Kymera Independent Physicians

400 Military Heights Place, **Roswell**, NM 88201 Tel: (575) 627-9500 Fax (575) 627-9535
407 W. Country Club Rd, **Roswell**, NM 88201, Tel: (575) 627-9110, Fax: (575) 623-2191
101 S. Canal St, **Carlsbad**, NM 88220, **Oncology/Endocrinology**: (575) 234-1466, Fax (575) 234-1473 /
Primary Care: (575) 628-1614 Fax (575)628-1099
3208 North Grimes, **Hobbs**, New Mexico 88240, Tel: (575) 392-0222, Fax: (575) 392-0200
311 Suite 1, **Roswell**, NM 88201 **Cardiology** (575) 625-3293, Fax: (575) 627-9535

NAME: ____
First Middle Last

Address: ____
Address Apt# City State Zip

Birthdate: ________________ **SS#:** ________________ **Sex:** __M / F__

Marital Status: ____Single ____ Married ____ Widowed ____ Separated ____ Divorced

Home Phone: ( ) ____________ **Work:** ( ) ____________ **Cell:** ( ) ____________

Preference for Reminders: _____Phone _____Printed _____ Electronic

Race *(please check primary race)*: ____ White ____ Black/African American ____ Asian ____ American Indian/Alaska Native
____ Native Hawaiian/Other Pacific Islander ____ Decline

Ethnicity *(please check one)*:
____ Hispanic or Latino ____ Non-Hispanic or Latino ____ Decline **Language Preference:** ____________

Primary Emergency Contact: ______________________ **Phone #** ( ) ____________

Secondary Emergency Contact: ______________________ **Phone #** ( ) ____________

Primary Care Physician/Provider: ______________________ **Phone #** ( ) ____________

Employer: ______________________ **Phone #** ( ) ____________

Work Address: ____
Address Apt# City State Zip

Spouse Name: ______________________

INSURANCE INFORMATION

Primary Insurance Carrier: ________________ **Group#:** ____________ **ID #:** ____________

Policy Holder: ________________ **DOB:** ____________ **SS#:** ____________

Phone #: ( ) ____________ **Pre-Cert Phone Number #**________________

Relationship of patient to Subscriber/Insured: ______Self ______ Spouse ______ Child _____ Other

Secondary Insurance Carrier:________________ **Group#:** ____________ **ID #:** ____________

Policy Holder: ________________ **DOB:** ____________ **SS#:** ____________

Phone #: ( ) ____________ **Pre-Cert Phone Number #**________________

Relationship of patient to Subscriber/Insured: ______Self ______ Spouse ______ Child _____ Other

Please Initial the Following:

_______ I understand that I am financially responsible for all charges for service rendered to me, which includes balance(s) after insurance benefits.

_______ I authorize the above physician to act as my agent in helping to obtain payment from my insurance Carrier(s).

NAME: ____
First Middle Last

_______ I authorize payment of insurance benefits to Kymera Independent Physicians.

_______ As your physicians, we may order tests necessary to diagnose and monitor your medical condition. Because of insurance guidelines, some lab studies may not be covered. By initialing this section, you acknowledge you may be responsible for some of these charges. If you have any questions, please notify Kymera reception and they will coordinate a consultation with out billing staff.

_______ **Kymera's Notice of Privacy**: Please initial that you have been provided with a copy of Kymera Independent Physicians' Notice of Privacy Practices (contained in the packet of documents provided for you to keep).

_______ **Patient Acknowledgement of Privacy Practices & Right to Restrictions**: "*I understand that I have certain rights to privacy regarding my Protected Health Information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by initialing this consent, I authorize Kymera to use and disclose my PHI to carry out: Treatment, Obtaining Payment from third party payers, and Kymera's day-to-day Operations. I have been informed of, and given the right to review and secure a copy of Kymera's Notice of Privacy Practices, which contains a complete description of the uses and disclosure of my Protected Health Information and my rights under HIPAA. I understand that Kymera reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions; however, if you do agree, you are then bound to comply with this restriction.*"

_______ **For Patients currently prescribed or requesting narcotic medications — Consent to View NM Pharmacy Board Website**: "I give consent to allow Kymera Providers and their clinical staff to check the NM Pharmacy Board website. I understand that I am currently prescribed a narcotic and/or wish to become an established patient of Kymera Clinics that Kymera Independent Physicians will verify compliance prior to and randomly during my care. I hereby release Kymera Independent Physicians from any and all liability in regards to check the NM Pharmacy Board Website.

Patient Signature: ______________________________ **Date:** ____________

Responsible Party/
Guarantor Signature: ______________________________ **Date:** ____________

Guarantor Information (If Patient Is Under 18)

Guarantor Name: ________________________ **Relationship to Patient:** ____________

Address: ____
Address Apt# City State Zip

Birthdate: ____________ **SS#:** ____________ **Sex:** M / F

Employer: ____________ **Work:** ( ) ____________ **Cell:** ( ) ____________

Notice to Patients about Disclosure Authorizations: Outside of HIPAA regulations, Kymera will only provide your Protected Health Information to individuals identified by you as having authorization to this information. If you wish to provide authorization(s) to a spouse, other family members, and/or third party individuals, or wish to specifically deny any release of information to relatives, please notify Kymera Reception and they will provide you with a Patient Disclosure Authorization Form for you to identify these individuals.

MEDICAL RECORDS RELEASE FORM

____
Patient Name   Address   City   State   Zip

____________________   (______)____________________   ______________________________
Date of Birth   Daytime Phone   SSN

____
Name of Health Care Provider/Plan/Other   Phone #

____
Address   City   State   Zip

TO DISCLOSE:

Date(s): From ______________ to __________________

_______ Entire Medical Record   _______ History and Physical Exam   _______ Lab/Pathology
_______ Billing History   _______ X-Ray   _______ Progress Notes
_______ Copies of X-Ray Images   _______ Other: ____________________

Reason for Request: ____

I am requesting my medical records to be transferred to Dr. ____

AUTHORIZED TO SEND INFORMATION TO:

Send to: Kymera Independent Physicians – Attention medical Records (please choose address below)

________ Oncology/Hematology/Rheumatology 407 W. Country Club Rd, Roswell, NM 88201, Tel: (575)627-9110, Fax: (575) 623-2191
________ Multi-Disciplinary/Neurology/Cardiology: 400 Military Heights Place, Roswell, NM 88201, Tel: (575) 627-9500, Fax: (575) 627-9535
________ Carlsbad Primary Care/Oncology 101 S. Canal Street, Carlsbad, NM 88220, Tel: (575) 234-1466, Fax (575) 628-1099
________ Hobbs Primary Care/Oncology 3028 N. Grimes, Hobbs, NM 88240, Tel: (575) 392-0222, Fax: (575) 392-0200
________ P. O. Box 1574, Roswell, NM 88202

Drug and/or alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release – I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatits B or C testing, and/or other sensitive information, I agree to its release.   Yes_____   No______   Initials__________

Time Limit and Right to Revoke Authorization – Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Kymera Independent Physicians at the above address. Unless revoked, this authorization will not expire.

PATIENT SIGNATURE____ DATE:__________________

RESPONSIBLE PARTY SIGNATURE___________________________ DATE:__________________

If signed by a person other than the patient, complete the following:

1. Individual is: ___ a minor   ___ deceased   ___ legally incompetent or incapacitated
2. Legal Authority: ___ parent   ___ legal guardian   ___ next of kin/executor of deceased   ___activated POA for Health Care

Identity of Requestor Verified by: ___Photo ID   ___ Matching Signature   ___ Other______________________________

Verified By: ____

rev 3-16

PATIENT INITIAL HISTORY

Name	Date of Birth

Past Medical History					
Yes	No		Yes	No	
		Heart Attack			Arthritis/Lupus
		Anemia			Broken Bones
		Asthma			Bronchitis/Emphysema/Asthma
		High Blood Pressure			Ulcers
		Stroke			Urinary
		Diabetes			Prostate Problems
		Seizures			Cancer in Past
		Thyroid Disorder			Blood Transfusions
		Recent Flu or Viral Infection			

Surgical History	
Type	Year

OBY/GYN History	
How Many	Date Of
Pregnancies	Last Menstrual Period
Births	Normal Duration Days
Miscarriage	Flow: Light Heavy
Abortion	Mammogram
	Pap Smear

Social History
Profession
Hobbies
Tobacco Use: __Yes __No Packs per Day ___ Years Smoked ___ Years Stopped ___
Alcohol Use: On Occasion ___ Daily ___ Weekends ___
Drugs:
Other:

Family History (List Father, Mother, Sibling, or Children)
High Blood Pressure:
Diabetes:
Heart Attack:
Blood Diseases:
Anemia:
Cancer:
Other:

Medication Name	Dose	How often/times a day

Allergic To:

If additional space is needed, please use the back of this form.

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

At Kymera Independent Physicians we believe that our patients have a right to adequate notice of our policies, procedures and practices with respect to their medical information. We are required by law to:

- Keep your medical information private.
- Provide you with a copy and follow the requirements of this notice.
- Notify you if we are unable to agree to a restriction that you have requested on the use of your medical information.
- Accommodate reasonable requests for alternate communication methods.

Consent for Treatment, Payment and Operation

Kymera Independent Physicians will use and disclose your medical information for **treatment, payment and operations (TPO)**. Although not required, our office will ask you to sign a **consent** form that will be used to obtain your medical information from other facilities and business associates for TPO.

- An example of **treatment** is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, technicians, medical students and others will share the information about you in the course of your treatment. This includes requesting and sending your medical information to the various facilities and care givers involved in your care.
- An example of **payment** includes sharing your medical information with an insurer or a third party that may be responsible for collecting payment from a health plan.
- An example of **operations** means sharing your medical information for the purpose of quality review.

Other Uses or Disclosers of Medical Information

Subject to certain requirements, we may give out medical information about you without your prior authorization for the following purposes.

- **Law**: We may disclose medical information when required by law, such as in response to a request from law enforcement in a specific circumstance or in response to valid judicial or administrative orders.
- **Public Health**: We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect as required by law.
- **Business Associates**: There are some services provided in our organization through contracts with business associates. Examples of this are billing companies that help us obtain payment for services rendered. To protect your health information we require the business associate to appropriately protect your information.
- **Notification**: Our office will contact you, a family member, a personal representative, or another person responsible for your care to provide appointment reminders or to provide you with information about alternative treatments or other health care services. We will identify ourselves when we call or leave a message on your answering machine. If you do not wish us to reveal this information, please notify us. We will ask you to make this request in writing and we will make every effort to accommodate your request.
- **Funeral Directors**: We may disclose health information to funeral directors consistent with applicable law for them to carry out their duties.
- **Organ Donation:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities for the purpose of tissue donation and transplant.
- **Food and Drug Administration (FDA)**: We may disclose to the FDA health information relative to adverse events.
- **Worker's Compensation or Social Security**: We may disclose health information necessary to comply with laws relating to Worker's Compensation or other similar programs established by law.
- **State Requirements**: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.
- **Correctional Institutions**: Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of other individuals.

Notice of Privacy Practices

Authorizations
Although rare, Kymera Independent Physicians may need to use your medical information for purposes ***other*** **than treatment, payment and operations.** If this need arises we will not share this information unless we have first obtained your express written **authorization**. This authorization will specify exactly what type of medical information needs to be shared and will carry an expiration date. You have the right to revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures. If an authorization form has been signed and our office is disclosing your medical information for purposes other than treatment, payment and operations, we will keep an accounting of the disclosures in your chart and you may request a listing of these accountings in writing. Such requests will be honored within 30 days, and you will be notified in writing of the date on which the accounting will be available to you.

Your Rights Regarding Your Medical Information
Although your medical record is the property of Kymera Independent Physicians, you have the right to:

- Request a restriction on certain uses and disclosures of your medical information for treatment, payment and operations, with the exception of emergency situations.
- Inspect and obtain a copy of your medical information.
- Request an amendment or correction to your medical record.
- Obtain an accounting of disclosures that were made based on authorizations.
- Obtain a paper copy of this notice of our privacy practices upon request.
- Request that medical information about you be communicated in a different manner.

All of these requests shall be made in writing on forms provided by our office, as required by law. Requests or appeals should be submitted to our Privacy Officer. We will consider your written request or appeal and notify you by writing within 30 working days. We are not legally required to agree to a requested restriction or appeal.

Kymera's Responsibilities under the Federal Privacy Standard
In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

If you believe that your privacy rights have been violated, you may send questions or complaints about this notice or Kymera's privacy practices to us and/or the Secretary of the Department of Health and Human Services (DHHS). Such communication with Kymera should be directed to:

HIPAA Privacy Officer Kymera Independent Physicians PO Box 1574 Roswell, NM 88202	or	Secretary of Health and Human Services 200 Independence Ave SW Washington, DC 20201

Filling a complaint will not negatively affect the treatment or coverage that your receive at Kymera Independent Physicians. Kymera Independent Physicians reserves the right to change this notice and to make the new provisions effective for all individually identifiable health information that we maintain. If we change this notice, we will mail a revised notice to the address that you have given us. We have the right to make the revised notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, containing the effective date of the notice, at each Kymera location. You may request a copy of the current notice each time you register with Kymera for treatment or health care services.

Effective March 16, 2016

Basic Financial Information for New Patients

We would like to take this opportunity to provide you with the basic financial information for our practice. We are aware and truly sensitive to the extra burden a patient's care and treatment places on the patient and their family. It has been our experience that discussion of this matter is better served when handled before treatment begins.

Because most insurance changes are done on the first of the month, we do require a copy of your insurance card at the time of each visit. If you carry Medicare, you will need only to provide this at the first visit. If you have a change in your secondary insurance, you will need to provide us with that information in order to keep our files current. For all other insurance carriers please bring your card to each visit.

Below are the basic financial requirements. If your physician has recommended a specific treatment plan, a separate plan will be provided for you prior to that service. At any time, our billing department can schedule an appointment with you to discuss financial plans that will meet your needs and the needs of Kymera. To schedule an appointment in Roswell & Hobbs, please call (575) 627-9500, for Carlsbad please call 627-9545.

Medicare If you have Medicare alone and your deductible has been met, you will be required to pay 20% at the time of each visit. We are unable to provide you with an exact amount because it will depend on the level of service provided. If you have Medicare supplement insurance, you will not be required to pay at the time of service.

Medicaid No payment is required. Medicaid-Salud may have a co-pay to be met.

HMO Co-Pay is payable at the time of each visit. This will apply to doctor visits, chemotherapy, injections, and/or blood draws.

Standard Payment requirements will depend on your insurance policy and benefits. We will be able to provide this information to you once we contact your insurance carrier and receive the necessary information

.

Self-Pay Payment is due at the time of service.

Please be assured we are here to care for your medical needs and are providing the above information as part of your introduction to our office. We will assist to locate financial assistance programs such as the Hospital Indigent Program, County Indigent Program, drug programs offered through drug companies and others. Qualification is determined by each individual association. We will be available to explore any of these programs as requested.

Tips for Refilling Prescriptions

Deal directly with your pharmacy for all non-narcotic medication refills.

- Call your pharmacy for refills. This is a service they provider for you. Have your bottle or box on hand.
- If you don't have this, be sure you know the name of the medication and if possible the dose and directions.

Most pharmacies will have your refill available in less than a day.

- When refills have run out or your prescriptions does not specify refills, your pharmacy will contact your providers' office.
- Your chart will be reviewed and the provider will decide what best meets your health care needs.

This will take extra time so call at least 3 (three) days before you run out of medication.

Anticipate Your Medication Needs

- Review all your medication with your primary care provider at each visit. Make sure you have enough medication to last until your next scheduled appointment.
- Even if your prescription is over a year old, you should call your pharmacy to have it refilled. Your pharmacy will call your provider to obtain authorization for refill.
- For more rapid service, call your pharmacist early in the day. Don't wait until the afternoon.
- Refills on weekends and holidays or after 4 (four) p.m. will take longer.

Policy for Prescription Refills

- We now require 72-hour (seventy-two hours) turn-around time for refills on any non-narcotic medication.
- All narcotic pain relief medication, sleeping aids, anti-anxiety medication, and mood elevating drugs are regulated by state law. They must be refilled by appointment during regular office hours ONLY.
- We will not honor refill requests for lost, stolen, or misused medications.
- For stolen narcotic medications, a provider may request a refill *only* if the patient schedules an appointment and delivers a police report of the theft. Refills based on police reports are at the discretion of the provider and may be refused at any time, regardless of whether it is documented in a police report, especially for consecutive occurrences of theft.

Dear Medicare Patient:

In order to properly file your charges with Medicare, we have been instructed to ask you the following questions. Please answer all of the questions in full; if you status changes at any time in the future, you must let us know at the time of your next date of service so that we can update your account.

Please check the appropriate answer or fill in the blank(s):

Name: ____ **Medicare Number:** ____________

Age: ____________ **Date of Birth:** _______________ **Sex:** ☐ **Male** ☐ **Female**

Basis for Medicare Eligibility: ☐ Age ☐ Disability ☐ End Stage Renal Disease

- Are you or your spouse working Full or Part-time? ☐ Yes ☐ No
  - If NO, please provide the following:
  - Retirement Date of Patient: _____________________________
  - Retirement Date of Spouse: _____________________________

- If you and/or your spouse work(s), how many employees does your employer or your spouse's employer have? ☐ Less than 20 ☐ More than 20

- Are you covered under an employer Group Health Plan based on the current employment of you or your spouse? ☐ Yes ☐ No
  - If YES, Please provide the following:
    - Name of insured and relationship to patient (self, spouse) ____;
    - Group Name and Address of Employer: ____ ____ ____;
    - Name and Address of Insurance Company: ____ ____ ____;
    - Group Identification Number ____;
    - Policy Identification Number ____;

- Are you entitled to Black Lung Medical Benefits? ☐Yes ☐ No

- Was the service for treatment of a work-related injury or illness? ☐Yes ☐ No

- If YES, provide the name and address of the Worker's Compensation Agency, the Worker's Compensation Carrier and your employer.

____
____
____
____

- Was the service of the treatment of an illness or injury which resulted from an automobile or other accident? ☐ Yes ☐ No
- If YES, provide the name, address, and policy number of the automobile or non-automobile liability or no-fault insurer:

____
____
____
____

Policy Number: ____

- Do you have a veteran Administration fee service card? ☐Yes ☐ No

- Is the service to be paid by government program such as a research grant? ☐Yes ☐No

____
Patient Signature Date

ONETIME MEDICARE FILING AUTHORIZATION

I authorize any holder of medical information concerning me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits of the benefits payable to related services.

____
Patient Signature Date

(If unable to sign) ____
Signature of person signing for patient and relationship

____
Reason for inability of patient to sign

Kymera Independent Physicians

Patient Disclosure Authorization

Patient Name ______________________________________ Date of Birth_____________

Patient ID #: __________________________

Street Address / Apt #: ____

City, State, Zip: ____________________________________

Kymera Independent Physicians is dedicated to ensure all of our Patients' Protected Health Information (PHI) remains secure. Your health information will not be released to any unauthorized individuals without prior consent. If you do not want any of your information released or wish to designate certain family members/friends to receive information on your behalf, please check the appropriate box below.

Patient's Authorization to Disclose Protected Health Information:

☐ I object to disclosing my health information [to all family members and friends]

☐ I do not object" to disclosing my health information to the following relatives and/or third party persons:

Name: ________________________________ Relationship: _____________________

Name: ________________________________ Relationship: _____________________

Name: ________________________________ Relationship: _____________________

Name: ________________________________ Relationship: _____________________

Name: ________________________________ Relationship: _____________________

Signed ____ Date ___________________