Clínica Para Todos
2170 East Lohman Ave, Suite A
Las Cruces, NM 88001
Phone: 575-644-0480
Email: Clinicaparatodos20@gmail.com

(As written on insurance card)

First Name: ______________________ Last Name: ______________________

Date of Birth ___/___/______________________ Married Single Child Other___

Social Security #: ___-___-______________________ Female Male ______________

Best Contact #: (___) ___-______________________ Email: ______________________

Address: ____

City: ______________________________________ State: ________ Zip ____________

Emergency Contact:

Name: ______________ Relationship: ______________________ Number: (___) __________

Name: ______________ Relationship: ______________________ Number: (___) __________

Insurance Holder: ________ Self ________ Spouse ________ Child ________ Other ______________

Employed: Yes No Employer Name ______________________ Number (___) __________

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CONSENT TO TREATMENT, RELEASE ACKNOWLEDGMENT FORM

Name: ____

CONSENT TO TREATMENT

I authorize the medical providers at **Clínica Para Todos** to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgement, become necessary while I am a patient of **Clínica Para Todos**. Routine diagnostic procedures and medical treatment include but are not limited to ECG's, X-Rays, blood test and administration of medications.

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 the results of treatments or examinations.

I understand that the Physician Practice, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, test and test results and treatment plans. I concur that this health information is used for the following:

- Care and treatment plans
- Billing Statements
- Communication between interdisciplinary healthcare providers
- Verification of services by third party payers and government payers
- Quality control by **Clínica Para Todos**

Patient Initials __________

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered, however in the event that I am entitled to medical care benefits of any types whatsoever, I hereby assign those benefits to **Clínica Para Todos** and any of its contracted health care providers. I authorize **Clínica Para Todos** and the appropriate health care provider to apply for benefits on my behalf for services rendered during this admission or visit.

I certify that the insurance or other coverage benefits information supplied by me is correct. If any insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to contact my personal office and or insurance carrier to obtain it. If I fail to do so, I could be liable for all part of otherwise. Covered expenses.

Patient Initials __________

Clinica Para Todos

Do you have any of the following symptoms:

- Fever or chills
  Yes or No
- Cough
  Yes or No
- Shortness of breath or difficulty breathing
  Yes or No
- Fatigue
  Yes or No
- Muscle or body aches
  Yes or No
- Headache
  Yes or No
- New loss of taste or smell
  Yes or No
- Sore throat
  Yes or No
- Congestion or runny nose
  Yes or No
- Nausea or vomiting
  Yes or No
- Diarrhea
  Yes or No
- In the past 2 wks have you encountered someone that was COVID positive?
  Yes or No

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Patient Initials ___________

ACKNOWLDEGEMENT OF RESPONSIBILITY FOR PAYMENT OF MEDICAL BILL

I guarantee payment of all charges incurred for services rendered by **Clínica Para Todos** for the patient named above less any amounts paid by any third-party payer, I guarantee the amount due for non-insurable charges including co-payments deductible, etc.

Patient Initials________

I am aware that if I do not give at least 24-hour notice of my cancellation for an appointment or if I do not show up without cancelling my appointment a total of 3 times, I will not be allowed to schedule an appointment but will be seen on a walk-in basis.

Patient Initials________

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have received a copy of **Clínica Para Todos** NOTICE OF PRIVACY PRACTICES. I understand that information the practice acquires or creates about me will only be related to the provision of medical care and will only be authorized by me in writing.

Patient Initials________

Acknowledgment of Clinical Restrictions at Clínica Para Todos

Unless previous arrangements have been made with the office manager and clinical provider, I am aware that **Clínica Para Todos:**

- Does not treat medical conditions associated with motor vehicle accidents.
- Does not treat medical conditions associated with workman's comp.

IT IS THE PROVIDERS PREROGATIVE TO CONTINUE TO TREAT A NEW PATIENTS MENTAL HEALTH ISSUS OR HIS/HERS CHRONIC PAIN. CONTINUATION OF PREVIOUSLY PRESCRIBED REGIMENTS THAT INCLUE CONTROLLED SUBSTANCES SUCH AS NARCOTICS, STIMULANTS OR BENZODIAZEPINES MAY NOT TAKE PLACE AND ALTERNATIVE THERAPIES MIGHT BE SUGESTED FOLLOWING PROPER EVALUTAION AND REVIEW OF PREVIOUS MEDCAL RECORDS.

Patient Initials________

I certify that I have read this form and that I understand contents.

____

Signature Date

Clínica Para Todos
2170 East Lohman Ave, Suite A
Las Cruces, NM 88001
Phone: 575-644-0480
Email: Clinicaparatodos20@gmail.com

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Clínica Para Todos defines "No-Show" appointment as any scheduled appointment in which the patient either:

1. Does not arrive to appointment.
2. Cancel with less than 24 hours' notice.
3. Arrives more than 15 minutes late and consequently unable to be seen.

Impact of a "Non-show" Appointment
"No-Show" appointments have significant negative impact on our practice and the healthcare we provide to our patients. When a patient "No-Shows" a scheduled appointment it:

1. Potentially jeopardizes the health of the "No-Show" patient.
2. Is unfair to other patients that would have happily taken the appointment slot
3. Disrespects not only the provider's time, but also the time of the entire clinic staff.

How to avoid getting a "No-Show"
1. Confirm your appointment
2. Arrive 15 minutes early
3. Give 24 hours' notice to cancel appointment.

Consequences of a "Non-Show" Appointments

If you miss 3 or more appointments within a year **Clínica Para Todos** reserves the right to **DISCHARGE** you from the clinic immediately.

I have read and understand the **Clínica Para Todos's** "No-Show" policy as described above.

____

Patient Name Date

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Date:__________/____________/__________

Authorization To Release Medical Records

I ____, authorize **Clínica Para Todos** to release my medical records and other information regarding my treatment to the following:

Location:
____

Address:
____

Phone:____

Fax:
____

Patient Initials________

Health Risk Assessment Form

General

Name: ______________________

DOB: ____________ Gender: ____________

Height: ____________ Weight: ____________

Race: ______________________

Medical History

Date of last check-up: ______________________

Allergies: ______________________

Medications: ______________________

Previous Medications: ______________________

Injuries: ______________________

Surgeries: ______________________

Blood Pressure: ______________________

Cholesterol: ______________________

History of...

Cancer: ❑ Me ❑ Relation: ____________

Diabetes: ❑ Me ❑ Relation: ____________

Stroke: ❑ Me ❑ Relation: ____________

Heart Disease: ❑ Me ❑ Relation: ____________

Heart Attack: ❑ Me ❑ Relation: ____________

Depression: ❑ Me ❑ Relation: ____________

Bipolar Disorder: ❑ Me ❑ Relation: ____________

Females

Last date of most recent cycle: ____________

Date of last PAP Smear: ____________

Date of last breast exam: ____________

Date of last rectal exam: ____________

Year of last pregnancy: ____________

Did the pregnancy come to term? ❑ Yes ❑ No

Males

Date of last prostate exam: ____________

Well-Being

Rate your overall well-being: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

Rate your health: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

How safe do you feel? ❑ Very ❑ Not Very ❑ Not at all

How satisfied are you with your life? ❑ Very ❑ Not Very ❑ Not at all

How often do you feel depressed? ❑ Always ❑ Often ❑ Occasionally ❑ Never

Current therapist: ____________

Frequency of sessions: ____________

Starting date: ____________

Nutrition

How many daily servings of vegetables do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of fruit do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of grains do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of meat do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of sugar/carbs do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

Drug Use

How often do you smoke tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to

How often do you chew tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to

When did the tobacco use start? ____________

How many cigarettes do you have per day? ____________

How many alcoholic drinks do you have per week? ____________

How often do you binge drink (5+ drinks in 1 hour)? ❑ Occasionally ❑ Weekly ❑ Daily ❑ Never

Have you ever been treated for alcoholism? ____________

How often do you black out/lose time? ____________

Have you ever used recreational drugs? ____________

Which drugs? ____________

Have you ever abused prescription drugs? ____________

Which drugs? ____________

Have you ever been treated for drug use? ____________

How often do you use recreational drugs? ❑ Daily ❑ Weekly ❑ Often ❑ Occasionally ❑ Rarely ❑ Never

Exercise

How many days per week do you work on cardio? ____________

Length of time spent on cardio each session: ____________

How many days per week do you work on strength? ____________

Length of time spent on strength each session: ____________

Injuries/conditions that interfere with exercise: ____________

Other

Volunteer Activities: ____________

Who do you live with? ____________

Do you require...? ❑ Hearing Aid ❑ Walker ❑ Cane ❑ Oxygen Tank ❑ Glasses

How often do you get headaches? ____________

Food Sensitivities: ____________

How many hours of sleep do you get per night? ____________

How restful is your sleep? ❑ Restful ❑ I wake up once or twice ❑ I wake up often ❑ Fitful

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Patient Name:______________________________ DOB:__________ Date:__________

General
___Weight Loss or gain
___Fatigue
___Fever or Chills
___Weakness
___Trouble Sleeping

Skin
___Rashes
___Lumps
___Itching
___Dryness
___Color Changes
___Hair and Nail Changes

Head
___Headaches
___Head Injury
___Hair and Nail Changes

Ear
___Decreased Hearing
___Ringing in Ears
___Earache
___Drainage

Eyes
___Vision Loss/Changes
___Glasses or Contacts
___Pain
___Redness
___Blurry or Double Vision
___Flashing Lights
___Specks
___Glaucoma
___Cataracts
___Last Eye Exam __________

Nose
___Stuffiness
___Discharge
___Nose bleeds
___Sinus pain

Throat
___Bleeding
___Dentures
___Sore Tongue
___Dry Mouth
___Sore Throat
___Hoarseness
___Thrush
___Non-healing Sores

Breasts
___Lumps
___Pain
___Discharge
___Self-exams
___Breast Feeding

Respiratory
___Cough
___Sputum
___Coughing up Blood
___Shortness of Breath
___Wheezing
___Painful Breathing

Cardiovascular
___Chest pain or discomfort
___Tightness
___Palpitations
___Short of breath with activity
___Hard breathing laying down
___Swelling
___Sudden awakening from sleep w/shortness of breath

Gastrointestinal
___Swallowing difficulties
___Heartburn
___Change in appetite
___Nausea
___Diarrhea
___Rectal bleeding
___Constipation
___Diarrhea
___Yellow eyes of skin

Urinary
___Frequency
___Urgency
___Burning/pain w/ urination
___Blood in unine
___Incontinence
___Change in urinary strength

Vascular
___Calf pain
___Leg cramping

Musculoskeletal
___Muscle/joint pain
___Stiffness
___Back pain
___Redness of joints
___Swelling of joints
___Trauma

Neuologic
___Dizziness
___Fainting
___Seizures
___Weakness
___Numbness
___Tingling
___Tremor

Hematologic
___Ease of brusing
___Ease of bleeding

Psychiatric
___Nervousness
___Stress
___Depression
___Memory loss

Neck
___Lumps
___Swollen Glands
___Stiffness