SOUTHWEST
CENTER ON AGING

1106 Centre Ct. | LAS CRUCES, NM 88011 | (575) 532-5455 | FAX (575) 532-5641

We serve the populations of people of age 55 and older
Our Mission is to make healthy aging a reality through excellence in clinical care.

Office Hours
Monday–Thursday 8:00 am – 5:00 pm
Friday 8:00 am – 12:00 pm

To schedule an appointment or speak with a clinician, please call our office at 575-532-5455

For after hours, please call the above office number and the phone call will be transferred to the on-call physician.
In case of an Emergency, call 9-1-1 immediately.

Southwest Center on Aging (SWCOA) offers a unique, comprehensive assessment of older persons in an outpatient setting. SWCOA uses multiple resources to look at the individual from medical, functional, and emotional perspectives. Our goal is to work with the patient's family to address strengths and weaknesses found during the assessment process. This assessment is valuable on a consultation basis or as a first step to ongoing primary care with us.

SWCOA coordinated medical, social, and hospice services for patients and families facing terminal illnesses. Assistance is provided in establishing Advance Directives, selecting resuscitation status and designing a Durable Power of Attorney. Care plans are individualized to the need of the patient and family, and focus on maximizing quality of life and comfort.

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Patient Portal Consent Form

Patient Portal is a secure online source of confidential medical information for patients. This gives patients a convenient 24-hour access to personal health information, from anywhere with an Internet connection. Using a secure username and password, patients can:

- Access personal health information
- Request refills for prescriptions
- Review results for Labs/Tests
- Correspond with our staff and providers regarding your care

I agree to the following:

1. I will abide by all terms and conditions of Southwest Center on Aging Patient Portal.
2. Southwest Center on Aging is not responsible for any breach of information caused by patient misuse.
3. I understand that my activities within the Patient Portal will become part of my medical record.

I understand the following:

1. For medical emergencies, dial 911. The Patient Portal is NOT to be used for urgent needs.
2. All communication is sent to the nursing staff. You will receive a response within 24-48 business hours.
3. The Patient Portal is NOT a substitute for office visits with your provider and prescription requests for medications not currently being prescribed will NOT be honored.

I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal.

☐ I DECLINE access to the Patient Portal ☐ I would like access to the Patient Portal

Patient Name: _____ DOB: _____/_____/_____ Last 4 SS#_____
Secure Email Address: _____

Patient Signature: _____ Date: _____
Relationship if representative: _____

For office use only
Portal Invite Sent by_____ on _____

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

I, the undersigned patient, hereby consent to participate in telehealth services offered by Southwest Center On Aging. I understand and agree to the following:

_____ Nature of Telehealth Services: I understand that telehealth services involve the use of electronic communications to enable healthcare providers at Southwest Center On Aging to diagnose, treat, and provide medical advice to me remotely.
_____ Benefits and Limitations: I understand that telehealth services have benefits and limitations compared to in-person medical visits. While telehealth can provide convenient access to healthcare, it may not replace all in-person visits and assessments.
_____ Privacy and Security: I acknowledge that Southwest Center On Aging will take reasonable steps to ensure the privacy and security of my medical information during telehealth services, but | also understand that there are inherent risks associated with electronic communication.
____ Emergency Situations: I understand that in case of a medical emergency, I should call 911 or go to the nearest emergency room. Telehealth services are not a substitute for emergency care.
____ Costs and Insurance: I acknowledge that telehealth services may be billed to my health insurance, and l am responsible for any applicable co-pays, deductibles, or other fees. I understand that it is my responsibility to check with my insurance provider regarding telehealth coverage.

I have read and understood the above information regarding telehealth services at Southwest Center On Aging. I consent to participate in telehealth services and acknowledge that no guarantees or assurances have been made regarding the outcome of these services.

This consent was signed by _____ (print name) DOB:_____
Signature: _____ Date: _____
Witness: _____ Date: _____

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HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Your rights:
- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

Our Responsibilities:
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill, please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

____ If an account is not paid in full within 90 days, a 25% collection processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

____ Checks returned for any reason will be assessed a $50.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

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____ We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. SWCOA also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current no-show fee is $50.00 and is subject to change without notice. (YOUR INSURANCE WILL NOT COVER THIS FEE)

____ The following fee will apply for copying medical records: If you request a copy of your medical records, there will be a $50.00 charge. The fee includes preparing electronic records exported on a CD, USB or printed, cost of labor, and supplies. If a new physician requests your medical records, you will not be charged. Please allow seven to 14 business days for completion of a medical records request. Please be aware that it can take up to 30 days as allowed by law.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time all full disclosures will then cease
- The practice may condition receipt of this treatment upon execution of this consent

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **HIPPA Policy and Responsibilities**
- **Patient Financial Responsibility including collections, returned checks and no-show policy**
- **Medical Records and Form Charge**

This consent was signed by _____ (print name) DOB:_____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Patient Authorization for Release of Medical Records

_____

Name (Please Print) Date of Birth

_____

Address City State Zip Phone #

I hereby authorize: Release to:

Name: _____ ____Dr. Jesus R. Duran____

Phone #: _____ ____Tyson Kay, PA-C____

Address: _____

Fax #: _____

Records requested are as follows:
___ Lab Reports, X-Rays, EKG Reports
___ History and Physical, Echocardiograms
___ Nuclear/ Regular Stress Test
___ Holter Monitor
___ Cath/PTCA/Stent Reports
___ All Records
___ Other: _____

I specifically authorize the release of information relating to:
___ Substance abuse (including alcohol/drug abuse)
___ STD related information (HIV and AIDS related testing
___ Mental health (including psychotherapy notes)

_____
Signature of patient or Legal Guardian

I understand that I have the right to revoke this authorization at any time. I also understand that I must do so in writing and present my written revocation to the Southwest Center on Aging at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

_____ _____ _____
Signature of the patient or legally authorized representative Date Relationship to Patient

_____ _____
Witness-Printed Name & Signature Date

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Release of Medical Information

I, _____ hereby give authority to _____
(Patient's Name) (Other than Physician)

_____, to have access to the medical information below, effective
(Relationship to Patient)

_____.
(Date)

_____ Procedures

_____ Medications

_____ Appointment times and cancellations

_____ Patient history

_____ All medical information may be released to the above mentioned person(s)

I understand that I may request to cancel this release of information in writing for whatever reason, at any time and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Southwest Center on Aging cannot be held liable for any misuse of information obtained by the mentioned above.

_____ _____ _____
Patients Signature **Date** **DOB**

_____ _____
Witness **Date**

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REQUEST FOR PHYSICIAN LETTERS AND FORMS

Fees are subject to change without notice

_____ Any letter for disability, competency, diagnosis, etc. **-$35.00**

_____ Jury Duty Excuse **-$25.00**

_____ Handicap parking placard form/ MVD Medical Report **-$20.00**

_____ Family Medical Leave Act form **-$100.00**

_____ Life Insurance Form **-$100.00**

_____ Mailing out any documents listed above as well as any documents in our file **-$5.00**

***Payment must be done before we start the process of any form. We will only accept cash or check addressed to: Dr. Jesus Duran**

***Please allow seven to 14 business days for completion of a letter or form request.**

_____ _____ _____

Patients Signature **Date** **DOB**

_____ _____

Witness **Date**

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General Information

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip Code: _____ Date of Birth_____

Employer: _____ Social Security #: _____

Marital Status: _____ Spouse/Partner: _____ Phone #: _____

Age: _____ Sex: _____ Preferred Language: _____

Race: _____ Ethnicity: _____

E-Mail Address: _____

Preferred Provider
(please circle)

Jesus R. Duran, III MD, CMD Tyson Kay, MSPAS, PA-C

*** In the event that preferred provider is not available, to avoid a delay in care, you agree to see an alternate provider. Schedules are subject to change.**

In Case of Emergency Contact
(other than spouse)

Name: _____ Relationship: _____

Cell Phone #: _____ Home Phone #: _____ Work Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
ID #: _____ ID#: _____
Group #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder Name: _____

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Medical Questionnaire

Name: _____ Date of Birth_____

Circle the highest year of education- Elementary:1 2 3 4 5 6 7 8 H.S.:1 2 3 4 College 1 2 3 4 Post- Grad 1 2 3 4

What is your marital status? Single Married Divorced Widowed

Reason for today visit: _____

Are you under a health care provider's care for any condition? YES ___ NO ___

If yes, what is the health care provider's name: _____ Last date seen by provider: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR GENERAL HEALTH

How would you rate your general health: Excellent___ Good___ Fair___ Poor___

PAST MAJOR ILLNESSES:

Lung Disease	Date: _____	Neurological Problems	Date: _____
Heart Disease	Date: _____	Gallbladder Disease	Date: _____
Kidney Disease	Date: _____	Epilepsy / Seizures	Date: _____
Tuberculosis	Date: _____	Migraine / Headaches	Date: _____
Blood Disorder	Date: _____	Blood Transfusion	Date: _____
Diabetes	Date: _____	Anxiety / Depression	Date: _____
Stroke / TIA	Date: _____	High Blood Pressure	Date: _____
Swelling	Date: _____	Parkinson's Disease	Date: _____
Glaucoma	Date: _____	Colitis / Bowel Disease	Date: _____
Cataracts	Date: _____	Seasonal Allergies	Date: _____
Gallbladder Disease	Date: _____	Loss of Consciousness	Date: _____
Epilepsy / Seizures	Date: _____	Osteoarthritis	Date: _____
Thyroid Problems	Date: _____	Rheumatoid arthritis	Date: _____
Migraine / Headaches	Date: _____	Cancer	Date:_____

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NAME:_____ **Date of birth:_____**

SURGERIES:

Appendectomy YES___ NO___ DATE_____
Cholecystectomy YES___ NO___ DATE_____

Hysterectomy YES___ NO___ DATE_____

Cataract Surgery YES___ NO___ DATE_____

Heart Surgery YES___ NO___ DATE_____

Heart Catheterization YES___ NO___ DATE_____

Hip surgery YES___ NO___ DATE_____
Tonsillectomy YES___ NO___ DATE_____

Other Surgeries not mentioned above:

_____

_____

Broken Bones:

_____

_____

Hospitalizations:

_____

_____

FAMILY HISTORY:

Parents: Mother living ___deceased___ age and cause of death _____
Father living ___deceased___ age and cause of death _____
Siblings: Number living ___ Number Deceased___
Children: Number living ___ Number Deceased___
Do you have family in the local area? YES___ NO___

Any family history of the following:

Cancer If so, who _____
Depression If so, who _____
Diabetes If so, who _____
Heart Disease If so, who _____
Stroke If so, who _____
Dementia/Senility If so, who _____
Have any of your friends or relatives pass away recently?
If so, who and when _____

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NAME:_____ Date of birth: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY:

Who would assist you in an emergency? _____
Are you Retired? YES___ NO___ YEAR_____
Do you have a living will or a Medical Power of Attorney ? YES___ NO___
What type of work have you done? _____
What kind of activities are you involved in now? _____
Do you live by yourself? YES___ NO___
If not, who do you live with? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR RECENT HEALTH STATUS:

When was your last Mammogram? YEAR____ Not applicable__

When was your last pelvic exam or Pap Smear? YEAR____ Not applicable__

When was your last Prostate exam? YEAR____ Not applicable__

When was your last hearing exam? YEAR____ Not applicable__

When was your last bone density exam? YEAR____ Not applicable__

When was your last eye exam? YEAR____

When was your last dental exam and cleaning? YEAR____

When was your last Colonoscopy? YEAR____

When was your last Pneumococcal Immunization? YES___ NO___ Date_____

Have you had a flu shot this season? YES___ NO___ Date_____

Have you had a Tetanus Immunization? YES___ NO___ Date_____
Do you exercise regularly? YES___ NO___
Do you smoke or have you ever smoked? YES___ NO___
If so, how many years? _____ How many packs a day? _____
Do you still smoke? _____ When did you quit? _____
Do you drink alcohol? YES___ NO___

- Social_____
- Occasional_____
- Daily_____

How many glasses a day? ____

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NAME:_____ Date of birth:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ACTIVIES OF DAILY LIVING:

Can you handle your own personal care (Toileting, Eating, Walking, Dressing, Bathing)?
YES___ NO___ SOME___

Do you do your own cooking? YES___ NO___
Do you do your own cleaning? YES___ NO___
Do you do your own shopping? YES___ NO___
Do you handle your own finances? YES___ NO___
Do you handle your own medications? YES___ NO___

If you answered no to any of these questions, who does these things for you?
_____

Do you use the phone to call family, friends or for emergencies? YES___ NO___
Do you drive? YES___ NO___
If so, have you had any accidents or near accidents in the last two years? YES___ NO___
Have you ever gotten lost? YES___ NO___

PLEASE INDICATE IF YOUR ARE HAVING PROBLEMS WITH ANY OF THE FOLLOWING:

Dizziness YES___NO___ Comments _____
Blurred Vision YES___NO___ Comments _____
Headaches YES___NO___ Comments _____
Swelling YES___NO___ Comments _____
Chest Pain YES___NO___ Comments _____
Insomnia YES___NO___ Comments _____
Sexual Function YES___NO___ Comments _____
Memory Loss YES___NO___ Comments _____
Easily Fatigued YES___NO___ Comments _____
Recent Fall YES___NO___ Comments _____
Painful/Burning Urination YES___NO___ Comments _____
Diarrhea/Constipation YES___NO___ Comments _____
Indigestion/Heartburn YES___NO___ Comments _____
Weight loss/ Weight gain YES___NO___ Comments _____
Muscle or Joint Pain YES___NO___ Comments _____
Anxiety/ Depression YES___NO___ Comments _____
Recent appetite changes YES___NO___ Comments _____
Shortness of Breath YES___NO___ Comments _____
Cough YES___NO___ Comments _____

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Consent Agreement
FOR PROVISION OF CHRONIC CARE MANAGEMENT

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline. CCM Services include 24-hours-a-day, 7 days-a-week access to a health care provider in providers practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transition among health care providers and settings. The provider will discuss with you the specific services that will be available to you and how to access those services.

Providers Obligations:

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable) and offer to you all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Rights:

You have the following rights with respect to the CCM Services:

- The provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30)-day period of services. You may revoke this agreement verbally (by calling 575-532-5455 or in writing to the Southwest Center on Aging office. Upon receipt of your revocation, the provider will give you written conformation including the effective date or revocation.

Beneficiary Acknowledgement and Authorization:

By signing and acknowledging the Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You Authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practioner can furnish CCM Services to you during a thirty (30)- day period.
- You understand that cost- sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary
Signature: _____
Print Name: _____
DOB:_____
Date: _____

Beneficiary's Representative and/or Caregiver (if applicable)

Signature: _____
Print Name: _____
Date: _____

☐ I DECLINE Chronic Care Management

☐ I ACCEPT Chronic Care Management

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NAME:_____ Date of birth:_____

Current Medication List

Medication Name	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Drug Allergies:_____

Preferred Pharmacy:_____

Mail Order Pharmacy:_____

PLEASE MAKE SURE TO BRING YOUR ALL MEDICATION BOTTLES TO ALL APPOINTMENTS WITH US.

THANK YOU!