ADULT

piñon
Family Practice

REQUEST TO BECOME A NEW PATIENT

The physicians and staff at Piñon Family Practice believe that delivering the highest quality patient care is the most valuable service we provide. For this reason, we cannot accept all patients, as some require a level of care and time more extensive than provided through family medicine.

In order to be considered as a new patient, *we ask that you complete the attached forms and return them to our office. Once returned, the forms will be reviewed for completeness and then passed along to the provider of your choice,* if stated, or the next available physician. The forms will be reviewed by the provider to ensure that the level of care needed can be provided by our office. **Please note, this process can take 2-3 weeks.**

To ensure there is no delay on processing, please complete the new patient packet fully, including medical information, all medications (prescription, over the counter, home remedies, any other substances), and insurance information, including ID numbers. ***Please note: False information or withheld information requested in this new patient packet may results in immediate termination from our practice.***

When you arrive for your first appointment, please plan to *arrive at least 15 minutes early* so we can be sure all your information is correct and current. Furthermore, *it is important that you bring your insurance card, a photo ID, and a list of all medications and supplements you are taking.*

Please note, you must be seen by a provider of our practice before any prescription, lab orders, or diagnostic orders will be provided to you.

Finally, you are expected to *pay your co-pay at the time of service.*

If you have any questions regarding the forms or you need any further information, please contact our office at (505) 324-1000. Our staff is here to help.

Attachments:

- **Registration Form** (Please complete all information and sign where indicated).
- **Financial Policy** (This explains our policy regarding insurance payments along with patient responsibility after insurance payments have been received).
- **Medical History Form** (Please complete this to the best of your ability).
- **HIPAA Notice** (This is your privacy information notice).
- **Patient Rights and Responsibilities** (This is a description of expectations that we believe ensure a healthy relationship between patient and physician).
- **No Show Policy** (This explains our policy regarding termination should you fail to show for your appointment).
- **Medication Refill Policy** (This explains our policy regarding all refills on medications from our office.)

Dear Patient,

Completion of this packet is not a guarantee to be accepted and established with our practice.

As stated on the "Request to Become a New Patient" form, our office cannot accept all patients at this time, as some patients require a level of care and time more extensive than provided through family medicine.

Also, due to a decrease in availability of primary care providers within the community, our practice has been extremely overwhelmed with new patient requests and we are only accepting patients on a limited basis at this time.

We apologize for any inconvenience this may cause.

Pinon Family Practice

piñon Family Practice

ADULT

PATIENT REGISTRATION

(Please Print Clearly)

Patient's Information:

Patient LAST Name	Patient FIRST Name	M.I.	Social Security No.

P.O. Box or Street/Apt #	City	State	Zip Code

Date of Birth: _____ **E-Mail Address:** _____

Primary Phone #: _____ (Area Code) _____ (Telephone Number)

Secondary Phone #: _____ (Area Code) _____ (Telephone Number)

Sex:
- ☐ Female
- ☐ Male

Marital Status:
- ☐ Single ☐ Divorced ☐ Significant Other
- ☐ Married ☐ Widowed ☐ Life Partner

Race:
- ☐ White ☐ Indian/ Alaskan ☐ Asian
- ☐ Black ☐ Hispanic ☐ Other/ Mixed

Primary Care Provider:
- ☐ Abernethy MD ☐ Bliss MD ☐ Faherty MD
- ☐ Young MD ☐ Heidi CNP ☐ Megan CNP

☐ **SELF PAY- PLEASE CHECK BOX IF YOU DO NOT HAVE INSURANCE COVERAGE**

Insurance Information:

Policy Holder: _____ DOB: _____ SSN: _____

Insurance: ☐ BCBS ☐ WebTPA ☐ UHC ☐ Cigna ☐ Presbyterian ☐ Medicare:_____

☐ Aetna ☐ Tricare ☐ Friday ☐ HMA ☐ Other:_____ ☐ Medicaid: _____

Insurance ID #: _____ Group #:_____ Effective Date:_____

Secondary Insurance Information: IF NOT APPLICABLE, CHECK HERE: ☐

Policy Holder: _____ DOB: _____ SSN: _____

Insurance: ☐ BCBS ☐ WebTPA ☐ UHC ☐ Cigna ☐ Presbyterian ☐ Medicare:_____

☐ Aetna ☐ Tricare ☐ Friday ☐ HMA ☐ Other:_____ ☐ Medicaid: _____

Insurance ID #: _____ Group #:_____ Effective Date:_____

(Continued on next page)

Responsible Party (Guarantor) Information: NOTE: IF SAME AS PATIENT, CHECK HERE ☐

Last Name | First Name | M.I. | Social Security Number

Occupation/Employer Name/Telephone:

Occupation | Employer Name | Employer Phone Number

Emergency Contact (PLEASE PRINT CLEARLY):

Name | Phone No. | Relationship

Guarantor's Mailing Address:

P.O. Box or Street/Apt # | City | State | Zip Code

Date of Birth: _____

Primary Phone #: **Secondary Phone #:**

Area Code | Telephone Number | Area Code | Telephone Number

ACKNOWLEDGEMENT/AUTHORIZATION OF FINANCIAL RESPONSIBILITY:
I have read and agree to the Financial Policy as stated in the Financial Policy Statement. I hereby authorize payment directly to Piñon Family Practice of any medical benefits otherwise payable to me.

Signature (Patient or Responsible Party) | Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
I have received copies of Piñon Family Practice's "Notice of Privacy Practices."

Signature (Patient or Responsible Party) | Date

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Piñon Family Practice to release any information acquired in the course of my treatment that is necessary for the referral process and to process claims.

Signature (Patient or Responsible Party) | Date

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT'S RIGHTS AND RESPONSIBILITIES:
I have reviewed Piñon Family Practice's "Patient Rights and Responsibilites".

Signature (Patient or Responsible Party) | Date

Verified by/Entered by: _____/_____

Revised 06/2021

ADULT HISTORY FORM

12 YEARS AND OLDER TODAY'S DATE:_____

PATIENT NAME:_____ DOB:_____

SPOUSE'S NAME:_____ CHILDREN(S) NAME(S):_____

THIS FORM WILL BE A PERMANENT PART OF YOUR RECORD. PLEASE FILL OUT CLEARLY.

CURRENT/RECENT PRIMARY CARE PROVIDER:_____ **REASON FOR SEPARATION**_____

IS THERE A SPECIFIC REASON FOR VISIT OR MEDICATION YOU ARE NEEDING PRESCRIBED?_____

_____

ALLERGIES (Medication & Food): _____

MEDICATIONS: List medications you take, including all prescriptions, over-the-counter medications, herbs, substances, or remedies. (Please list everything you take regularly and/or occasionally.)

☐ **BY CHECKING THIS BOX, I CONFIRM THAT I AM NOT TAKING ANY MEDICATION TREATMENTS.**

Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____
Name:_____ Dosage:_____ How often:_____

***Please provide a separate list of medications if needed**

Past Medical History- Check if you now have, or have every had, any of the following **medical problems:**

☐ Arthritis	☐ Epilepsy	☐ Heart Disease	☐ Other:_____
☐ Asthma	☐ Gall Bladder Issues	☐ Hepatitis	☐ Other:_____
☐ Bronchitis	☐ Gout	☐ Kidney Stones	☐ Other:_____
☐ Cancer	☐ High Cholesterol	☐ Kidney Disease	☐ Other:_____
☐ Diabetes	☐ Hypertension	☐ Lung Disease	☐ Other:_____

HOSPITALIZATIONS/SURGERIES, SERIOUS INJURIES, MAJOR TREATMENTS/CHRONIC ILLNESS:

	YEAR:	REASON FOR TREATMENT/VISIT:	TREATMENT CLINIC/HOSP:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ADULT HISTORY FORM
CONTINUED

PATIENT NAME:_____ DOB:_____

SOCIAL HISTORY:

Have you ever smoked?	☐ YES	☐ NO	☐ QUIT	YEAR:_____	HOW OFTEN?_____/TIMES A DAY
Do you drink alcohol?	☐ YES	☐ NO	☐ QUIT	YEAR:_____	HOW OFTEN?_____/TIMES A DAY
Do you drink caffeine?	☐ YES	☐ NO	☐ QUIT	YEAR:_____	HOW OFTEN?_____/TIMES A DAY
Do you use smokeless tobacco?	☐ YES	☐ NO	☐ QUIT	YEAR:_____	HOW OFTEN?_____/TIMES A DAY
Do you use E-Cigarettes/Vape?	☐ YES	☐ NO	☐ QUIT	YEAR:_____	HOW OFTEN?_____/TIMES A DAY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED

OCCUPATION:_____ **YEARS EMPLOYED:**_____

RELIGION:_____

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO

FAMILY HEALTH HISTORY:

FATHER	☐ Good	☐ Poor	☐ Died	AGE:_____	CAUSE OF DEATH:_____
MOTHER	☐ Good	☐ Poor	☐ Died	AGE:_____	CAUSE OF DEATH:_____
SISTER/BROTHER	☐ Good	☐ Poor	☐ Died	AGE:_____	CAUSE OF DEATH:_____
SISTER/BROTHER	☐ Good	☐ Poor	☐ Died	AGE:_____	CAUSE OF DEATH:_____
SISTER/BROTHER	☐ Good	☐ Poor	☐ Died	AGE:_____	CAUSE OF DEATH:_____
SISTER/BROTHER	☐ Good	☐ Poor	☐ Died	AGE:_____	CAUSE OF DEATH:_____

DO YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING?

☐ Allergies	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Blood Disorder
☐ Cancer	☐ Diabetes	☐ Epilepsy	☐ Gall Stone	☐ Glaucoma
☐ Goug	☐ Hearing Loss	☐ Heart Disease	☐ Heart Murmur	☐ High Blood Pressure
☐ Infectious Disease	☐ Kidney Disease	☐ Lung Disease	☐ Mental Illness	☐ Migraine
☐ Nephritis	☐ Obesity	☐ Stroke	☐ Thyroid Disease	☐ Other_____

ANY OTHER CONCERNS YOU WOULD LIKE TO NOTE OR HAVE REVIEWED:

_____

_____

_____

_____

_____

_____

_____

piñon
Family Practice

2300 East 30th Street, Building C-2
Farmington, NM 87401
Phone 505.324.1000 ♦ Fax 505.324.1199

NO SHOW POLICY

We make it our mission to provide effective medical care to our patients. In doing so, we ask that you contact our office in the event that you will not make your scheduled appointment, as no-show appointments have a negative impact on patient care, productivity, and take potential availability away from patients in need of being seen by our practice.

New patients that fail to contact our office for cancellation before their first appointment will immediately be terminated from the practice.

Established patients that fail to contact our office for cancellation within 24 hours of their appointment will have their appointment marked as a "no-show". In the event that a patient has multiple "no-show" appointments and/or cancellations, the provider may choose to terminate you as a patient.

We understand at times there may be a situation outside of your control. Please contact the Clinic Manager with any special circumstances that resulted in your no-show.

Failure to agree and sign for these no-show terms will result in immediate termination from the Practice upon your first no-show.

Print Name of Patient	Date of Birth
Signature of Patient/Guardian	Date Signed

piñon
Family Practice

PATIENT RIGHTS AND RESPONSIBILITIES

This is an overview. It is not exhaustive. It may be modified or amended without notice. Rights and responsibilities will be applied without regard to: 1) sex; 2) cultural, economic, educational, or religious background; or 3) source of payment for care. All personnel will abide by and observe patient rights.

PATIENT RIGHTS:

Patients are entitled to:

- Receive considerate and respectful care.
- Know the name of the physician who has primary responsibility for coordinating care; know the names and professional relationships of other physicians and non-physicians who will see the patient.
- Receive information about a suspected of diagnosed illness, the course of treatment, and prospects for recovery in language that the patient can understand.
- Receive information about any proposed treatment or procedure in order to give or refuse consent; information will include a description of the treatment of procedure, medically significant risks, alternate course(s) of treatment including non-treatment and its associated risks.
- Participate actively in decisions regarding medical care; this includes the right to refuse treatment as permitted by law.
- Be assured of privacy regarding medical care; understand that discussion, consultation, examination, and treatment are confidential and will be managed according to HIPAA standards; the patient has the right to know the reason for any person's presence when the patient is being examined, treated or discussed.
- Be assured of privacy regarding all personal records and communication pertaining to the patient; know that written permission from the patient will be required before any medical records will be made available to anyone not directly concerned with the patient's care.
- Be advised if the patient's physician proposes to engage in or perform human experimentation affecting the patient's care or treatment with clear understanding that the patient has the right to refuse to participate in such research projects.
- Receive reasonable responses to reasonable requests for service.
- Leave the facility even against the advice of the patient's physician.

- Receive reasonable continuity of care, and know in advance the time and location of appointments along with the name of the physician who will provide medical care.

- Be informed by the physician of the physician's delegate, the details of continuing heath care associated with the patient's illness and/or recovery.

- Examine all bills and receive an explanation for any and all items regardless of the source of payment.

- Be assured that all patient's rights apply to the person who has legal responsibility for making decisions regarding medical care on behalf of the patient.

PATIENT RESPONSIBILITES:

In addition to rights, patients have responsibilities which, when followed, will ensure the most effective medical care possible. These responsibilities are founded in mutual trust and respect between patients and physicians- cornerstones that promote the best outcomes for all stakeholders.

Patients are responsible for:

- Providing accurate and complete information concerning present complaints, medical history, and other pertinent health matters.

- Asking questions, or restating information, in order to demonstrate comprehension of the course of medical treatment.

- Asking questions, or restating information, in order to establish clarity and comprehension of what is expected of the patient.

- Following the plan of treatment directed by the physician including compliance with instructions of nurses and other healthcare professionals as they carry out the physician's orders.

- Keeping appointments, and notifying Piñon Family Practice within 24 hours if the patient is unable to keep an appointment.

- Accepting consequences for refusing treatment or failing to follow the physician's instructions and orders.

- Providing insurance information that is current, correct and applicable.

- Ensuring that financial obligations for medical care are fulfilled promptly.

- Being considerate of the rights of other patients.

- Being respectful and considerate to all facility staff.

- Understanding personal insurance health plans.

FINANCIAL POLICY

To inform you of our financial policy and your financial responsibility, please review the sections below:

Patient Without Insurance (Private Pay)

Payment in full is expected at the time of each patient visit.

Patient With Insurance

You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by the insurance company. Co-payments and co-insurance amounts are expected at the time of service. Any remaining patient balance should be paid within 30 days of the first billing cycle after notification from the insurance company. If you or your insurance carrier makes payment exceeding your balance, a refund will be issued.

In-Network vs. Out-of-Network Coverage

It is your responsibility to confirm whether your insurance is considered in-network or out-of-network with Piñon Family Practice. All patients who have insurance coverage that is considered "out-of-network" will be responsible to pay the full balance of charges that your insurance does not cover.

Worker's Compensation

You may be covered by workers' compensation insurance if your injury is reported at work and verified with your employer. Piñon Family Practice is not currently accepting new patients for Worker's Compensation. Should you need care for an injury that occurred at work and you do not have a provider assigned for your care, please contact your employer for guidance.

Personal Injury (Third Party Liability)

If you are a personal injury patient, it is your responsibility to provide our office with the correct billing and insurance information. If we are unable to obtain payment the charges for the services rendered will become the responsibility of the patient.

Medicare

Our office will submit your charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, co-pays, and any non-covered services.

Medicaid/Centennial

Eligibility will be verified each visit. If we are unable to establish eligibility, the visit will be considered self-pay, and payment will be expected in full at the time of service. Should coverage be under Medicaid, but you fail to present coverage information to our office in a timely manner, the visit will be considered self-pay and payment will be expected in full at that time, in accordance with New Mexico Medicaid Program Rules.

All Accounts

NSF checks are collected through CBF Services.

Collections are processed through CBF Services. Patient balances over 90 days may be subject to collections. Repeated non-payment of an account may result in termination of the physician/patient relationship.

If the indebtedness guaranteed hereby is not paid and is placed in the hands of a third party for collection after default, the undersigned responsible party agrees to pay all costs of collection, including reasonable attorney fees.

Failure To Provide Coverage Information:

It is your responsibility to ensure Piñon Family Practice has up to date insurance coverage information. Should you fail to present the information at time of service and/or within the required timely filing limits, you will be responsible for all charges associated with your visit.

Please Note: Your provider may order laboratory tests and/or diagnostic testing not done in our facility. If any service is provided by another entity, you may be billed for those services. We will provide your insurance information to them and they will bill your insurance as contracts allow.

Piñon Family Practice

2300 East 30th Street, Building C-2

Farmington, NM 87401

Phone 505.324.1000 • Fax 505.324.1199

MEDICATION REFILL POLICY

It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to ***2 full business days***. If you use a mail order pharmacy, please contact us ***fourteen*** (14) ***days*** before your medication is due to run out.

Medication refills will only be addressed during regular office hours (Monday-Friday, 8:00am-5:00pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday, or Holidays.

Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills.

Patients requesting new prescriptions or antibiotics must schedule an appointment with a provider. New medications are not prescribed over the phone, as it generally requires an office visit.

Refills can only be authorized on medications prescribed by providers from our office. We ***WILL NOT*** refill medications prescribed by providers outside of Piñon Family Practice without an appointment.

Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider, and this process does not begin until after you have been prescribed your medication. Any prior authorizations required by our office will be processed as quickly as possible. Neither the pharmacy, nor the provider, can guarantee that your insurance company will approve the medication.

It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no-shows or cancelations may result in a ***denial*** of refills.

Our office may not process out of state refills if you have not had your required follow up appointment(s) within the last year.

If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact our office immediately.

_____ _____

Print Name of Patient Date of Birth

_____ _____

Signature of Patient/Guardian Date Signed

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights
Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Certain time restrictions and paperwork may apply.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by completing the "Request for Restrictions on Uses and Disclosures of PHI. This form can be obtained from the Piñon Family Practice front desk personnel.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing by completing the "Request for Confidential Communications of PHI".

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 by completing an "Accounting of Disclosures" form. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us.

3. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (505) 324-1000 for further information about the complaint process.

This notice was published and becomes effective on April 1, 2003.

NOTICE OF PRIVACY PRACTICES

Piñon Family Practice
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.

If you have any questions about this Notice please contact the Piñon Family Practice Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information by Piñon Family Practice
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your PHI that Piñon Family Practice is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI protected. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

***Healthcare Operations*:** We may use or disclose, as-needed, your PHI in order to support the business activities of Piñon Family Practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI 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. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.