# AGAPE

Pain Management and Lifestyle Center
2170 E Lohman Ave., Suite C
Las Cruces, NM 88001
Phone: 575.449.7002
Fax: 575.652.4684

## Registration Form

**Patient Information:**

**Name:** _____ **Date of Birth:** _____

**Mailing Address:** _____ **Sex:** _____

_____

**Home Phone:** _____ **Cell Phone:** _____

**Email:** _____

**Social Security Number:** _____

**Marital Status:** _____

**Who may we release information to:**

**Name/Relationship:** _____

**Emergency Contact:**

**Name/Relationship:** _____

**Phone Number:** _____

**Who Sent You Here:**

**Referring physician:** _____

**Family Physician:** _____

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## Accident Information Form

**Were you injured at work or in a car accident?**

**Date of injury:** _____

**Was your injury related to an automobile accident?** _____

**Claim number:** _____

**Name of the insurance company handling the claim:** _____

**Do you have a letter of protection?** _____ **Who is your attorney?** _____

**Attorney phone number:** _____

**Was your injury related to employment?** _____

**Body part injured at the time of the accident:** _____

**Employer at the time when the accident occured:** _____

**Name of the insurance company handling the claim:** _____

**Name of the adjuster handling the claim:** _____

**Phone number of the adjuster handling the claim:** _____

**Email of the adjuster handling the claim:** _____

**Claim number:** _____

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## Cancellation / No Show Policy

In order to ensure effective scheduling and patient flow, Agape Pain Management & Lifestyle Center requires a 24 hour cancellation notice for all scheduled appointments.

A $100.00 charge will be billed directly to you if you cancel or no-show for a scheduled procedure with less than 24 hour notice without the presence of an emergency that could not be avoided.

A $25.00 charge will be billed directly to you if you cancel or no-show for a scheduled appointment with less than 24 hour notice without the presence of an emergency that could not be avoided.

The determination of an "emergency" shall be at the sole discretion of Agape Pain Management & Lifestyle Center.

Agape Pain Management & Lifestyle Center will not bill your insurance company for this charge.

Thank you for your cooperation and understanding. Feel free to call our office anytime with questions or concerns. 575-449-7002.

I have read and fully understand this policy.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

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## HIPAA Privacy Consent to Privacy Act

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rul;e was also created in ordert o provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care options. As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take resonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment realtionships with you such as laboratories that only interact with physicians and not patients and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent in this document at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previoyusly signed consent. If you have any objections to this form, please ask to view our HIPAA Compliance Reference. You have the right to review our privicy notice (posted in the lobby in English and Spanish), to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____

Date: _____

Signature: _____

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## Medication List

Date of Birth: _____

Medications:

| Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies:

1:
2:
3:

Patient printed name: _____

Patient Signature: _____

Date: _____