

**Srirengam Muralidhasan, M.D. LLC**  
1605 El Paseo Rd, Las Cruces NM 88001  
P: 575-523-5400 F: 575-523-5401

**Patient Demographic Form**  
**Please PRINT**

**Patient Demographic Sheet**

Last name First Name Middle Initial

Date of Birth Social Security Number Gender  Male  Female

Marital Status  Married  Single  Divorced  Life Partner  Separated  Widowed Language other than English

Race  Black- Non Hispanic  American Indian/  
Alaskan Native  Hispanic  Asian/  
Pacific Islander  White- Non Hispanic  other

Ethnicity  Hispanic or Latin  Not Hispanic or Latin  refused to Report

Home Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

Email Address Employment Status  Child  Disabled  Employed Full-Time  Employed Part-Time  
 Homemaker  Retired  Student  Self-Employed  other

Employer Employer Phone

**Physician Referral Information**

Primary Care Physician

Referring Physician

**Responsible Party (Parent or Guardian of a minor under 18 or dependent child)**

Relationship to Patient  Self (if self, skip to Emergency / Next of Kin)  Spouse  Parent  other

Last Name First Name Middle Initial

Date of Birth Social Security Number

Home Address Apt # City State Zip Code

Home Phone Work Number Cell Phone

Employer Employment Status  Child  Disabled  Employed Full-Time  Employed Part-Time  
 Homemaker  Retired  Student  Self-Employed  other

Employer Phone

NOTE: PLEASE PROVIDE INSURANCE CARD AND PICTURE ID TO BE SCAN TO FILE.

## Emergency / Next of Kin Contact Information

Last Name	First Name	Relationship to Patient		
Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Cell Phone		

## Other Contact Information – Not Living with Patient

Last Name	First Name	Relationship to Patient		
Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Cell Phone		

### CONSENT TO TREATMENT

*Authorization for treatment, release of medical information, and assignment of insurance benefits.*

**CONSENT TO TREATMENT:** The undersigned authorizes the physician/provider assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of S. Murali, M.D. LLC. This treatment may require diagnostic procedures including but not limited to laboratory tests, blood drawing for those tests, x-ray and electrocardiogram.

**AUTHORIZATION TO RELEASE:** I hereby authorize S. Murali, M.D. LLC or my attending physician/provider, to release or disclose to insurance companies and/or outpatient benefit programs information from my medical record pertaining to my treatment as needed to process insurance claims.

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN/PROVIDER:** I certify that the information given by me in applying for payment under title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, and authorize such physician/provider for services rendered.

**MEDICAID PATIENT CERTIFICATION:** I certify that the information given by me in applying for payment as a recipient of Medicaid Title XIX Program is correct and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the New Mexico Medicaid Commission any requested information concerning medical, insurance, or financial records relating to my outpatient visits or hospital treatment. I hereby certify all insurance benefits shall be assigned to the S. Murali, M.D. LLC or to my attending physician/provider for services rendered.

**FINANCIAL AGREEMENT:** For services rendered to the patient named below, I the undersigned, agree to pay all professional, outpatient and/or hospital visit charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment. I further agree to allow S. Murali, M.D. LLC to contact my employer to verify employment.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:** By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Printed Patient Name	Signature of Patient	Date
Printed Name of Guardian	Signature of Guardian (if patient is minor)	Date



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**Review of Systems**

Which of the following do you have?

Patient's name: \_\_\_\_\_

Date: \_\_\_\_\_

**Skin/Lymphatic**

Rash	Yes	No
New skin spots	Yes	No
Skin infection	Yes	No
Change in a mole	Yes	No
Non-healing sores	Yes	No
Swollen Lymph nodes	Yes	No

**Neurologic**

Severe headache	Yes	No
Fainting spells	Yes	No
Seizures and convulsions	Yes	No
Dizziness	Yes	No
Memory loss	Yes	No

**Eyes**

Vision problem	Yes	No
Glaucoma	Yes	No

**ENT**

Hoarseness	Yes	No
Nose bleeds	Yes	No
Hearing loss	Yes	No
Ringing in the ears	Yes	No
Difficulty swallowing	Yes	No
Tooth pain or infection	Yes	No

**Urologic**

Burning with urination	Yes	No
Blood in urine	Yes	No
Frequency of urination	Yes	No

**Allergies/Immune Disorders**

Hay fever	Yes	No
Anaphylactic reaction	Yes	No
Rheumatoid disease	Yes	No
Other autoimmune disease	Yes	No

**Gastrointestinal**

Heartburn	Yes	No
Abdominal pain	Yes	No
Nausea	Yes	No
Jaundice	Yes	No
Bloody stool	Yes	No
Black Stool	Yes	No

**Reason for Visit:**


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**Musculoskeletal**

Joint pain	Yes	No
Joint swelling	Yes	No
Back pain	Yes	No
Neck pain	Yes	No
Muscle pain	Yes	No

**Hematologic**

Easy bruising	Yes	No
Excessive bleeding	Yes	No

**Constitutional**

Chronic fatigue	Yes	No
Weight loss	Yes	No
Excessive weight gain	Yes	No
Fever	Yes	No
Night sweats	Yes	No

**Cardiovascular**

Chest pain	Yes	No
Chest pain at rest	Yes	No
Chest pain with exertion	Yes	No
Shortness of breath	Yes	No
Racing heart beat	Yes	No
Poor circulation	Yes	No

**Psychological**

Depression	Yes	No
Anxiety	Yes	No

**Respiratory**

Asthma	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Persistent cough	Yes	No
Cough up blood	Yes	No

**Name of specialist that you see:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Additional Notes: \_\_\_\_\_

\_\_\_\_\_

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**HIPAA NOTICE OF PRIVACY PRACTICES**

Effective Date: *June 2013*

**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.**

If you have any questions about this notice, please contact [Patty Quintana](#).

**OUR OBLIGATIONS:**

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

***For Treatment.*** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment.*** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations.*** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.*** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Individuals Involved in Your Care or Payment for Your Care.***

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as

your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Research.*** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**SPECIAL SITUATIONS:**

***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.

***To Avert a Serious Threat to Health or Safety.*** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

***Organ and Tissue Donation.*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Risks.*** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

## **USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT**

### ***Individuals Involved in Your Care or Payment for Your Care.***

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

**Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

## **YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

### **YOUR RIGHTS:**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to ***Viridiana Prieto***. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health

Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

***Right to Amend.*** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to [Patty Quintana](#).

***Right to an Accounting of Disclosures.*** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to [Bernice Navarro](#).

***Right to Request Restrictions.*** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to [Patty Quintana](#). We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

***Right to Request Confidential Communications.*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to [Patty Quintana](#). Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

***Right to a Paper Copy of This Notice.*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, [www.lascrucesurgentcare.com](http://www.lascrucesurgentcare.com). To obtain a paper copy of this notice, you can ask anyone in the practice.

## **CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

## **COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact [Patty Quintana](#). All complaints must be made in writing. **You will not be penalized for filing a complaint.**

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, [www.acog.org](http://www.acog.org), or call (202) 863-2584.