Sunrise Clinics

Providing Exceptional Rural Healthcare

PATIENT WELCOME FORM...PLEASE COMPLETE

Today's Date: _____

Office Location: _____

Sunrise Clinics encourages all of our patients to consider applying for SLIDING SCALE FEE ADJUSTMENTS. Please review the info on pages 2 & 3, or ask someone at our Front Desk if you'd like more info.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____ Sex at Birth: M F

Address: _____ City: _____ St: _____ Zip: _____

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

E-Mail: _____ Marital Status _____ How did you find us? _____

Preferred method of communication ☐ **CELL PHONE** ☐ **HOME PHONE** ☐ **WORK PHONE** ☐ **TEXT** ☐ **EMAIL**

Ethnicity: ☐ Hispanic/Latino ☐ African American ☐ White ☐ Other _____

- ☐ You will need to provide a copy of your government issued ID.... a copy of your Driver's License
- ☐ You will need to provide a copy of each of your Insurance Cards & authorize pmt for Ins Co's to us
- ☐ You will need to acknowledge receipt & review our Privacy Practices. These are on p 2-3
- ☐ We will obtain Medical Records as agreed below in the Medical Records Release.
- ☐ We will need you to sign the Consent to Treat section of this form to proceed with your care.
- ☐ Please consider applying for a Sliding Scale Fee Reduction. See p 4-5 or ask our Front Desk Staff

Primary Insurarance Information

Insurance Co: _____

Policy ID#: _____

Group #: _____

Policyholder Name: _____

Relationship: _____

Secondary Insurance Information

Insurance Co: _____

Policy ID#: _____

Group #: _____

Policyholder Name: _____

Relationship: _____

MY SIGNATURE ACKNOWLEDGES AGREEMENT WITH, AND APPROVAL OF, EACH SECTION BELOW

I AUTHORIZE MY INSURANCE COMPANIES TO MAKE PAYMENTS DIRECTLY TO SUNRISE CLINICS

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND I AM FINANCIALLY REPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE SUNRISE MEDICAL GROUP OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS

I HAVE RECEIVED, REVIEWED AND APPROVED THE PRIVACY PRACTICES FOR SUNRISE CLINICS

I AGREE TO RECEIVE COMMUNICATIONS VIA EMAIL, TEXT OR THE "SUNRISE PORTAL" REGARDING MY APPOINTMENTS, AND HEALTHCARE USING THE SECURE COMMUNICATIONS OF SUNRISE CLINICS. I FURTHER AUTHORIZE THE TAKING OF MY PHOTO FOR PURPOSES OF IDENTIFICATION.

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO SUNRISE CLINCS FROM THE FOLLOWING

I AUTHORIZE THE USE OR DISCLOSURE OF THE COMPLETE MEDICAL RECORDS OF MY HEALTH INFORMATION. I UNDERSTAND THAT MY DISCLOSIRE CARRIES WITH IT POTENTIAL FOR UNAUTHORIZED RE-DISCLOSURE, THEREFORE THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. I ALSO ACKNOWLEDGE BEST-FAITH EFFORTS OF SUNRISE CLINICS TO USE THESE MEDICAL RECORDS APPROPRIATELY.

Request Records From: _____ Phone #: _____ FAX: _____

Period of Time Records Requested From _____ **to** _____ **or** ☐ **ALL PERIODS**

MY SIGNATURE BELOW SERVES AS MY CONSENT TO BE TREATED BY SUNRISE CLINICS

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN & WILL BE USED TO CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN MY TREATMENTS, DIRECTLY & INDIRECTLY.

I ACKNOWLEDGE RECEVING AN OFFER TO APPLY FOR THE SLIDING FEE SCALE

AFTER REVIEWING THE SLIDING FEE DICOUNT PROGRAM INFORMATION, I HAVE MADE A DECISION TO SUBMIT THE APPLICATION TO SEE IF i QUALIFY FOR THE NEXT 12 MONTHS. I ACKNOWLEDGE THAT I WILL NEED TO RE-APPLY ANNUALLY FOR THIS PROGRAM, AND IF MY FINANCIAL CIRCUMSTANCES CHANGE DURING THE UPCOMING 12 MONTH PERIOD, MY QUALIFICATION TO HAVE THIS BENEFIT MAY CHANGE.

- ☐ **YES. I would like to see if I qualify. I have completed the Sliding Scale Fee Application & Returned to the Front Desk**
- ☐ **NO. I would not like to see if I qualify for Sliding Fee Scale at this time. I agree to be offered this again, in 12 months**

Patient Signature **Date:**

An Advanced Directive Form is offered to each patient and one is included in this packet.

SUNRISE CLINICS

NOTICE OF PRIVACY PRACTICES

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

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties ancf your rights concerning your information.

Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that 1s currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes Vvithout your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders: or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. *We may* use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. *We may also use or* disclose your information for certain other purposes allowed by 45 CFR Part 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others,
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

- Basic identifying information regarding your visits to our facilities may be shared Vvith t he HIEs for the purposes of diagnosis and treatment. This includes health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIE's may access this information as part of your treatment.

3. Uses and Disclosures with Your Written Authorization. Other uses and disclosures not describe d in this Notice Vvill be m a de o nly w ith y o ur w ritten authorization, including mos t uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

We normally contact you by telephone mail at your home address and possibly by e-mail if you have given your email address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may aeny your request under limited circumstances, e.g., if vve determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes to This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the Operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you behave your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer: Chuck Brown
Phone: 575-472-4311

Address: Sunrise Clinics - HIPAA Oversight
CONFIDENTIAL: Chuck Brown, Clinics Manager
116 Camino de Vida Suite 300
Santa Rosa, NM 88435

E-mail: chuck.brown@sunrisenm.org

8. Effective Date. This Notice is effective June 1, 2020

SUNRISE CLINICS

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Applicants Name _____ Today's Date _____

Address _____City _____ State ____ Zip_____

It is policy of Sunrise Clinics to provide primary health care services to patients in need regardless of their ability to pay. Discounts are offered to members of households with combined income of 200% and below of the Federal Poverty Level. To determine the percentage for which you qualify we've provided below, a helpful guide for you to look at to see if you qualify. We are anxious to offer reduced co-pays if you qualify.

Sunrise Clinics

Medical and Mental Health

Effective February 1, 2023

# in family	At or below 100% A		101% - 125% B		126% - 150% C		151% - 175% D		176% - 200% E		Over 200% F
(Collect Today)	No Fee		$1		$5		$8		$10		100% Pay
	From	To	From	To	From	To	From	To	From	To	Equal to or Greater Than
1	$0.00	$ 14,580	$ 14,581	$ 18,225	$ 18,226	$ 21,870	$ 21,871	$ 25,515	$ 25,516	$ 29,160	$ 29,161
2	$0.00	$ 19,720	$ 19,721	$ 24,650	$ 24,651	$ 29,580	$ 29,581	$ 34,510	$ 34,511	$ 39,440	$ 39,441
3	$0.00	$ 24,860	$ 24,861	$ 31,075	$ 31,076	$ 37,290	$ 37,291	$ 43,505	$ 43,506	$ 49,720	$ 49,721
4	$0.00	$ 30,000	$ 30,001	$ 37,500	$ 37,501	$ 45,000	$ 45,001	$ 52,500	$ 52,501	$ 60,000	$ 60,001
5	$0.00	$ 35,140	$ 35,141	$ 43,925	$ 43,926	$ 52,710	$ 52,711	$ 61,495	$ 61,496	$ 70,280	$ 70,281
6	$0.00	$ 40,280	$ 40,281	$ 50,350	$ 50,351	$ 60,420	$ 60,421	$ 70,490	$ 70,491	$ 80,560	$ 80,561
7	$0.00	$ 45,420	$ 45,421	$ 56,775	$ 56,776	$ 68,130	$ 68,131	$ 79,485	$ 79,486	$ 90,840	$ 90,841
8	$0.00	$ 50,560	$ 50,561	$ 63,200	$ 63,201	$ 75,840	$ 75,841	$ 88,480	$ 88,481	$ 101,120	$ 101,121
For each additional person add	$5,140		$6,425		$7,710		$8,995		$10,280		$10,280

Based on 2023 Federal Poverty Guidelines for Family Size and Income

To participate in this program, patients must provide current proof of income at time of service and upon request.

If patients do not have proof of income at time of service, it must be provided within 30 days or patient will be billed for full amount of service fees

To Participate in the program, patients must provide current proof of income at the time of service. If patients to not have proof of income at the time of service, it must be provided within 30 days, or the patient will be billed for the full amount of the service.

ACCEPTANCE OF SLIDING FEE DISCOUNT

☐ **YES** I would request to be considered for the Sliding Fee Discount. I will complete the Assessment Form & provide proof of income today, or within 30 days of service.

_____ _____ _____

Patient Name (Please Print) Signature of Patient or Guarantor Date

WAIVER OF SLIDING FEE DISCOUNT – do not sign below if you wish to be considered for a Sliding Fee Discount

☐ **NO** I choose not to complete the Sliding Fee Application at this time. I am waiving my right to any discount for which I may otherwise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

_____ _____ _____

Patient Name (Please Print) Signature of Patient or Guarantor Date

FAMILY (Helping you calculate how many family members in your family):

Relationship	Include	Do Not Include	Number
Yourself			1
Your spouse	Include if you are legally married, regardless of sex. Include if you are legally married but living apart (for example, spouse is away on military duty, away on work, or away for some reason other than legally separated or divorced).	Do not include if you are legally separated or divorced. You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.	
Child(ren)	Include number of tax dependent children. Include adopted and foster children, living with you that you can claim as a tax dependent. Include the number of children with whom you share custody if you can claim them as a tax dependent.	Do not include if a child is a non-dependent. Do not include if a child is unborn.	
Other dependents:	Include the number of parents you claim as tax dependents. Include the number of siblings and others who you claim as dependents.	Do not include unmarried domestic partner unless you have a child together or you will claim them as a tax dependent. Do not include roommates.	
TOTAL NUMBER OF PEOPLE SUPPORTED BY THE FAMILY INCOME ABOVE:			

List all household members below:

Name:	Date of Birth	Name:	Date of Birth
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

INCOME:

Income	Verification	Amount
Wages, salaries, tips, etc.	Two (2) recent pay stubs. Most recent Form 1040 Line 22 Most recent W2 Box 1 Most recent form 1099 (for self-employment, significant business expenses should be reported on a form 1040 Schedule C) Payroll & Earnings Verification Statement	
Alimony	Most recent month's check stubs	
Unemployment Compensation	Most recent month's check stub or itemized verification letter.	
Social Security Benefits	Most recent month's check stub or itemized verification letter.	
IRA or retirement plan distributions	Most recent month's check stub	
Interest, dividends, rental income	Most recent form 1040	
Bank Account Statement showing deposits from the most recent month		
Business income	Most recent form 1040	
Capital gains	Most recent form 1040	
Self-Declaration of Income (Migrant or Seasonal workers only)	Attached form or indicate verbally for recording	
Other		
	TOTAL FAMILY ANNUAL INCOME $	

Supporting documentation is required before Sliding Fee Scale Discount can be approved and approved discounts will be valid for twelve (12) months.

Certification:

I certify the following:

1. That my family size and income information listed are accurate.

2. I understand that I am required to provide documentation to verify my family's financial position before my discount can be approved. I agree to provide this information within thirty (30) calendar days of the date on this form.

3. I agree to update my application if my financial situation changes.

4. I will complete a new application each calendar year and no later than twelve (12) months from the date on this form.

5. Sunrise Clinics has provided me with information about the program and I agree to abide by the terms of the Sliding Fee Discount Program (SLDP).

6. I understand that the SLDP applies only to services provided by Sunrise Clinics and that services provided outside of Sunrise Clinics are not covered by the Sunrise Clinics SLDP. Examples of services not covered include, but are not limited to:
   a. Reference laboratory testing
   b. Drugs
   c. X-ray interpretation by a consulting radiologist

7. I understand that if I qualify for the sliding fee discount program, I will pay the lesser of the sliding fee discount or my insurance requirement for each of my appointments.

8. If an unpaid balance exists on my account, I will make payment arrangements and honor the terms of that arrangement. If I am unable to make a payment according to the terms, I will contact the Billing Office at 575-282-2455 before the due date of the payment to discuss my need to modify the payment arrangements.

9. If I am unable to make a payment, I will contact the Billing Office at 575-282-2455.

_____	_____	_____
Patient Name (Please Print)	Signature of Patient or Guarantor	Date

FOR OFFICE USE ONLY:

ANNUAL GROSS INCOME CALCULATOR: Income received (frequency):	PER PAY PERIOD	GROSS ANNUAL INCOME
A. Weekly (each week):	$_____x 52 =	$_____
B. Bi-Weekly (every two weeks):	$_____x 26 =	$_____
C. Semi-Monthly (twice a month):	$_____x 24 =	$_____
D. Monthly (each month):	$_____x 12 =	$_____

SUNRISE CLINICS FRONT OFFICE (PATIENT CARE COORDINATOR)

Documentation of Earnings Provided by the Patient: _____ _____
Date Name of Sunrise Employee

SUNRISE CLINICS BILLING OFFICE:

Application ____ Approved _____ _____
Date Name of Sunrise Employee

____ Incomplete

SUNRISE CLINICS FRONT OFFICE:

Patient to be notified by Sunrise Clinics Front Office using Phone or Email

Sunrise Clinics
Providing Exceptional Rural Healthcare

HOW WOULD YOUR FRIENDS OR FAMILY MANAGE YOUR HEALTHCARE IF YOU COULDN'T??

To our valued patients,

One of the greatest challenges for family members and Providers is what to do if a patient becomes too ill to authorize the next steps of their care. For that, we recommend that all our patients have an Advance Directive. This is a short legal document that can be used to guide your health care team and loved ones when they need to make these decisions or to decide who will make decisions for you when you can't.

We recommend that you consult with your attorney if you want them to make one for you. We also have sample Advance Directives at each of our Offices which you can complete today (we can help if you'd like), or take home, complete and return to us. .

This is super important stuff. It will allow your healthcare wishes to be carried out, even if you're too sick to request those and by someone you know and trust. 2023 would be a great year to get this done.

Ask our Front Desk Staff if you'd like a copy to review and/or complete.

Thanks,

Dr. James Gonzales
Chief Medical Officer

Dr. Randy Brown
Chief Executive Officer