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 page 4, 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 ☐ Native American ☐ 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.

Primary Insurarance Information	**Secondary Insurance Information**
Insurance Co: _____	Insurance Co: _____
Policy ID#: _____	Policy ID#: _____
Group #: _____	Group #: _____
Policyholder Name: _____	Policyholder Name: _____
Relationship: _____	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 pp 5-6

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.

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

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

THE FOLLOWING INDIVIDUALS HAVE AUTHORITY TO DISCUSS MY HEALTHCARE WITH MY PROVIDER

_____ **Relationship** _____ **Relationship** _____ **Relationship**

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 p 4

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:**

Sunrise Clinics offers healthcare to all, regardless of their ability to pay, or their race, ethnicity, religious affiliation or sexual orientation.

As a result, we are required to obtain the following information to comply with government regulations. This information is for statistical reporting purposes only. Your personal information will not be shared with anyone or any company. Completion of this section allows us to serve all members of our community with the professionalism and compassion we here at Sunrise Clinics, embrace.

Date of Birth _____

Birth Sex ☐ Male ☐ Female

Sexual Orientation
- ☐ Lesbian, Gay or Homosexual
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Do Not Know
- ☐ Choose not to Disclose
- ☐ Something else (please describe) _____

Gender Identity
- ☐ Male
- ☐ Female
- ☐ Female-to-male Transgender Male
- ☐ Male-to-Female Transgender Female
- ☐ Genderqueer - neither exlusively male or female
- ☐ Choose not to disclose
- ☐ Transgender
- ☐ Additional Gender Category or other, please specify _____

Do you want to apply for the Sliding Fee Copay Discount? ☐ Yes ☐ No

Are you a Veteran ☐ Yes ☐ No

Are you here Seasonally ☐ Yes ☐ No

Are you a Migrant Worker ☐ Yes ☐ No

Are you Homeless ☐ Yes *Circle One: Living on Street - Doubling Up - Transitional Housing Homeless Shelter- Permanent Supportive Housing - Other*

☐ No

Are you living in Public Housing ☐ Yes ☐ No

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to Specify

Race
- ☐ White (incl Hispanic/Latino & Anglo) ☐ African American
- ☐ Native American (incl Hawaiian) ☐ Asian
- ☐ Declined to identify

How Many Dependants do you Claim? _____

Gross Household Income per Year: $_____

Sunrise Clinics THANKS YOU for your honesty in providing these answers. It will help us help others in our Community

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Sliding Fee Discount Program Application

Applicant's Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip _____

Sunrise Clinics is committed to providing primary healthcare services to patients regardless of their ability to pay. Discounts are offered to members of households with a combined income of 200% and below the Federal Poverty Level. Please look at the chart below[1] to see if you qualify.

	A		B		C		D		E		F
Family Size	100% & Below		101% - 125%		126% - 150%		151% - 175%		176% - 200%		Above 200%
	No Fee		$1		$5		$8		$10		No Discount
	From	To	From	To	From	To	From	To	From	To	Equal to or Above
1	$-	$ 15,060	$ 15,061	$ 18,825	$ 18,826	$ 22,590	$ 22,591	$ 26,355	$ 26,356	$ 30,120	$ 30,121
2	$-	$ 20,440	$ 20,441	$ 25,550	$ 25,551	$ 30,660	$ 30,661	$ 35,770	$ 35,771	$ 40,880	$ 40,881
3	$-	$ 25,820	$ 25,821	$ 32,275	$ 32,276	$ 38,730	$ 38,731	$ 45,185	$ 45,186	$ 51,640	$ 51,641
4	$-	$ 31,200	$ 31,201	$ 39,000	$ 39,001	$ 46,800	$ 46,801	$ 54,600	$ 54,601	$ 62,400	$ 62,401
5	$-	$ 36,580	$ 36,581	$ 45,725	$ 45,726	$ 54,870	$ 54,871	$ 64,015	$ 64,016	$ 73,160	$ 73,161
6	$-	$ 41,960	$ 41,961	$ 52,450	$ 52,451	$ 62,940	$ 62,941	$ 73,430	$ 73,431	$ 83,920	$ 83,921
7	$-	$ 47,340	$ 47,341	$ 59,175	$ 59,176	$ 71,010	$ 71,011	$ 82,845	$ 82,846	$ 94,680	$ 94,681
8	$-	$ 52,720	$ 52,721	$ 65,900	$ 65,901	$ 79,080	$ 79,081	$ 92,260	$ 92,261	$ 105,440	$ 105,441
9	$-	$ 58,100	$ 58,101	$ 72,625	$ 72,626	$ 87,150	$ 87,151	$ 101,675	$ 101,676	$ 116,200	$ 116,201
10	$-	$ 63,480	$ 63,481	$ 79,350	$ 79,351	$ 95,220	$ 95,221	$ 111,090	$ 111,091	$ 126,960	$ 126,961

☐ **Yes**, I would like to be considered for the Sliding Fee Discount. I warrant that based on the chart above, based on family size and income, I quality for the following Discount: A B C D E

☐ **No**, I do not want to be considered for the Sliding Fee Discount. I understand that I will be responsible for full payment of all charges at the time of service.

Print Name: _____ Sign Name: _____ Date: _____

For Office Use Only

Applicant's Gross Income: _____ **Circle One:** Daily Weekly Bi-weekly Monthly Annually

Family Size: _____ **Proof of Income (Circle One):** Paystub or other documentation Self-Attestation

Proof of Income (Circle One): Paystub or other documentation Self-Attestation

[1] Based on 2024 Federal Poverty Guidelines for family size and income.

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 and 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 is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without 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 with the 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. Health Information Exchange. We may participate in one or more health information exchanges, or other health information registries ad may use and disclose your health information through these exchanges for certain purposes described in this notice. We may use a Health Information Exchange to obtain information for payment for the care you receive. We may also disclose or obtain your health information through a Health Information Exchange for quality assessment or improving health and reducing health care costs. We may disclose your health information to an electronic Health Information Registry to report certain diseases or for other public health purposes.

4. Uses and Disclosures with Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most 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.

5. 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 deny your request under limited circumstances, e.g., if we 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.

6. 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.

7.. 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.

8. 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: 572-472-4311

Address: Sunrise Clinics
CONFIDENTIAL: Chuck Brown, Clinics Manager
117 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