'Provider) any and all claims, causes of action, and right to any proceeds and/or benefits that I may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred by me from Provider up to the full amount of the charges and I grant a contractual lien on proceeds of any settlement and/ or judgment in any pending or future legal claim or action. **THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.**

I acknowledge that the amount subject to this lien constitutes the ordinary and customer charges by Provider for such services, supplies and/or treatment, and may include administrative charges for costs, expenses and risk of collection typically incurred by Provider. Thus, the amount of the lien may or may not constitute the same charge of such medical services, supplies and/ or treatment for similar services to others. I authorize Provider to establish PIP, Med Pay and/or UM claim on my behalf. I also authorize Provider to prosecute said claim and/or action either in my name or its name, as it sees fit, and further authorize it to comprise, settle, or otherwise resolve said claims as it sees fit. However, Provider shall have no duty whatsoever to prosecute the claim or litigation. Provider shall not be liable for any costs and/or expenses associated with any claims or litigation unless Provider files that litigation. Nothing herein shall prevent me from pursuing any claim or litigation that I otherwise have a right to pursue. However, I will not settle any case or claim involving recovery of Provider's medical bills without the permission of Provider. I understand that whatever amounts Provider does not collect from insurance proceeds (whether it be all or part of what is due), I personally remain responsible and owe and agree to pay the outstanding balance in a current manner. I agree to notify Provider of any payment received by me for medical services from an insurance company or other source, and I hereby instruct my attorney, if any, to likewise notify Provider.

**Any and all services rendered under this agreement shall be at the sole discretion of Provider and in no way shall** this agreement be construed to obligate Provider to provide any certain services.

INSTRUCTIONS TO INSURANCE COMPANIES: I hereby irrevocably authorize, direct and instruct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entity (herein after referred to as 'payers'), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future (herein after referred to as 'condition) to **PAY DIRECTLY AND EXCLUSIVELY TO ESPERANZA MEDICAL AND WELLNESS** such sums as may be outstanding and owed to said Provider for charges incurred by me at the office relating to my condition, with such payment **TO BE MADE BY SEPARATE CHECK AND PAYABLE EXCLUSIVELY IN THE NAME OF ESPERANZA MEDICAL AND WELLNESS** and deliver such payment to 4420 N. Sonoma Ranch Blvd. Ste. B, Las Cruces, NM 88011. Payment directly to me, even if Provider's name is on the check, does not constitute payment to Provider and does not comply with the terms of this instruction. For the purposes of this document, 'proceeds' shall include, but not be limited to, monies/ proceeds from any settlement judgment, or verdict, as well as any monies/ proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability insurance, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

This instruction applies irrespective of whether I have hired an attorney to pursue my other claims. In the event that I retain one or more attorneys to represent my other claims in this matter, I, nevertheless, irrevocably direct any 'payer' (auto insurance and/or health insurance) to directly issue full and separate medical payment to **ESPERANZA MEDICAL AND WELLNESS.**

**INSTRUCTIONS TO ATTORNEYS:** In the event that I retain one or more attorneys to represent my other claims in this matter and any settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts that are outstanding on my account to Provider and remit payment of all such sums fully and directly to Provider contemporaneously with any disbursement of money to me, my attorney, or any other party from said settlement or judgment. I further irrevocably instruct and authorize my attorney to furnish to Provider any documents relating to my insurance settlement and distribution of funds, upon request of Provider, in order that Provider may be made aware of the full settlement disbursement of any recovery I may receive.

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## ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

**AUTHORIZATION TO RELEASE INFORMATION:** Provider is authorized to release any information it deems appropriate concerning my physical condition and treatment to all payers as defined above or my attorneys to facilitate collection under this assignment. I further authorize and direct all payers to release to Provider all information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, the amount of settlement, and the amount of any outstanding claims. I hereby authorize and direct Provider to file a copy of this assignment, together with any applicable charges, with any or all payers and seek collection of payments, regardless of whether a claim has been established with said payers. I also hereby grant to Provider the limited power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company for treatment and services rendered by the Provider. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account of forwarded to me upon request in writing to Provider.

**DEMAND FOR PAYMENT:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the Provider, you are hereby tendered a demand to pay in full the bill for services rendered by Provider within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy.

**STATUTE OF LIMITATIONS:** In further consideration of deferred billing and the services rendered and/ or to be rendered, I waive my right to claim any statute of limitations regarding claims for or collection of the amount due for services rendered or to be rendered by Provider, in addition to reasonable cost of collection, including attorney fees and court cost incurred. This assignment and contract shall not be modified or revoked without the mutual written consent of Provider and myself. I hereby revoke and resend any previously signed authorizations and assignments, whether executed at this office or any other office to the extent that the terms of those authorizations or assignments conflict with the terms of this assignment and contract.

**BY MY SIGNATURE, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND FULLY UNDERSTAND THE ABOVE DOCUMENT AND ACKNOWLEDGE THAT IT IS A VALID AND IRREVOCABLE ASSIGNMENT AND CONTRACTUAL LIEN.**

X_____ _____
Signature of patient and/ or responsible parties Date

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**AFFIDAVIT**

I HEREBY AFFIRM THAT I SUSTAINED PHYSICAL INJURIES AS A RESULT OF THE INCIDENT ON: _____.

NO ONE HAS OFFERED OR GIVEN ME ANY MONEY, INCENTIVE, REMUNERATION, ANYTHING OF VALUE OR ANY OTHER FORM OF INDUCEMENT FOR THE PURPOSE OF TREATING AT THIS CLINIC. NO ONE HAS MADE ANY PROMISES OR GAURANTEES WITH REGARD TO MY MEDICAL TRATMENT OR ANY OTHER ASPECT OF MY CASE. I UNDERSTAND THAT I HAVE A CHOICE REGARDING WHERE I SEEK TRATMENT FOR MY INJURIES, AND I HAVE CHOSEN, OF MY OWN FREE WILL, TO SEEK TREATMENT AT THIS CLINIC.

X_____
Signature of patient and/or responsible parties

Sworn to and subscribed before me by _____on _____,20_____.

_____
Notary Public in and for
the State of New Mexico

My commission expires: _____

HOPE
SURGICAL MEDICAL GROUP

**4420 Sonoma Ranch Blvd. Ste B.**
**Las Cruces, NM 88012**
**Phone: (575) 532-1334**
**Fax: (575) 532-1173**

**Insurance Company Notice of Assignment and Contractual Lien**
**VIA FAX AND CMRRR**

Dear Sir/Madam:
It is our understanding that your insurance company may elect or be obligated to pay or provide certain proceeds or benefits to the above referenced patient for medical conditions and treatment related to an incident. For your file, I have enclosed a copy of the signed and notarized Assignment of Proceeds and Contractual Lien that the patient has executed. That document legally assigns to our clinic 'all claims, causes of action, and right to any proceeds and/or benefits' of the patient. Please take note that the patient gives the following instruction:

**'PAY DIRECTLY AND EXCLUSIVELY TO HOPE SURGICAL MEDICAL GROUP** such sums as may be outstanding and owed to said Provider for charges incurred by me at the office relating to my condition, with such payment **TO BE MADE BY SEPARATE CHECK AND PAYABLE EXCLUSIVELY IN THE NAME OF HOPE SURGICAL MEDICAL GROUP** and deliver such payment to 4420 N. Sonoma Ranch Blvd. Ste. B, Las Cruces, NM 88011

I have also enclosed for your file a separate letter signed by the patient with the same instructions.

This document is legally enforceable and it is our office policy that if a company does not honor our Assignment, Contractual Lien, and patient instructions, and the account is not satisfied by the patient, we pursue all available legal collection efforts against any responsible entity, **including direct action against the insurance company.** We expect that your company will honor this valid Assignment, Contractual Lien, and written payment instructions from the patient. If you do not believe that the Assignment is valid and legal, or that for some reason you are not required to honor them, please contact our office immediately and put the basis for such decision in writing to us.

Thank you for your anticipated cooperation.

Sincerely,

*Hope Surgical Medical Group*

Hope Surgical Medical Group

_____
Date

HOPE
SURGICAL MEDICAL GROUP

**4420 Sonoma Ranch Blvd. Ste B.**
**Las Cruces, NM 88012**
**Phone: (575) 532-1334**
**Fax: (575) 532-1173**

**Insurance Company Request for Payments**
**VIA FAX AND CMRRR**

Dear Sir/Madam:

When any settlement agreement or any payment is made for this case, please issue a separate check payable to **HOPE SURGICAL MEDICAL GROUP** for the amount of my outstanding balance with their office and deliver such payment to **4420 N. Sonoma Ranch Blvd. Ste. B, Las Cruces, NM 880.** I have previously agreed to this in writing and signed an irrevocable Assignment of Benefits and Contractual Lien when I began treatment with **HOPE SURGICAL MEDICAL GROUP**.

Sincerely,

X_____
Signature of patient and/or responsible parties

_____
Date

HOPE
SURGICAL MEDICAL GROUP

**4420 Sonoma Ranch Blvd. Ste B.**
**Las Cruces, NM 88012**
**Phone: (575) 532-1334**
**Fax: (575) 532-1173**

# HIPPA NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**PLEASE REVIEW IT CAREFULLY.**

if you have any questions about the above notice, please contact our Office at (575) 532-1334

**Our Obligations:**
We are required by law to:
- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect

**How We May Use and Disclose Health Information:**
Described as follows are the ways we may use and disclose health information that identifies you ('Health Information'). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, and insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may also share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

**Special Situations**
**As required by law.** We will disclose Health Information when required to do so by international, federal, state, or local law. **To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.**

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

**Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
may

**Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.
necessary,

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the president, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

**Your Rights**
You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request and accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You obtain a copy of this notice by contacting our office.
may

**Changes to This Notice**
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page in the top right hand corner.

**Complaints**
If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with your office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

X_____ _____
Patient Signature Date

HOPE
SURGICAL MEDICAL GROUP

**4420 Sonoma Ranch Blvd. Ste B.**
**Las Cruces, NM 88012**
**Phone: (575) 532-1334**
**Fax: (575) 532-1173**

## ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

In consideration for deferred billing and the services rendered and/ or to be rendered, I, the undersigned patient and/or responsible patty, hereby irrevocably and exclusively assign and transfer to HOPE SURGICAL MEDICAL GROUP (herein after 'Provider) any and all claims, causes of action, and right to any proceeds and/or benefits that I may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred by me from Provider up to the full amount of the charges and I grant a contractual lien on proceeds of any settlement and/ or judgment in any pending or future legal claim or action. **THIS ASSIGNMENT AND CONTRACTUAL LIEN IS IRREVOCABLE UNLESS BOTH THE PROVIDER AND I AGREE TO REVOKE IT IN WRITING.**

I acknowledge that the amount subject to this lien constitutes the ordinary and customer charges by Provider for such services, supplies and/or treatment, and may include administrative charges for costs, expenses and risk of collection typically incurred by Provider. Thus, the amount of the lien may or may not constitute the same charge of such medical services, supplies and/ or treatment for similar services to others. I authorize Provider to establish PIP, Med Pay and/or UM claim on my behalf. I also authorize Provider to prosecute said claim and/or action either in my name or its name, as it sees fit, and further authorize it to comprise, settle, or otherwise resolve said claims as it sees fit. However, Provider shall have no duty whatsoever to prosecute the claim or litigation. Provider shall not be liable for any costs and/or expenses associated with any claims or litigation unless Provider files that litigation. Nothing herein shall prevent me from pursuing any claim or litigation that I otherwise have a right to pursue. However, I will not settle any case or claim involving recovery of Provider's medical bills without the permission of Provider. I understand that whatever amounts Provider does not collect from insurance proceeds (whether it be all or part of what is due), I personally remain responsible and owe and agree to pay the outstanding balance in a current manner. I agree to notify Provider of any payment received by me for medical services from an insurance company or other source, and I hereby instruct my attorney, if any, to likewise notify Provider.

**Any and all services rendered under this agreement shall be at the sole discretion of Provider and in no way shall** this agreement be construed to obligate Provider to provide any certain services.

INSTRUCTIONS TO INSURANCE COMPANIES: I hereby irrevocably authorize, direct and instruct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entity (herein after referred to as 'payers'), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future (herein after referred to as 'condition) to **PAY DIRECTLY AND EXCLUSIVELY TO HOPE SURGICAL MEDICAL GROUP** such sums as may be outstanding and owed to said Provider for charges incurred by me at the office relating to my condition, with such payment **TO BE MADE BY SEPARATE CHECK AND PAYABLE EXCLUSIVELY IN THE NAME OF HOPE SURGICAL MEDICAL GROUP** and deliver such payment to 4420 N. Sonoma Ranch Blvd. Ste. B, Las Cruces, NM 88011. Payment directly to me, even if Provider's name is on the check, does not constitute payment to Provider and does not comply with the terms of this instruction. For the purposes of this document, 'proceeds' shall include, but not be limited to, monies/ proceeds from any settlement judgment, or verdict, as well as any monies/ proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability insurance, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

This instruction applies irrespective of whether I have hired an attorney to pursue my other claims. In the event that I retain one or more attorneys to represent my other claims in this matter, I, nevertheless, irrevocably direct any 'payer' (auto insurance and/or health insurance) to directly issue full and separate medical payment to **HOPE SURGICAL MEDICAL GROUP**

**INSTRUCTIONS TO ATTORNEYS:** In the event that I retain one or more attorneys to represent my other claims in this matter and any settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts that are outstanding on my account to Provider and remit payment of all such sums fully and directly to Provider contemporaneously with any disbursement of money to me, my attorney, or any other party from said settlement or judgment. I further irrevocably instruct and authorize my attorney to furnish to Provider any documents relating to my insurance settlement and distribution of funds, upon request of Provider, in order that Provider may be made aware of the full settlement disbursement of any recovery I may receive.

HOPE
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## ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

**AUTHORIZATION TO RELEASE INFORMATION:** Provider is authorized to release any information it deems appropriate concerning my physical condition and treatment to all payers as defined above or my attorneys to facilitate collection under this assignment. I further authorize and direct all payers to release to Provider all information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, the amount of settlement, and the amount of any outstanding claims. I hereby authorize and direct Provider to file a copy of this assignment, together with any applicable charges, with any or all payers and seek collection of payments, regardless of whether a claim has been established with said payers. I also hereby grant to Provider the limited power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company for treatment and services rendered by the Provider. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account of forwarded to me upon request in writing to Provider.

**DEMAND FOR PAYMENT:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the Provider, you are hereby tendered a demand to pay in full the bill for services rendered by Provider within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy.

**STATUTE OF LIMITATIONS:** In further consideration of deferred billing and the services rendered and/ or to be rendered, I waive my right to claim any statute of limitations regarding claims for or collection of the amount due for services rendered or to be rendered by Provider, in addition to reasonable cost of collection, including attorney fees and court cost incurred. This assignment and contract shall not be modified or revoked without the mutual written consent of Provider and myself. I hereby revoke and resend any previously signed authorizations and assignments, whether executed at this office or any other office to the extent that the terms of those authorizations or assignments conflict with the terms of this assignment and contract.

**BY MY SIGNATURE, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND FULLY UNDERSTAND THE ABOVE DOCUMENT AND ACKNOWLEDGE THAT IT IS A VALID AND IRREVOCABLE ASSIGNMENT AND CONTRACTUAL LIEN.**

X_____ _____
Signature of patient and/ or responsible parties Date