

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Registration Form

Patient's last name:	First:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status:		
		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="radio"/> Single <input type="radio"/> Mar <input type="radio"/> Div <input type="radio"/> Sep <input type="radio"/> Wid		
Is this your legal name: <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name:	(Former name):		Birth Date:	Age	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		Social Security no.:		Cell Phone no.: ()		
P.O. Box:	City:	State:		Zip Code:		
Occupation:	Employer:		Employer phone no.: ()			
Email:						
Chose clinic because/referred to clinic by (please check on box):		<input type="checkbox"/> Close to home/Work		<input type="checkbox"/> Other		
Best time to contact:		Best way to contact:		<input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email		

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for the bill:	Birth Date:	Address (if different)	Home Phone no.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation:	Employer:	Employer Address:	Home Phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary Insurance:			
Subscriber's Name:	Subscriber's SS no:	Birth Date:	Group no: Policy no:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's Name:	Group no: Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home Phone no.: ()	Work Phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Amanecer Community Counseling Center or the insurance company to release any information required to process my claims.			
_____ Patient/Guardian Signature			_____ Date

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Medical History

Patient Name: _____ Date of Birth: _____

Name of Physician/Pediatrician: _____

Pharmacy Preference: _____

Last Physical: _____ Most Current: Height- _____ Weight- _____

Allergies: Yes No If yes, please specify: _____

Check if 'yes':

Tuberculosis: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	High Blood Pressure: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Hepatitis: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	
Seizure/Neuro Disorder: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	Head Trauma- <input type="checkbox"/>
Asthma/Lung Disease: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	Weight/Appetite Change: <input type="checkbox"/>
Sexually Trans Dis: <input type="checkbox"/>	
HIV Test: (Most recent date):	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No

Sleep Disorder: <input type="checkbox"/>	Vision/Glaucoma: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Cardiovascular Disease/Symp: <input type="checkbox"/> (Fam Hist: <input type="checkbox"/>)	Thyroid Dis/Symp: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Blood Disorder: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	Liver Disease: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Renal Disease/Symp: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	Hypertension: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Diabetes: <input type="checkbox"/> (Family History: <input type="checkbox"/>)	Cancer: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Diarrhea: <input type="checkbox"/>	Hyperlipidemia: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Gait/Balance Disturbance: <input type="checkbox"/>	Bipolar Disorder: <input type="checkbox"/> (Family History: <input type="checkbox"/>)
Depression: <input type="checkbox"/> Anxiety: <input type="checkbox"/>	Sexual Dysfunction: <input type="checkbox"/>
Fainting Spells/Dizziness: <input type="checkbox"/>	Alcohol Use/Abuse History: <input type="checkbox"/> (Family History: <input type="checkbox"/>)

Medical History: (Comments on above medical problems, other medical problems, and any hospitalization, including dates and reasons)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in my medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Date: _____ Patient Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle One)

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

Client's Name: _____

Date of Birth: _____

_____ (initials) I understand if I become suicidal, I need to call 911 or 800.273.8255

_____ (initials) I understand that all medications have some chance of dangerous side effects.

I understand that not fully disclosing which current medications I am taking could lead to life-threatening complications.

I am currently only taking the following medications:*(please provide the name of the provider prescribing medication)*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ (initial if applicable) I understand that I should not take these medications while pregnant and if I discover I am pregnant, I should inform my doctor immediately.

I understand that by giving this consent. I am voluntarily permitting the use of medication for the treatment of my mental disorder. I also understand that there may be risks associated with my treatment, as well as benefits for discontinuation of the prescribed medication(s), without consulting my physician, may result in worsening of my condition.

Client's Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

CONFIDENTIALITY

I understand that my counseling sessions are confidential. I also understand that there are limits to confidentiality and that my counselor will need to notify appropriate authorities if I should:

- 1. Threaten or try to harm myself.
- 2. Threaten or try to harm someone else.
- 3. If there is physical or sexual abuse, neglect of a child or elderly person.

I also understand that if my counselor is subpoenaed or ordered to testify in a court of law, he/she will notify me, or my attorney(s), and he/she may have to surrender files.

 X _____ X _____
Signature Date

AUTHORIZATION TO COUNSEL A MINOR

I, _____ (Parent, Guardian) of _____
Minor

Authorize Amanecer Community Counseling Center to provide services to my child. I have been informed of the importance of confidentiality as well as the limits of confidentiality. We also understand that because I am a minor, should my counselor feel it is necessary to inform me (parent(s)/guardian), of a situation, he/she will do so.

 X _____ X _____
Parent/Guardian Signature Date

ADVANCE DIRECTIVES (ages 18 and over)

I, _____ have an Advance Directive for Mental Health Treatment.

OR

I, _____, do not have an advance directive, but I wish to obtain additional information on how to create an Advance Directive for Mental Health Treatment.

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

RELEASE OF CONFIDENTIAL INFORMATION TO/FROM AMANECER

I hereby authorize Amanecer Community Counseling Center to **release/Obtain Information to/from the following:**

_____ My primary care physician, Dr. _____ Phone#: _____

_____ My current therapist _____

_____ The person/agency who referred me here _____

Agency/Entity: _____

Person: _____

Address: _____

Telephone#: _____ Fax #: _____

___ Pediatric/PCP Records ___ In/Outpatient Psychiatric Records ___ Most Recent Labs/EKG/Sleep Study

___ Discharge Summary ___ Copy of Entire Record ___ Discharge Instructions ___ Med Reconciliation/Treatment

___ Evaluation ___ Treatment Plans ___ Biopsychosocial ___ Safety Plans ___ Discharge Plan

Regarding the following individual:

Name: _____ D.O.B.: _____

I understand that all such information released is to be treated as confidential.

This Release of Information will expire on _____.

Signature Relationship Date

Amanecer Community Counseling Center Staff Title Date

If you do not want to release information, please fill out the bottom box.

At this time, I _____ do not want any information released to anyone.

Signature Date

Staff Signature Date

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Telemedicine/Telephone Consent Form

Amanecer Community Counseling Center uses an online Telemedicine platform called ZOOM to allow psychologists, nurse practitioners, counselors, BMS, and/or CCSS to have continuity of care, given the current pandemic and COVID-19 risks. ZOOM has high standards to provide a secure and encrypted Telemedicine/Telephonic platform and does not record any communications between you and the psychologist, nurse practitioner, counselor, BMS, and/or CCSS, whether audio or video. The same limits and laws that were reviewed when you signed a consent for treatment that include statements of non-intent to harm yourself, others, or abuse of children apply in Telemedicine/Telephonic services.

Although Electronic means for counseling appointments are increasingly common, there are potential risks to using an online counseling platform:

- Internet services may malfunction, or there may be technological challenges. Therefore, a telephone backup may need to be used, which results in potential misunderstanding due to a lack of visual cues.
- Though every effort is made to ensure confidentiality, the limitations and risks in teleconferencing include public discovery, the possibility of hackers, household noise or interruptions, and other potential risks outside of our control.
- Even with best practices using Telemedicine/Telephonic sessions, any information transmitted via the internet/land, or cell phone lines may not be 100% secure.
- Confidentiality should be treated like an in-office session: no outside distractions, turn off cell phones, close other programs on the computer, and do your best not to be late.

Rights

- Patients can withdraw and withhold this consent at any time, and they can end the treatment at any time they would like to. Any action of patients will not affect the future treatment of or accessibility to counseling services.
- Patients will be given the option to choose which method of service they prefer to include: in-office, telemedicine, or telephonic services

Consent

- By signing this form, I agree that I know and understand the information above. My questions were answered completely during the discussion with the Amanecer staff. I hereby give my consent to participate into telemedicine/telephone counseling services provided by Amanecer Community Counseling Center.

Date: _____

Patient Name: _____

Patient Signature: _____

Parent/Guardian Signature: _____

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

CLIENT RIGHTS and RESPONSIBILITIES

Clients have rights and responsibilities for their care.

CLIENT RIGHTS

Amanecer Community Counseling Center believes that every client has the following rights:

1. All clients have the right to be treated fairly, with dignity, and with respect for their right to privacy.
2. All clients have the right to receive all health care services in a caring, non-judgmental way.
3. All clients with communication-related disabilities have the right to receive all information in a format that meets their needs.
4. All clients have the right to receive health care services in a way that respects their culture, including interpreters for those who do not speak English.
5. All clients have the right to understand any treatment to which they agree ("Informed Consent"). Specifically, clients have the right to understand the benefits, risks, and alternatives of any proposed treatment, non-treatment, or procedure.
6. All clients shall have the right to take part in all health care decisions about them, including treatment planning and the right to refuse treatment.
7. All clients shall have the right to choose someone to help with care choices.
8. All clients have the right to make a complaint about their care or decisions about their care without worrying about retaliation, limitation of services, or any negative effect on their care. This complaint can be against Amanecer Community Counseling Center or a provider contracted with Amanecer Community Counseling Center.
9. All clients have the right to choose their providers from within Amanecer Community Counseling Center.
10. All clients shall have the right to have psychiatric advance directives (PAD) and have providers abide by them. A PAD is a legal document allowing a client to direct his or her behavioral health treatment/wellness management if he or she cannot make or communicate decisions about that treatment. A PAD can say which people the client does or does not want to make choices on his or her behalf.
11. All clients have the right to see their own mental health and substance abuse treatment records based on federal and New Mexico laws and rules, and to restrict access to the records based on those laws and rules.
12. All clients have the right to have all information about their diagnoses and care kept private, as allowed by law, unless they give consent for the release of information.
13. All clients have the right to take part in decisions related to their mental/behavioral health care. This includes the right to refuse treatment, except when required by law.
14. All clients have the right to receive services without regard to race, color, religion, sex, sexual orientation, age, or ethnic background.
15. All clients have the right to ask for and get information about Amanecer Community Counseling Center, including its services, its network providers, and how to access them.

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

16. All clients have the right not to have their care negatively affected in any way if conflicts arise between Amanecer Community Counseling Center and its network providers.
17. All clients have the right to be free from any form of restraint or seclusion as specified in federal or State rules on the use of restraints and seclusion.

Client Responsibilities

Amanecer Community Counseling Center asks that every client take to heart the following responsibilities:

1. All clients are responsible for providing, whenever possible, any information Amanecer Community Counseling Center and its providers need to provide the consumer with quality care.
2. All clients are responsible for understanding their problems and shall participate in developing mutually agreed-upon treatment and recovery goals.
3. All clients are responsible for following these agreed-upon treatment and recovery plans and for letting providers know if changes are needed.
4. All clients are responsible for respecting their providers by keeping, changing, or cancelling appointments instead of not showing up.
5. All clients are responsible for confirming their scheduled appointments the day prior to avoid any cancellation or rescheduling of appointments.

----- <> -----

CLIENT GRIEVANCE PROCEDURE

It is the policy of Amanecer Community Counseling Center, LLC, that every effort shall be made to resolve a client's grievance fairly and equitably, and that all client grievances will be investigated and resolved promptly in accordance with New Mexico Statutes.

1. All staff members shall be aware of a client's needs and shall pay close attention to those situations that could lead to a grievance situation. Clients may grieve directly to any staff member. Clients may grieve about any violation of their rights.
2. Staff members shall make every effort to resolve the grievance informally by discussing the situation or circumstances with the client.
3. Staff members who are involved shall not be included in acceptance, investigation, or decision-making concerning the grievance.
4. Clients who are not able to resolve their grievances by discussion must put their grievance in writing, including date and signature.
5. Amanecer Community Counseling Center will provide pens, paper, envelopes, postage, and access to a telephone upon request to file a complaint. Amanecer Community Counseling Center shall assist clients who cannot read or write or have difficulty reading and writing.

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

6. The Clinical Director or designee will acknowledge receipt of the grievance within 24 hours and investigate the grievance and interview the client as necessary.
7. A written report of the investigation and initial disposition shall be made to the client by the Clinical Director or designee within seven (7) calendar days.
8. A client who is still dissatisfied may appeal the decision to the governing authority, and a written report of the decision will be forwarded to the appropriate monitoring commission, with a written response given to the client within 30 days.
9. There shall be no retaliation, formal or informal, against a grieving client.
10. Amanecer Community Counseling Center shall retain full records of all grievances in a confidential file for three years, but not in a client's case file.
11. Clients may submit their grievance at any time directly to:

Amanecer Community Counseling Center, LLC
Attn: Clinical Director/Designee
P.O. Box 2671
Anthony, NM 88021

12. Clients may elect to choose a staff member, family member, friend, or other individual of their choice choosing to advocate for them in the grievance procedure.

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Financial Policies and Procedures

Discharge of a Client

I understand that Amanecer Community Counseling Center has the right to discharge any client from this agency at any time for various reasons, including but not limited to failure to abide by Amanecer Community Counseling Center's financial policies, noncompliance with recommended treatment plans, drug-seeking activity, and any abuse of Amanecer Community Counseling Center providers and staff. If this occurs, I understand that my medical records will be released to a physician or healthcare facility of my choice only after an appropriately signed documentation is received by Amanecer Psychological Services.

Authorizations

Assignment of Benefits

I certify that the information I have given to Amanecer Community Counseling Center is true and correct to the best of my knowledge. I promise to pay to Amanecer Community Counseling Center all charges and expenses for services provided to me by Amanecer Community Counseling Center in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance or by another payment source such as Medicare or Medicaid. I request that payment of authorized benefits under any private or government insurance program that covers me, including the Medicare program, be made on my behalf to Amanecer Community Counseling Center for any services furnished to me by Amanecer Community Counseling Center. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine my Medicare benefit, if any, for services furnished by Amanecer Community Counseling Center. I understand that possession of medical insurance does not relieve me of financial responsibility to Amanecer Community Counseling Center. I will personally be responsible for all charges for services that are not covered by my insurance carrier.

Record Usage

I give my consent to the Amanecer Community Counseling Center, its staff, and business associates to use my medical records for data gathering and research purposes. I understand that ALL identifying information in my record will be coded for confidentiality. I understand that all client and provider communication is and will be held in the strictest confidence.

Consent for Medical Treatment

I consent to treatment as deemed necessary and appropriate by clinical providers at Amanecer Community Counseling Center.

Consent for Use and Disclosure of Health Information for Treatment, Payment, and Operations

I consent to the use and disclosure of my protected health information by Amanecer Community Counseling Center, its staff, and business associates for the purposes of treatment, payment, and health care operations. My protected mental health information includes any information that reasonably identifies me and related (1) to the provision of healthcare to me, (2) to any of my past, present, or future mental health and/or health conditions, (3) to the past, present or future payment for any provision of mental health and/or healthcare to me. The information that is protected includes information related to my physical or mental health. I understand that I have the right to request that the practice restrict its uses and disclosures of my protected mental health information that the practice is otherwise permitted to make for treatment, payment, and health care operations. Amanecer Community Counseling Center, however, is not required to agree to these restrictions. Nevertheless, if Amanecer Community Counseling Center agrees to any restrictions, those restrictions are binding on it. Finally, I understand that I have the right to revoke this consent in writing, except to the extent that Amanecer Community Counseling Center has acted in reliance on it.

Appointed Representative

Amanecer Community Counseling Center may pursue collection of benefits in my name or in the name of Amanecer Community Counseling Center as my appointed representative and agency.

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Attestation:

My signature below verifies that on the date indicated on this form, I have read and understand my rights, and I was provided with a copy of the Client Rights.

Date: _____

Client Name (Print): _____

Client Signature: _____

Parent/Guardian: _____

Staff Name (Print): _____

Staff Signature: _____

CLIENT GRIEVANCE PROCEDURE

ATTESTATION:

My signature below confirms that on the date indicated on this form, I received a copy of the Amanecer Community Counseling Center Client Grievance Procedure.

SIGNATURES:

Client Signature

Date

Parent or Legal Guardian Signature

Date

Amanecer Community Counseling Center Staff

Date

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Financial Policy

I have read and understand the financial policies, procedures and authorizations of Amanecer Community Counseling Center to include payment methods, uninsured accounts, financial responsibility resulting from insurance, insurance policy provisions, collection activities, service fees, economic hardship, out-of-network, final cost of services, discharge of patient, and authorizations to include assignment of benefits, record usage provision, consent for medical treatment, consent to use and disclosure of health information for treatment payment and operations and appointment representative.

I understand that these policies, procedures, and authorizations outlined in the Financial Policies and Procedures may be amended from time to time at the discretion of the practice and apply to me. I authorize the use of a copy of this authorization.

Please print client’s name: _____

Client Signature: _____ Date: _____

Date of Birth: _____

If the client is a minor (less than 18 years of age) or incapacitated:

Please print responsibility party name: _____

Responsible Party Signature: _____ Date: _____

Relationship to Client: _____

Financial Responsibility & Insurance Disclosure

Conduent Medicaid Non-Participation Notice

Patient Name: _____

Date: _____

Date of Birth: _____

Important Insurance Disclosure

Our facility is **not contracted with Conduent Medicaid** and does not accept Conduent Medicaid as payment for services rendered.

Conduent Medicaid benefits state:

“Medicaid benefits are limited to paying for Medicare coinsurance, deductible, and copayments only, unless this client has other overlapping Medicaid coverage.”

Acknowledgment of Financial Responsibility

If you have Conduent Medicaid:

- We will not bill Conduent Medicaid for services.
- If you have primary insurance (including Medicare or commercial insurance), your primary insurance will be billed.
- You are responsible for any copayments, deductibles, coinsurance, or remaining balances left after your primary insurance processes the claim.
- If your Conduent Medicaid coverage does not include overlapping full Medicaid benefits, you understand you may be responsible for the full balance not covered by your primary insurance.

Retroactive Eligibility & Coverage Changes

You agree that:

- If you are later determined to have Conduent Medicaid eligibility (including retroactive eligibility) and we are not contracted with that plan, you remain financially responsible for services rendered.
- It is your responsibility to inform our office of any changes in insurance coverage prior to services being provided.
- Failure to disclose active Medicaid coverage at the time of service does not eliminate your financial responsibility if we are not contracted with that plan.

Amanecer Community Counseling Center

785 Anthony Drive/PO Box 2671
Anthony NM, 88021

5340 McNutt Road
Santa Teresa, NM 88008

320 McCombs Space C
Chaparral, NM 88081

128 Wyatt Drive
Las Cruces, NM 88005

Phone: (575) 882-5100[Fax] (575)882-1151

Patient Rights

You understand that you have the right to seek care from a provider who accepts Conduent Medicaid.

By signing below, you confirm that:

1. You have been informed that this facility does not accept Conduent Medicaid.
2. You understand the limitations of Conduent Medicaid benefits as described above.
3. You agree to be financially responsible for any balances not paid by your primary insurance.
4. You have had the opportunity to ask questions and receive clarification.

Date: _____

Client Name (Print): _____

Client Signature: _____

Parent/Guardian: _____

Staff Name (Print): _____

Staff Signature: _____