Scot A. Martin, M.D., LLC
Plastic & Reconstructive Surgery

141 Roadrunner Pkwy, Ste 129
Las Cruces, NM 88011

Phone: (575) 521-7111
Fax: (575) 521-0563

NEW PATIENT INFORMATION

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **SSN:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Email Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work:** _____
Messages are left by our office staff may we leave messages at any of the numbers above?

YES_____ NO-please list _____

Occupation: _____ **Employer:** _____

Insurance Carrier (if applicable): _____ **Policy**: _____
Please allow us to make a copy of your insurance card

Reason for visit: _____

Primary Care Physician: _____

Referring Physician(if different): _____

How did you hear about Dr. Martin (other than physician): Please circle-Yellow pages, Radio, TV, Magazines, Newspaper (which one), etc. _____

Person to notify in case of emergency: _____ **Phone:** _____

I hereby authorize Dr Scot Martin to furnish information to insurance carriers regarding my visits and/or treatments. I hereby assign to Dr. Scot Martin all payments for medical services rendered to my dependents or me. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ **Date:** _____

DATE: _____

PATIENT NAME: _____

PLEASE CHECK ALL OF THE FOLLOWING MEDICAL CONDITIONS YOU NOW HAVE OR HAVE HAD IN THE PAST:

- o Heart attack
- o Bleeding tendency
- o Blood transfusions
- o Chest pain
- o Irregular heart beat
- o High blood pressure
- o Hepatitis
- o Diabetes
- o Glaucoma
- o Dry eyes
- o Bronchitis
- o Emphysema
- o Asthma
- o Stroke
- o Epilepsy
- o Heart burn
- o Depression
- o Mental illness
- o Drug or alcohol addiction
- o Serious illness or injury
- o Breast Biopsy
- o Family history of breast cancer
- o Other_____

DATE OF LAST MAMMOGRAM: _____

HAVE YOU EVER HAD A BLOOD CLOT IN ONE OR BOTH LEGS? YES/NO

HAS ANY ONE IN YOUR FAMILY EVER HAD A BLOOD CLOT IN ONE OR BOTH LEGS? YES/NO IF YES, WHO?

_____

PAST SURGICAL HISTORY: (INCLUDE PLASTIC SURGERY)

_____

_____

_____

_____

CHILDREN: (IF SO HOW MANY?)_____

MISCARRIAGES: (IF SO HOW MANY?)_____

MEDICATION(S): AMOUNT FREQUENCY

_____

_____

_____

_____

DRUG OR FOOD ALLERGIES: _____

_____

HEIGHT _____ WEIGHT _____

WEIGHT CHANGES OVER THE LAST YEAR? _____

ARE YOU A SMOKER? YES/NO EX-SMOKER? YES/NO QUIT HOW LONG AGO? _____

HOW MUCH ARE (WERE) YOU SMOKING? _____ HOW LONG? _____

HOW MUCH ALCOHOL DO YOU DRINK? _____ HOW OFTEN? _____

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

SCOT A. MARTIN, M.D., L.L.C.
141 Roadrunner Parkway, Suite 129
Las Cruces, NM 88011

NOTICY OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGMENT

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices* .

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____
Relationship to Patient: _____
Signature: _____
Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this *Notice of Privacy Practices* Acknowledgment, but was unable to do so, as documented below: