Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

New Patient Registration

Account #_____ Date_____

Last Name_____Date of Birth_____

First Name_____

Address_____

City_____State_____Zip_____

Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____

Email Address_____

Male Female Marital Status: Married Single Widowed Divorced Separated

Social Security Number_____ Preferred Language_____

Occupation:_____Employer_____

Emergency Contact:_____ Phone:_____

Relationship:_____Address:_____

How did you hear about us? _____

Check here **ONLY IF** you would **NOT** like to receive our Health and Wellness Newsletter ___

Would you like information on Botox, Juvaderm, or Latisee? ___ Yes ___ No

The following questions are a government requirement for our electronic medical record.

Ethnicity (please circle): Hispanic Non-Hispanic Other

Race: (Please circle) White Native Hawaiian/Pacific Islander Asian Black or African-American American Indian Decline Other Race_____

Patients 18 and Older: Do you have an Advance Directive?* Yes No

Do you want information regarding Advance Directive? Yes No

*An Advance Directive is a living will.

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

New Patient Health History

Name_____**DOB:**_____

Reason for today's visit: What would you like to discuss today?_____
_____
_____

Review of Systems: Currently or in the *recent* past have you had?

__Fatigue	__Swelling	__Allergies/Hay Fever
__Weight Change	__Cough	__Joint Pain
__Headaches	__Shortness of breath	__Rash
__Vision/Eye Problems	___Abdominal Pain	__Anxiety
__Chest Pain/Palpitations	__ Urinary Problems	__Depression

__Wrinkles/Fine Lines/Thin Eyelashes

Social History:
Alcohol: Number of drinks per week, including beer and wine_____
Tobacco Use: Do you smoke? YES NO If yes, how many cigarettes per day?_____
If no, did you smoke in the past? YES NO How many and for how long?_____
Any use of recreational drugs? (heroin, cocaine, etc.) YES NO
Have you ever used intravenous drugs? YES NO
Do you drink caffeinated beverages? (Soda, Tea, Coffee, Energy Drinks) YES NO
If so, which type?_____Number per day_____
Do you exercise?_____
General Diet Description:_____
What do you do for fun?_____
I live: ___alone ___with partner/spouse ___with my children ___with parent(s) ___other_____

<u>FAMILY</u> Health History: Please list any first degree relative (parent, sibling, child) with:

Diabetes_____	Thyroid Problems_____
High Blood Pressure_____	Dementia/Alzheimers_____
Heart Attack/Coronary Artery Disease_____	Depression_____
Stroke_____	Drug/Alcohol Abuse_____
Cancer: Type_____	Suicide_____
_____	Genetic Disease_____ _____
Asthma_____	Other_____

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

Name_____**DOB**_____

Medical and Surgical History: Please list **ALL** illnesses, diagnoses, conditions, hospitalizations, etc.

1._____Date_____

2._____Date_____

3._____Date_____

4._____Date_____

5._____Date_____

6._____Date_____

Medications: Please list any medications you use at least once a month. This includes prescription medications, birth control pills, and non-prescription medicines such as pain relievers, vitamins, antacids, laxatives, sinus medications, herbal supplements, etc.
Include dose and number of times per day.

MEDICATION	**DOSE**	**TIMES PER DAY**

Allergies: Please list any allergies or bad reactions to *medications.* Please list medication and type of reaction.

_____

_____

Reproductive History -Women Only-

Date last Menstrual Period Started: _____ Currently Using Birth Control? YES NO
Number of Pregnancies_____ Number of Births_____ Type of Birth Control_____

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

Office Policies & Consent for Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC

***** THIS FORM MUST BE COMPLETED PRIOR TO SEEING THE DOCTOR *****

● **Full payment is due at the time of service.** We accept cash, check, MasterCard, Visa, and Discover. All patients/legal guardians are financially responsible for any balances due on office visits or procedures, which are not covered by your insurance.

● We charge a $25 fee for returned checks.

● All balances are due prior to your appointment. Any unpaid balance is subject to appointment cancellation.

● Your signature below indicates your agreement with our terms for any unpaid balance due. Balance is due upon receipt of bill. If it becomes necessary to employ an attorney or collection agency for the collection of any unpaid balance, those fees will be added to the balance due.

● By signing below, I request payment of authorized medical benefits be made to Serenity, Inc (for services provided under the practice of Kurt Kastendieck, MD), Ron Press, MD, LLC (for services of Ron Press, MD), and Eric Grasser, MD, LLC (for services of Eric Grasser, MD) for covered services rendered. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

● It is your responsibility to notify our office of any changes to your insurance coverage and personal information.

● Appointment cancellations must be made more than one business day (24 hours) in advance of all routine, scheduled appointments to avoid penalty. Any routine appointments canceled or missed with less than one business day will automatically be charged a $50 cancellation fee.

● If you are more than 15 minutes late for your appointment, you may be asked to reschedule. In this event, the appropriate cancellation fee will be applied.

● Afterhours access: If you have an emergency, please call 911. If you have an urgent medical matter, please call our office number and follow the recorded directions.

● All in-depth forms that you may need completed require an office visit for completion. All other forms require a $25 completion fee.

● All diagnostic test results require doctor review/interpretation before copies will be provided to you. You must attend an office visit to receive interpretation and treatment guidance for all abnormal results. Normal lab results can be communicated by mail, phone, or sent by secure email upon request. Medical records fees may apply for large volume requests.

● In accordance with American Medical Association recommendations, we hereby disclose that we profit from the sale of products.

● Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient. I fully understand and accept the above listed policies, and I do hereby voluntarily consent to evaluation and care with a medical provider including physical exam and any mutually agreed upon diagnostic testing and treatment recommendations.

_____	_____	_____
Patient/Guardian Printed Name	Signature	Date

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

Narcotic Pain Killer Policy Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC

It is our policy not to prescribe narcotic pain killers. This includes drugs, which contain opioid or opiate chemicals, such as codeine, hydrocodone, oxycodone, morphine, or fentanyl, sold as brand names such as Tylenol #3, Lortab, Lorcet, Vicodin, Percocet, Demerol, or Oxycontin. These medications have little evidence which show that they have long-term benefit, and do not treat the root cause of symptoms or disease. Exceptions to this policy *may* be made at our discretion in the case of conditions such as cancer or shingles or acute injury. We are happy to work with you to provide better alternatives to pain management. By signing below, I agree to this policy.

_____

Patient/Guardian Printed Name

_____

Signature

_____

Date

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

Acknowledgment of Privacy Policies

I acknowledge that I have been provided with Notice of Privacy Practices ("Notice"):

- It tells me how Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC ("Doctors") will use my health information for the purposes of my treatment, payment for my treatment, and health care operations.
- The Notice explains in more detail how the doctors may use and share my health information for other than treatment, payment, and health care operations.
- Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC will also use and share my health information as required/permitted by law.
- Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC may also exchange my health information for treatment purposes when participating in Health Information Exchange (HIE).

I consent to the medical providers using and disclosing my treatment records maintained by Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC for the purposes detailed in the Notice of Privacy Practices.

Patient's Complete Legal Name: _____
(please print)

Patient's DOB _____ Date: _____

Signature: _____
(Patient or legal representative*)

*May be requested to show proof of representative status

Office use only:

I attempted to obtain the patient's signature on this acknowledgement, but was unable to do so as documented below:					
Date attempted:		Name:		Reason:	

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

Notice of Privacy Practices for Serenity, Inc, Ron Press, MD, LLC, & Eric Grasser, MD, LLC

This Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please keep this notice for your records.

The law requires that we protect the privacy of your Protected Health Information (PHI) and that we give you a Notice of our legal duties and privacy practices with respect to PHI. PHI contains information that may identify your past, present or future physical or mental health conditions or healthcare services. This Notice explains how we can use or disclose the PHI in course of providing treatment, collecting payment and managing healthcare operations, and for other specific purposes permitted or required by law.

Protected Health Information includes:
- Information we place in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about your health and healthcare in our computer systems
- Billing information about you at our practice

The Notice also explains your health information privacy rights. The privacy practices described in this Notice will be followed by our entire workforce (employees, volunteers and contractors). We will not use or disclose your PHI without your written authorization, except as described in this Notice.

Your Health Information Privacy Rights

You have the right to:

1. **Receive the Notice of our Privacy Policies (this Notice) that tells you how your health information may be used and shared.** In most cases, this Notice should be made available to you on your first visit, and you can ask for a copy of it at any time.
2. **Inspect and obtain a copy of your health records**. You can ask to see and get a copy of your Protected Health Information (PHI) including its electronic format. You may be charged a fee for the cost of copying and mailing necessary to fulfill your request. We may deny your request to inspect and obtain a copy of your PHI in certain limited circumstance. For example, if your doctor decides something in your file might endanger you or someone else, the doctor may not give this information to you. You have the right to appeal the denial.
3. **Amend your health information**. You may request that we amend any incorrect or incomplete PHI that we maintain about you. For example, if we both agree that your file has the wrong test result, we will change it. In certain cases, we may deny your request for amendment. If we deny your request for amendment you have the right to disagree with our decision.

4. **Authorize disclosure of your PHI.** In general, your health information including psychotherapy notes will not be given to your employer, used or shared for sales calls or marketing, or used or shared for many other purposes unless you give your permission by signing an authorization form.
5. **Request a report on how we disclosed your health information.** Under the law, your health information may be used and shared for particular reasons, like making sure we give good care, reporting when the flu is in your area, or making required reports to the police, such as reporting gunshot wounds. You can request a list of all non-authorized disclosures and whom your health information has been shared with.
6. **Request to be contacted at different address or in a different way than we contact you now.** You have the right to ask us to contact you about your PHI at a different address or in a different way than we contact you now. For example, you can have the nurse call you at your office instead of your home. These requests are often made when a person feels his or her health or safety is in danger if PHI is sent to his or her home address. We will do our best to accommodate all reasonable requests.
7. **Request restrictions on certain use or disclosure of PHI.** You can request additional restrictions on the use or disclosure of your PHI. However, we are not required to agree with your request for additional restrictions.
8. **Request a restriction on disclosure of PHI to a health plan** with respect to health care for which you are paying out of pocket in full. You have to make this request before services are provided and you may be asked to pay in full for those services at that time.
9. **Ask for additional information or file complaints.** If you believe your health information was used or shared in a way that is not allowed under the privacy law, or if you were not able to exercise your rights, you can file a complaint with us or with the U.S. Government. This Notice tells you who to talk to and how to file a complaint.
10. **You have the right to opt out of our fundraising/marketing communications** if we engage in those.
11. **You have the right to be notified about data breaches** of your unsecured PHI.

We ask that you **exercise your rights in writing.** We offer forms and templates to help you exercise your privacy rights and to help us protect your health information. Our front desk staff will make these forms available to you upon your request.

<u>Reasons and Examples of How We May Use or Disclose Your PHI</u>

1. Treatment - so you can get medical care. For example, we may share your medical information with your other doctor or pharmacy so that they can give you medical care and the right medicine. We may also call or write to provide refill reminders, to tell you about treatment options or other health-related services. We will not disclose PHI without authorization for marketing purposes.
2. Payments - so we can determine plan coverage, billing/collection, and assist another health care provider with payment activities or recover payment from medical

insurance. For example, the information accompanying the bill or insurance verification request may identify you as well as your treatment.

3. Operations - so we can perform our duties. For example, we may use or share your medical information to assess quality of care, conduct training or to manage your care. We may also disclose PHI to an oversight agency in case of audits, complaint investigations and inspections necessary for our licensure, to satisfy government monitoring activities and regulatory compliance.
4. There are some services provided by us through contracts with Business Associates, for example billing, scheduling or transcription services. When these services require access to your PHI we will disclose only minimum necessary information, so the contractors may perform their job. To protect your PHI we require Business Associates to safeguard PHI appropriately.
5. To comply with the law. We may share your medical information to comply with legal proceedings, or in response to valid court or administrative order or subpoena.
6. For other reasons. Examples include:
    i. We may disclose PHI to support law enforcement (e.g. government authority such as police, social services) to protect someone's health and safety (e.g. victims of abuse, domestic violence);
    ii. We will use our professional judgment and may share information with a family member, friend or other relative to help you obtain or pay for your health care;
    iii. We may share PHI to notify a family member, relative, personal representative, or other person responsible for your care about your general condition and location;
    iv. So a personal representative you appoint or a court appoints for you can help you get health benefits;
    v. To support research as long as the privacy and security of PHI is ensured;
    vi. So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
    vii. To support, in limited circumstances an organ procurement organization;
    viii. To protect you against a serious threat to your health or safety, or the health or safety of others;
    ix. To support a government agency overseeing health care programs. For example, we may disclose your PHI to Food and Drug Administration (FDA) to enable investigations, drug/product recalls or replacements;
    x. We may disclose your PHI as authorized or necessary to comply with worker's compensation laws or other similar programs;
    xi. For lawful national security purposes including intelligence or national security activities;
    xii. For public health purposes to prevent or control disease; and
    xiii. For military purposes, if you are a member of the armed forces.

Dr. Kurt Kastendieck, MD
Loretta Kastendieck, PA-C
Dr. Ronald Press, MD
Dr. Eric Grasser, MD

We will obtain your written authorization before using or disclosing your PHI for purposes other than those described in this Notice or as otherwise permitted by law e.g. marketing, sale of PHI. You will be able to revoke this authorization at any time.

2. Changes to this Notice

We reserve the right to change this Notice and to make the revised Notice effective for all health information we create or maintain. Upon request we will make the revised Notices available to you. The revised Notices will be posted and available at each location where we provide medical services and on our website if we maintain one.

3. **For More Information or to Report a Problem**

If you have questions and would like to obtain additional information about our privacy practices, please contact our Office Manager at 505-992-3334 or 421 St. Michaels Drive, Santa Fe, New Mexico 87505. If you believe your privacy rights have been violated, you may file a complaint with our Office Manager or with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

This Notice of Privacy Practices is effective as of September 23, 2013

The Notice of Privacy Practices was last revised on: 09/20/2013