PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

In the event that you have a medical or dental question after normal business hours, please call our nurse advice line:

Call 4 Health
THE COMPASSIONATE CALL CENTER

1-855-741-3400

If you are experiencing a behavioral health crisis, please call your location-specific crisis line listed below.

Alamogordo/Ruidoso	1-855-564-6253
Artesia	1-855-240-7774
Carlsbad	1-855-211-1196
Deming	1-855-282-3865
Farmington	1-855-785-1390
Grants/Gallup/Quemado/Thoreau	1-855-384-6884
Rio Rancho	1-855-517-0498
Santa Fe Community Guidance Center	1-855-223-7111
Santa Fe Family Wellness Center	1-855-416-4104
Socorro	1-855-207-1628
Torrance	1-855-817-5058
Totah	1-855-279-7507
Valley/Espanola Wellness Center	1-855-738-3680

If you do not reside in one of the areas listed above, please call the statewide behavioral health crisis line to talk to a licensed counselor:

1-855-NMCRISIS (662-7474)

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WELCOME and thank you for choosing the Presbyterian Medical Services (PMS) family of clinics. PMS is a community-based organization which strives to provide quality accessible, cost effective, and affordable health and human services to the multi-cultural people of the Southwest. Presbyterian Medical Services is a Health Center Program grantee under 42 U.S.C. 254b and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).

We accept Medicare, Medicaid, and most insurance plans. We have other financial options, including a sliding fee scale. For additional information, please refer to our financial responsibility form included in this packet, or speak with one of our Customer Access Representatives in our reception area.

For people without insurance coverage, we are able to offer assistance. Please inquire about receiving medications, medical, behavioral health and dental services from our clinic or patient assistance programs. Payment for services is required at the time of your visit.

Appointments are preferred, and often, we are able to get you an appointment on the same day as you call. We request that you notify us if you are unable to keep your appointment. In turn, we will attempt to call you to remind you the day before your appointment. Every effort will be made to accommodate walk-ins.

Our office hours are posted at the reception area in each clinic or can be found on our website.
We value you as a customer and look forward to working with you and your family in meeting your healthcare needs.

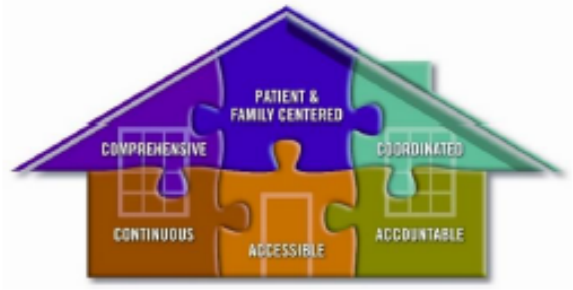
Thank you once again for selecting us as your healthcare provider.

Steven C. Hansen
CEO & President

PMS
PRESBYTERIAN MEDICAL SERVICES

Presbyterian Medical Services: Your Primary Care Medical Home

When you choose a PMS health center, you get more than a clinic--you get a Medical Home. A Primary Care Medical Home (PCMH) is a partnership between you and your primary care team. You are the center of this team! Through the Medical Home, our goal is to work with you to provide coordinated healthcare throughout your lifetime so that you will be as healthy as you can possibly be.



Your PCMH care team will:	We trust you to:
Provide team-based care led by your primary care provider (PCP).	Work with our clinic to select a PCP.
Work with you to improve your health.	Make sure your provider knows your entire health history and current concerns.
Review your medications with you and discuss any potential problems.	Tell your provider all of the medications, supplements and remedies you are taking.
Partner with you to develop a personal plan that you can use to reach good health and wellness.	Actively participate in planning your care and in self-management activities.
Reserve space within our schedule for same-day appointments.	Keep appointments as scheduled or call to reschedule or cancel as early as possible.
Inform you of test results in a timely manner.	Request that any other provider you see sends reports and results to PMS.
Speak with you clearly and in language you can understand.	Ask questions if something is not clear.
Connect you to other members of your care team and refer you to available community resources when needed.	Let us know how we are doing and how we can improve your care.
Collaborate with other care providers who you see for specialty care or second opinions.	Tell your PMS team about other health care professionals who care for you.

MISSION: Presbyterian Medical Services designs and delivers quality accessible integrated health, education, and human services in response to identified community needs of the multi-cultural people of the Southwest. VISION: We are the leaders in improving the health and lives of all people of the Southwest.

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

CLIENT CONSENT AND ACKNOWLEDGEMENT FORM

CONSENT TO EVALUATION AND SUBSEQUENT TREATMENT

I hereby consent to an evaluation and treatment by the clinical staff of Presbyterian Medical Services (PMS) and understand that an explanation of treatment will be provided.

_____ _____
Patient's Signature or Printed Name of Minor Date

_____ _____
Patient/Legal Guardian's Signature Date

_____ _____
Staff Signature Date

STATEMENT OF FINANCIAL RESPONSIBILITY

By signing where indicated below, I agree to assume responsibility for payment of all costs, charges and fees to PMS for services, medications, supplies and other items provided by PMS, which are not otherwise paid by third party payor programs in which I am enrolled, including, without limitation, co-pays and deductibles. I am also aware that insurance claims not paid in 90 days will become my responsibility. I authorize any third party to pay directly and solely to PMS any and all benefits due to me for services or items provided by PMS. I acknowledge that failure to provide PMS with the information necessary to bill any applicable third party payor will result in my being designated as financially responsible and all fees for services provided by PMS shall be due in full at time of service.

I further grant PMS permission to release/disclose any and all health records including alcohol and substance abuse records covered under 42 CFR, part 2 necessary for purposes of registration, determining eligibility, for coordination of care, and billing my insurance company or other third party payment programs in which I am enrolled, and release PMS and any related entities, employees and Directors from any and all liability related to or arising from any such release or disclosure. The information used for the above purposes will be kept strictly confidential in accordance with all federal and state confidentiality laws. I understand that I may revoke this consent at any time: however, if I revoke my signed consent I may no longer be eligible for coverage by my insurance company, or other third party payment programs.

_____ _____
Patient/Legal Guardian's Signature Date

ACKNOWLEDGEMENT OF RECEIPT

By signing below I acknowledge that I have received and had the opportunity to discuss with my provider, the following documents:

1) PM Notice of Privacy Practices; 2) PM policy/procedure on Reporting of Abuse, neglect and Exploitation; 3) PM Grievance procedure; 4) PMS Notice of Advanced Directives; and 5) Consumer Rights and Responsibilities.

_____ _____
Patient/Legal Guardian's Signature Date

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

Collection of Fees for Services Provided

PMS charges patients and clients for all services that we provide. PMS does offer financial options to you and your family.

Client Financial Options and Responsibilities

PMS will bill third parties for services. You are responsible for your co-pay and **other charges your insurance company requires you to pay**. This would include co-insurance and deductibles. If we do not take your insurance or your visit is not a covered benefit, you will be responsible for payment.

New Mexico Medicaid plans:

- We accept all New Mexico **Medicaid** plans.
- You will be responsible for payment of services that are not covered by your Medicaid plan.

Medicare:

- We accept most Medicare plans, as well as standard Medicare.

For further information call 1-800-Medicare or go to their website at www.medicare.gov

Private Pay

If you have no insurance or other coverage, you may be eligible for a discount. Eligibility for the sliding fee scale discount is based on family size and total household income.

To access this benefit, you must provide **proof of income.** Any **one** of the following is acceptable as proof of income:

- Paycheck Stub / Social Security Check Stub
- Most recent W-2 tax form (Gross income)
- Most recent Tax Return (Gross income)
- Letter from employer stating annual income
- Court document stating child support/alimony income
- Social Security award letter or benefit letter
- Statement from ISD stating income and level of support.
- Letter from responsible party providing Room and Board

Your sliding fee discount will applied upon receipt of this documentation and eligibility has been determined.

It is your responsibility to provide documentation and to update the information at least annually. Once family size and family income have been reported, the sliding fee scale will be used to determine the amount you owe.

All private pay clients are responsible for paying their bill at the time of service **including amounts remaining after a discount**. If you are unable to pay at the time of service, please ask to speak with someone in the billing office to make other payment arrangements.

Other Options

- Please ask about other programs available to assist with payment for services such as: County Health Funds, Payment for Breast and Cervical Cancer Screening and Family Planning. These will vary between programs.

- Assistance with medication through patient assistance programs.

You are responsible for paying your bill, including your deductible and co-pay, not covered by insurance, Medicare or Medicaid. In addition, payment is expected for all prescriptions at the time they are filled.

If you have any questions ask to speak to the billing/registration staff or call your clinic administrator.

Thank you for choosing PMS as your provider.

MRN: _____

Patient #_____

Sliding Fee Income Verification Form

Family Size	Income Above		Income At or Below	Income Above		Income At or Below	Income Above		Income At or Below	Income Above		Income At or Below	Income At or Above		
1	$0	-	$12,880	$12,881	-	$17,773	$17,774	-	$23,183	$23,184	-	$25,759	$25,760	-	OVER
2	$0	-	$17,420	$17,421	-	$24,039	$24,040	-	$31,355	$31,356	-	$34,839	$34,840	-	OVER
3	$0	-	$21,960	$21,961	-	$30,304	$30,305	-	$39,527	$39,528	-	$43,919	$43,920	-	OVER
4	$0	-	$26,500	$26,501	-	$36,569	$36,570	-	$47,699	$47,700	-	$52,999	$53,000	-	OVER
5	$0		$31,040	$31,041	-	$42,834	$42,835	-	$55,871	$55,872	-	$62,079	$62,080	-	OVER
6	$0	-	$35,580	$35,581	-	$49,099	$49,100	-	$64,043	$64,044	-	$71,159	$71,160	-	OVER
7	$0	-	$40,120	$40,121	-	$55,365	$55,366	-	$72,215	$72,216	-	$80,239	$80,240	-	OVER
Each Addit'l	$4,540			Each Addit'l		$ 6,265	Each Addit'l		$ 8,172	Each Addit'l		$ 9,080	Each Addit'l		

- **Family** is defined as a group of two people or more related by birth, marriage, or adoption and residing together in the same household (i.e., at the same physical address); all such people (including related subfamily members residing in the same household) are considered as members of one family.
- **Income** includes combined earnings of all family members, including wages, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) **do not** count as income.

List All Family Members living in your household:

_____

_____

Check the box that best matches your current situation:

□ I CERTIFY that the level of income specified represents the total income for my family for the past TWELVE MONTHs and I am applying for any applicable sliding fee discount for my entire family. For annual approval of a discount attached is proof of income. (e.g. current tax return, W-2, check stubs, or disability award, etc)

□ I CERTIFY that the level of income specified represents the total income for my family for the past TWELVE MONTHs and I am applying for any applicable sliding fee discount for my entire family. I DO NOT have my proof of income at this visit but will bring in my proof no later than _____, 2021/2022 to continue to receive any applicable discount.

□ I CERTIFY that I have not worked for the past _____ months and that my only means of support is: _____ _____ or I am working and receiving cash, but I have no documented proof of Income.

□ I have REFUSED to apply for and/or provide qualifying documentation for the Sliding Fee Discount. I understand I am responsible for paying my full balance at the time of service.

I declare the above information is true and have given Presbyterian Medical Services permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify Presbyterian at my next visit to the clinic

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Witness **Date**

100.017 Created 5/2012 Revised 03/15/2021

PLEASE PRINT Date: _____

NEW CLIENT REGISTRATION FORM

Patient Last Name:	**First Name:**	**Middle Initial:**
Social Security:	Birth Date: __/__/___	Sex: □ Male □ Female
Address:	City, State, Zip Code	
Mailing Address if different:	City, State, Zip Code	
Check preferred contact: □ No Phone:	□ **Cell Phone:**	□ **Home Phone:**
□ **Alternate Phone:**	Email address:	

Patient's Responsible Party Information Relationship to Patient □ Self □ Spouse □ Child □ Other _____

Last Name:	First Name:	Middle Initial:	Birth Date: __/__/___
Social Security:	Email address:		
Address:	City, State, Zip Code		
Mailing Address if different:	City, State, Zip Code		
Emergency Contact	**Phone Number ( )**		

For Patients Under 18		**Lives with**
Mother's Name	Day Phone ( )	□
Father's Name	Day Phone ( )	□
Guardian's Name	Day Phone ( )	□

What is Patient's Primary Language? □ English □ Navajo □ Spanish □ American Sign language □ Other _____

Are You Hearing Impaired? □ Yes □ No **Do you need an Interpreter**? □ Yes □ No

Marital Status: □ Single □ Married □ Life Partner □ Legally Separated □ Divorced □ Widowed □ Unknown

Student Status: □ Full Time □ Part Time □ n/ **Military Status**: □Veteran □Active Duty □ Branch_____ □ n/a

Migrant Worker Status: □ Migrant (work in agriculture seasonally and have temporary Home during this time)
□ Seasonal (work in Agriculture seasonally and DO NOT have a temporary home during this time)
□ Not a migrant or seasonal Farm Worker

Current Living Situation: □ Rent or own house/apartment □ Live with friends or Relatives/Family (doubling Up) □ Shelter
□ Live on the Street (Care, Park, Camp, Etc) □ Supportive, Public or Transitional Housing □ Other (includes Motel/hotel)

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino *Tribe:* Census # (IHS)

Race: □ American Indian/Alaskan Native □ native Hawaiian □ Asian □ Other Pacific Islander □ Black/African American
□ White □ More than one Race □ Decline to specify

PATIENT'S INSURANCE COVERAGE *** Please present Insurance Cards to Front Desk***

PRIMARY Insurance Name: _____ Insured Name: _____
Group Number: _____ Member/Id Number: _____ Member SSN: _____
Effective Date: _____ Date of Birth _____ Insured Sex: □ Male □ Female

SECONDARY Insurance Name: _____ Insured Name: _____
Group Number: _____ Member/Id Number: _____ Member SSN: _____
Effective Date: _____ Date of Birth _____ Insured Sex: □ Male □ Female

_____ _____
Patient/Legal Guardian's Signature Date

PLEASE PRINT Date:

Adult Patient History

Patient Name:	Occupation	Birth Date: __/__/___
Education (# of Years completed)	Do you have any financial concerns about your healthcare? □ Yes □ No	
Religion/Cultural Concerns that will effect your healthcare? □ No □ Yes explain: _____		
Do you have a Living Will? □ Yes □ No	Do you have written Advance Directives? □ Yes □ No	
Gender: □ Female □ Male □ Transgender □ Female to Male □ Male to Female □ Other_____		
Sexual Orientation Identity: □ Bisexual □ Gay □ Heterosexual/Straight □ Lesbian □ Questioning □ Not Sure □ Don't Know □ Other		
Do you need any information about safer sex techniques? □ No □ Yes with: □ Men □ Women □ Both		

ADVERSE REACTIONS

	Reaction:	Foods (please Specify)	Reaction:
□ Iodine/ Shellfish		□ Nuts	
□ Latex		□	
□ Bee sting/Insect Bite		□	
□ Adhesive Tape		□	

Drugs (please Specify)	Reaction:	Other (please Specify)	Reaction:
□		□	
□		□	
□		□	
□		□	

CURRENT MEDICATIONS

Please include Over the counter and herbal Medications taken regularly

□	□	□	□
□	□	□	□
□	□	□	□

IMMUNIZATIONS

*Please indicate date of last injection

□ Flu	□ Diphtheria	□ Tetanus
□ Pneumonia	□ Hepatitis B	□ Chicken Pox
□ MMR	□ Hepatitis A	
□ TB Test	□ Pertussis	

OTHER DOCTORS

*Please list all other doctors that you are currently seeing

Name/ Specialty	Reason
□	
□	
□	
□	
□	

HOSPITALIZATIONS , SURGERIES, OR PROCEDURES

Reason/Date

□ _____ □ _____

□ _____ □ _____

□ □

FUNCTIONAL ASSESSMENT

What is the easiest way for you to learn new things? □ Reading □ Listening □ Pictures □ Demonstration □ Video

Do You have any difficulty with reading or writing? □ No □ Yes explain: _____

Do you have any problems with: □ Vision □ Hearing □ Speech □ Walking □ lifting

Are you experiencing any stress/stressful situations? □ No □ Yes explain: _____

Have you experienced any traumatic or abusive situations? □ No □ Yes explain: _____

Do you live alone? □ No □ Yes If you have a Caregiver what is their name? _____

NUTRITIONAL ASSESSMENT

Without trying, have you gained/lost 10 pounds or more in the last six months □ No □ Yes

Are you Worried about a possible eating disorder? □ No □ Yes

Are you having problems with your teeth or gums? □ No □ Yes

Are you having difficulty swallowing? □ No □ Yes

Are you having difficulty chewing? □ No □ Yes

HEALTHY HABITS AND LIFESTYLE

□ Alcohol □ Yes □ No Type_____ □ Daily □ Weekly □ Social Date Quit_____

□ Coffee or other Caffeinated Drinks □ No □ Yes How Many per Day _____

□ Smoke □ No □ Yes No of Packs daily _____ Date Quit _____

□ Recreational/Street Drug use □ No □ Yes Type _____ Date Quit _____

□ Exercise □ No □ Yes How Often _____ Type: _____

□ Bike/Motorcycle Helmet? □Yes □ No

□ Do you feel safe at home?

□ Do you require help with activities at home? □ Yes □ No

□ Seatbelts □ Yes □ No

□ Sexually Active □ Yes □ No

□ Practice Safe Sex □ Yes □ No

□ Glasses/Contacts □ Yes □ No

□ HIV Risk/Exposure □ Yes □ No

□ Date of last physical exam _____

□ Date of last dental exam _____

□ Date of last vision exam _____

□ Date of last hearing exam _____

□ Date of last bone density exam _____

□ Date of last foot exam(if Diabetic) _____

MEN ONLY

□ Date of last Prostate exam: _____

□ Date of last PSA: _____

□ Monthly Testicular Self Exam □ Yes □ No

□ Vasectomy □ No □ Yes Date: _____

WOMEN ONLY

□ Last menstrual Period: _____

□ Age at onset: _____ □ Regular □ Irregular

Flow: □ Heavy □ Moderate □ Light

Pain/Cramps with menses: □ Yes □ No

Days of Flow: _____

Last Pap smear: _____

Last Mammogram_____

Monthly self breast exam: □ Yes □ No

Flushing/Menopause □ Yes □ No

Pregnant □ Yes □ No

Planning Pregnancy □ Yes □ No

Number of Pregnancies: _____

Number of Live births: _____

Number of miscarriages: _____

Birth control method: _____

PAST MEDICAL HISTORY

* Please check all that apply

AIDS/HIV	□ No □ Self □ Mother □ Father □ Other _____
Alcoholism	□ No □ Self □ Mother □ Father □ Other _____
Allergies	□ No □ Self □ Mother □ Father □ Other _____
Alzheimer's Disease	□ No □ Self □ Mother □ Father □ Other _____
Anxiety	□ No □ Self □ Mother □ Father □ Other _____
Arthritis	□ No □ Self □ Mother □ Father □ Other _____
Asthma	□ No □ Self □ Mother □ Father □ Other _____
Bleeding Disorders	□ No □ Self □ Mother □ Father □ Other _____
Bronchitis	□ No □ Self □ Mother □ Father □ Other _____
Cancer (Type_____)	□ No □ Self □ Mother □ Father □ Other _____
Cataracts	□ No □ Self □ Mother □ Father □ Other _____
Chicken Pox	□ No □ Self □ Mother □ Father □ Other _____
Congestive Heart Failure	□ No □ Self □ Mother □ Father □ Other _____
Depression	□ No □ Self □ Mother □ Father □ Other _____
Diabetes	□ No □ Self □ Mother □ Father □ Other _____
Drug Addiction	□ No □ Self □ Mother □ Father □ Other _____
Eating Disorder	□ No □ Self □ Mother □ Father □ Other _____
Epilepsy	□ No □ Self □ Mother □ Father □ Other _____
Glaucoma	□ No □ Self □ Mother □ Father □ Other _____
Gout	□ No □ Self □ Mother □ Father □ Other _____
Heart Attack	□ No □ Self □ Mother □ Father □ Other _____
Hepatitis □ A □ B □ C	□ No □ Self □ Mother □ Father □ Other _____
Hernia	□ No □ Self □ Mother □ Father □ Other _____
Herpes	□ No □ Self □ Mother □ Father □ Other _____
High Blood Pressure	□ No □ Self □ Mother □ Father □ Other _____
High Cholesterol	□ No □ Self □ Mother □ Father □ Other _____
Kidney Disease	□ No □ Self □ Mother □ Father □ Other _____
Liver Disease	□ No □ Self □ Mother □ Father □ Other _____
Lung Disease	□ No □ Self □ Mother □ Father □ Other _____
Measles	□ No □ Self □ Mother □ Father □ Other _____
Menstrual Dysfunction	□ No □ Self □ Mother □ Father □ Other _____
Mental Illness	□ No □ Self □ Mother □ Father □ Other _____
Mumps	□ No □ Self □ Mother □ Father □ Other _____
Neurological Disorder	□ No □ Self □ Mother □ Father □ Other _____
Osteoporosis	□ No □ Self □ Mother □ Father □ Other _____
Pacemaker	□ No □ Self □ Mother □ Father □ Other _____
Prostate Disease	□ No □ Self □ Mother □ Father □ Other _____
Seizures	□ No □ Self □ Mother □ Father □ Other _____
Stroke	□ No □ Self □ Mother □ Father □ Other _____
Suicide Attempt	□ No □ Self □ Mother □ Father □ Other _____
Tuberculosis	□ No □ Self □ Mother □ Father □ Other _____
Thyroid Disease	□ No □ Self □ Mother □ Father □ Other _____
Ulcers	□ No □ Self □ Mother □ Father □ Other _____
Venereal Disease	□ No □ Self □ Mother □ Father □ Other _____
Other: _____	□ No □ Self □ Mother □ Father □ Other _____

_____ _____

Patient/Legal Guardian's Signature Date

PLEASE PRINT Date: _____

Child Patient History (0-17 Years)

Patient Name: | Form Completed by: | Birth Date: __/__/___

Child's Gender: □ Female □ Male □ Transgender □ Female to Male □ Male to Female □ Other_____

Child's Sexual Orientation: □ Bisexual □ Gay □ Heterosexual/Straight □ Lesbian □ Questioning □ Not Sure □ Don't Know □ Other

Does your child need any information about safer sex techniques? □ No □ Yes with: □ Men □ Women □ Both

HOUSEHOLD

please list all those living in child's home

Name	Relationship to Child	Birth Date	Any Health Problems

I name of Siblings **not** living in Child's home

Name	Relationship to Child	Birth Date	Any Health Problems

If mother and/or father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does the child see the parent/parents not in the home?

BIRTH HISTORY

Birth Weight _____ Delivered □ Vaginally □ Cesarean
Was the child born at term? □ Yes □ No If Cesarean, why?_____
If early, how many weeks gestation? _____
Did the child have any problems right after birth? □ No □ Yes Explain _____
Did the mother have any illness or problem with her pregnancy? □ No □ Yes Explain _____
Was Initial feeding □ Breast □ Bottle □ Both
During Pregnancy did mother smoke? □ No □ Yes How many packs per day? _____
During Pregnancy did mother drink alcohol? □ No □ Yes type: _____ □ Daily □ weekly □ socially
During Pregnancy did mother use Recreational/street drugs? □ No □ Yes type: _____ □ Daily □ weekly □ socially
Did baby go home with mother from the hospital? □ Yes □ No Explain _____

CURRENT MEDICATIONS

Please include Over the counter and herbal Medications taken regularly by your child

□ _____	□ _____	□ _____	□ _____
□ _____	□ _____	□ _____	□ _____
□ _____	□ _____	□ _____	□ _____

IMMUNIZATIONS

*Please indicate date of last injection

□ Flu	□ Diphtheria	□ Tetanus
□ Pneumonia	□ Hepatitis B	□ Chicken Pox
□ MMR	□ Hepatitis A	
□ TB Test	□ Pertussis	

OTHER DOCTORS

*Please list all other doctors that your child are currently seeing

Name/ Specialty	Reason
□	
□	
□	
□	
□	

HOSPITALIZATIONS , SURGERIES, OR PROCEDURES

Reason/Date

□	□
□	□
□	□

FUNCTIONAL ASSESSMENT

What is the easiest way for your child to learn new things? □ Reading □ Listening □ Pictures □ Demonstration □ Video
Does your child have any problems with: □ Vision □ Hearing □ Speech □ Walking □ lifting
Is your child experiencing any stress/stressful situations? □ No □ Yes explain: _____
Has your child experienced any traumatic or abusive situations? □ No □ Yes explain: _____

NUTRITIONAL ASSESSMENT

Without trying, has your child gained/lost 10 pounds or more in the last six months □ No □ Yes
Are you worried about a possible eating disorder? □ No □ Yes
Are you having problems with your child's teeth or gums? □ No □ Yes

ADVERSE REACTIONS

	Reaction:	Foods (please Specify)	Reaction:
□ Iodine/ Shellfish		□ Nuts	
□ Latex		□	
□ Bee sting/Insect Bite		□	
□ Adhesive Tape		□	

Drugs (please Specify)	Reaction:	Other (please Specify)	Reaction:
□		□	
□		□	
□		□	
□		□	

GENERAL HEALTH

Do you consider your child to be in good health? □ Yes □ No Explain _____
Has your child had serous injury or accidents? □ No □ Yes Explain _____

□ Date of last physical exam _____
□ Date of last dental exam _____
□ Date of last vision exam _____

DEVELOPMENT

Are you concerned about your child's physical development? □ No □ Yes Explain _____
Are you concerned about your child's mental or emotional development? □ No □ Yes Explain _____
Are you concerned with your child's attention span? □ No □ Yes Explain _____
If your child in school
How is his or her behavior in school? _____
Has your child failed or repeated a grade? _____
How is the child doing in academic subjects? _____
Is he or she in special education or resource classes? _____

PAST MEDICAL HISTORY

* Please check all that apply to your child

AIDS/HIV	□ No □ child □ Mother □ Father □ Other _____
Alcoholism	□ No □ child □ Mother □ Father □ Other _____
Allergies	□ No □ child □ Mother □ Father □ Other _____
Alzheimer's Disease	□ No □ child □ Mother □ Father □ Other _____
Anxiety	□ No □ child □ Mother □ Father □ Other _____
Arthritis	□ No □ child □ Mother □ Father □ Other _____
Asthma	□ No □ child □ Mother □ Father □ Other _____
Bleeding Disorders	□ No □ child □ Mother □ Father □ Other _____
Bronchitis	□ No □ child □ Mother □ Father □ Other _____
Cancer (Type_____)	□ No □ child □ Mother □ Father □ Other _____
Cataracts	□ No □ child □ Mother □ Father □ Other _____
Chicken Pox	□ No □ child □ Mother □ Father □ Other _____
Congestive Heart Failure	□ No □ child □ Mother □ Father □ Other _____
Depression	□ No □ child □ Mother □ Father □ Other _____
Diabetes	□ No □ child □ Mother □ Father □ Other _____
Drug Addiction	□ No □ child □ Mother □ Father □ Other _____
Eating Disorder	□ No □ child □ Mother □ Father □ Other _____
Epilepsy	□ No □ child □ Mother □ Father □ Other _____
Glaucoma	□ No □ child □ Mother □ Father □ Other _____
Gout	□ No □ child □ Mother □ Father □ Other _____
Heart Attack	□ No □ child □ Mother □ Father □ Other _____
Hepatitis □ A □ B □ C	□ No □ child □ Mother □ Father □ Other _____
Hernia	□ No □ child □ Mother □ Father □ Other _____
Herpes	□ No □ child □ Mother □ Father □ Other _____
High Blood Pressure	□ No □ child □ Mother □ Father □ Other _____
High Cholesterol	□ No □ child □ Mother □ Father □ Other _____
Kidney Disease	□ No □ child □ Mother □ Father □ Other _____
Liver Disease	□ No □ child □ Mother □ Father □ Other _____
Lung Disease	□ No □ child □ Mother □ Father □ Other _____
Measles	□ No □ child □ Mother □ Father □ Other _____
Menstrual Dysfunction	□ No □ child □ Mother □ Father □ Other _____
Mental Illness	□ No □ child □ Mother □ Father □ Other _____
Mumps	□ No □ child □ Mother □ Father □ Other _____
Neurological Disorder	□ No □ child □ Mother □ Father □ Other _____
Osteoporosis	□ No □ child □ Mother □ Father □ Other _____
Pacemaker	□ No □ child □ Mother □ Father □ Other _____
Prostate Disease	□ No □ child □ Mother □ Father □ Other _____
Seizures	□ No □ child □ Mother □ Father □ Other _____
Stroke	□ No □ child □ Mother □ Father □ Other _____
Suicide Attempt	□ No □ child □ Mother □ Father □ Other _____
Tuberculosis	□ No □ child □ Mother □ Father □ Other _____
Thyroid Disease	□ No □ child □ Mother □ Father □ Other _____
Ulcers	□ No □ child □ Mother □ Father □ Other _____
Venereal Disease	□ No □ child □ Mother □ Father □ Other _____
Other: _____	□ No □ child □ Mother □ Father □ Other _____

_____ _____

Patient/Legal Guardian's Signature Date

PLEASE PRINT Date: _____

Medical History for Dental Services

Patient Name:	Occupation	Birth Date: __/__/___
Education (# of Years completed)	Do you have any financial concerns about your healthcare? □ Yes □ No	
Religion/Cultural Concerns that will effect your healthcare? □ No □ Yes explain: _____		
Do you have a Living Will? □ Yes □ No	Do you have written Advance Directives? □ Yes □ No	
Gender: □ Female □ Male □ Transgender □ Female to Male □ Male to Female □ Other_____		

ADVERSE REACTIONS

	Reaction:	Drugs cont	Reaction:
□ Latex		□ Novacaine, Xylocaine	
□ Metals		□ Valium	
□ Aspirin		□	
□ Percodan		□	
	Reaction:	**Other (please Specify)**	**Reaction:**
□ Penicillin		□	
□ Erythromycin		□	
□ Sulfa		□	
□ Tylenol, Ibuprofen,		□	

CURRENT MEDICATIONS

Please include Over the counter and herbal Medications taken regularly

□	□	□	□
□	□	□	□
□	□	□	□

HEALTHY HABITS AND LIFESTYLE

□ Alcohol □ Yes □ No Type_____ □ Daily □ Weekly □ Social Date Quit_____ □ Glasses/Contacts □ Yes □ No

□ Coffee or other Caffeinated Drinks □ No □ Yes How Many per Day _____ □ HIV Risk/Exposure □ Yes □ No

□ Smoke □ No □ Yes No of Packs daily _____ Date Quit _____

□ Recreational/Street Drug use □ No □ Yes Type _____ Date Quit _____

HOSPITALIZATIONS , SURGERIES, OR PROCEDURES

Reason/Date

□	□
□	□
□	□

CURRENT MEDICAL STATUS

□Are You Presently Ill or under the care of a physician? □ No □ Yes explain: _____

□ If in pain, describe you pain on a scale of 0 (no pain) to 10 (extremely intense pain)

Circle One **0 1 2 3 4 5 6 7 8 9 10**

□Are you now or have you ever taken intravenous chemotherapy for Cancer with drugs such as Aredia, Zometa, Bonefos, or have you ever received an intravenous infusion of the drug Reclast to prevent Osteoporosis?

□ No □ Yes explain: _____

□Have you ever have any excessive bleeding requiring special treatment? □ No □ Yes explain: _____

□ Have you ever been advised to take antibiotics prior to a dental appointment? □ No □ Yes explain: _____

WOMEN ONLY

□ Are you pregnant now? □ Yes □ No
□ Are you nursing a child? □ Yes □ No

PAST MEDICAL HISTORY

* Please check all that apply

AIDS/HIV	□ No □ Yes explain: _____
Alcoholism	□ No □ Yes explain: _____
Allergies/Sinus Troubles	□ No □ Yes explain: _____
Anemia	□ No □ Yes explain: _____
Anxiety	□ No □ Yes explain: _____
Artificial Joints	□ No □ Yes explain: _____
Asthma	□ No □ Yes explain: _____
Bleeding Disorders	□ No □ Yes explain: _____
Blood Transfusion	□ No □ Yes explain: _____
Cancer (Type_____)	□ No □ Yes explain: _____
Chemotherapy	□ No □ Yes explain: _____
Congestive Heart Failure	□ No □ Yes explain: _____
Developmental Delays	□ No □ Yes explain: _____
Diabetes	□ No □ Yes explain: _____
Drug Addiction	□ No □ Yes explain: _____
Epilepsy	□ No □ Yes explain: _____
Glaucoma	□ No □ Yes explain: _____
Hepatitis □ A □ B □ C	□ No □ Yes explain: _____
High Blood Pressure	□ No □ Yes explain: _____
Liver Disease	□ No □ Yes explain: _____
Osteoporosis	□ No □ Yes explain: _____
Pacemaker	□ No □ Yes explain: _____
Radiation Treatments	□ No □ Yes explain: _____
Seizures	□ No □ Yes explain: _____
Stroke	□ No □ Yes explain: _____
Tuberculosis	□ No □ Yes explain: _____
Thyroid Disease	□ No □ Yes explain: _____
Other: _____	□ No □ Yes explain: _____

_____ _____

Patient/Legal Guardian's Signature Date

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

Consumer Rights and Responsibilities

Consumers have rights and responsibilities for their care.

Consumer Rights

Presbyterian Medical Services (PMS) believes consumers or their legal guardians have the right to:

1. Be treated fairly, with dignity, and with respect for their right to privacy.
2. To receive all health care services in a caring, non-judgmental way.
3. For those with communication-related disabilities receive any information in a format that meets your needs.
4. Get services in a way that respects your culture, including having an interpreter if you do not speak English.
5. Take part in making all health care decisions. This includes making treatment plans. You also have the right to refuse treatment.
6. Decide on treatment after being informed of your options.
7. Choose someone to help with care choices.
8. Make a complaint about your care or decisions about your care you are receiving without worrying about retaliation.
9. Make wishes known through advance directives, a legal document allowing you to direct your care if you cannot make or communicate decisions about your care or choose people you do or do not want to make choices on your behalf if you are ill.
10. Have access to medical records based on federal and New Mexico laws and rules, and to restrict access to the records based on those laws and rules.
11. Get information about PMS:
    - Its services.
    - How to access services.
    - Other information to help with your PMS health care needs.
12. Be free from unlawful restraint or seclusion based on New Mexico and Federal law.

Consumer Responsibilities

PMS asks that every consumer or their legal guardian has the responsibility to:

1. To treat service providers with dignity and respect.
2. Provide, when able, clearly your information that PMS providers need to serve you.
3. Understand your health issues and take part in planning treatment goals.
4. Follow the plans for care that you have agreed on.
5. Let provider know if changes to your care are needed.
6. To notify provider if medications change by another practitioner.
7. To receive a medication refill, call 1 week prior to running out and expect up to 3-business days after request is made.
8. Make sure PMS has your current contact information so we can reach you if necessary.
9. To provide a safe environment for care to be provided when such care is being provided in your provide home.
10. To attend appointments sober.
11. No weapons are allowed on the premises.eep, change or cancel appointments instead of not showing up.

PMS
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Our purpose is you.

Advance Directives

In New Mexico, the Uniform Health-Care Decisions Act enables an individual to prepare an Advance Health-Care Directive, which is a written document that lets you give instructions about your own health care and/or name someone else (an agent) to make health care decisions for you if you become unable to make your own decisions. You have to be 18 or older to create an advance directive.

The Mental Health Care Treatment Decisions Act is the New Mexico law that allows written instructions for psychiatric treatment if you are unable to make or communicate your instructions. In New Mexico, "an advance directive for mental health treatment" is called a **PAD** or Psychiatric Advance Directive.

These documents are called Advance Directives because they are filled out by you and signed in advance so that in the future, your doctor and other health care providers know what your wishes are concerning medical or psychiatric treatment. Advance directives only take effect when you can no longer make your own health care decisions. As long as you are able to make your own decisions and give informed consent for your own care, your health care providers will rely on YOU and NOT your advance directives.

Before making this decision or writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends and other appropriate people such as someone at your church or your lawyer.

ADVANCE DIRECTIVE IS OPTIONAL It is entirely up to you whether you want to prepare an Advance Directive, but if questions arise about the kind of medical or psychiatric treatment that you want or do not want, they will help solve these important issues. If you have not completed an Advanced Directive or told your doctor whom you want to make your health care decisions, New Mexico law allows these people, in the following order, to make your health care decisions (if these people are reasonably available):

1. spouse
2. significant other
3. adult child
4. parent
5. adult brother or sister
6. grandparent
7. close friend

New Mexico does not require you to fill out a specific Advance Directive form, you may write out your wishes. However, it does requires three things: 1) you must sign the Advanced Directive, 2) a **PAD** must be witnessed and if you wish, have it notarized, and 3) if you appoint an agent have the agent sign that he or she is accepting the appointment. That may be done on a separate piece of paper, but it may be helpful to have the acceptance a part of your Advanced Directive.

We have some samples available of Advanced Directive forms. If you are interested please ask your doctor or provider for a copy. You have the right to revoke (cancel) or replace an Advanced Directive at any time. If you complete an Advanced Directive, give copies of the signed form to your health care providers and institutions, any health care agents you name, and your family and friends.

Any complaints concerning noncompliance with Advance Directive requirements may be directed to the Presbyterian Medical Services Quality Management Department, and /or the state survey and certification agency, the New Mexico Department of Health.

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

RESPONDING TO YOUR NEEDS AND CONCERNS

All individuals interacting with Presbyterian Medical Services (PMS) are treated with dignity, care, and respect. PMS does not discriminate on the basis of race, color, national origin, sex, age, or disability. PMS recognizes and observes the rights of clients/patients, families/guardians, and residents or visitors to provide compliments or grievances about conditions, treatments, or actions with which they are satisfied or dissatisfied. PMS also recognizes that compliments and grievances serve as a source of information for validating and improving processes. We are focused on continually improving patient safety and quality of care.

If you would like to share a compliment, grievance, quality or safety concern related to your care, services or safety, please follow these steps:

Step 1: If you have a concern, please feel free to discuss it with the Site Administrator. Should you feel your concern has not been adequately addressed, please contact the PMS Compliance Department at:

Mail: PMS Compliance Department
Presbyterian Medical Services
1422 Paseo de Peralta
Santa Fe, NM 87501
Phone: 1-800-477-7633, or (505) 982-5565
Fax: (505) 992-4990

Step 2: If a satisfactory solution is not reached, you may utilize the PMS Grievance Procedure as follows:

1. Discuss your grievance with the Site Administrator.
2. The Administrator will document the details of the grievance and witnesses (if any) will be noted.
3. Within ten (10) working days the Administrator will conduct an investigation on the grievance resulting in a resolution decision.
4. Within five (5) working days of the completion of the investigation you will be notified of the resolution decision.
5. If the resolution decision is not satisfactory to you, you may submit a written request, which should include your name and address, for review by a Grievance Committee within thirty (30) working days.
6. The Grievance Committee will review the case and give a final written decision to you and the Administrator. The decision is final and binding.

Additional Options:

As a Joint Commission accredited organization, PMS has demonstrated that it meets the nation's highest standards for healthcare. If you have a concern about your care you may contact the Joint Commission at 800-994-6610. They can only evaluate complaint information as it relates to their accreditation standards: they do not resolve individual complaints or disputed matters.

This procedure does not prevent you from filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: *https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf* or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201 or phone 1-877-696-6775.

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

Notice of PMS Policies and Procedures on

Reporting of Abuse, Neglect, and Misappropriation of Property

THIS NOTICE DESCRIBES HOW PMS REPORTS ABUSE, NEGLECT OR EXPLOITATION ITS CONSUMERS AND HOW YOU CAN REPORT SUSPECTED ABUSE, NEGLECT AND EXPLOITATION.

Protection against Abuse, neglect and Misappropriation of Property: It is the policy of Presbyterian Medical Services to prohibit the use of physical, verbal, sexual or psychological abuse, neglect and exploitation. To protect the rights of consumers, Presbyterian medical Services complies with state laws, regulations and guidelines on ensuring safety and the reporting of abuse, neglect, exploitation and misappropriation of property.

Purpose of Notice: This notice describes how PMS reports abuse, neglect, exploitation and misappropriation of property of its consumers as required by New Mexico State Law.

Our Duties: All PMS licensed health care facilities and community based services providers are required by law to:

- Report all incidents of suspected abuse, neglect and misappropriation of property immediately to Adult Protective Services or Child Protective Services' Statewide Central Intake (SCI)
- Incidents of suspected abuse, neglect and exploitation which involve a PMS licensed health care facility of PMS Community Based Services site are to be reported to the Department of Health's Division of Health Improvement (DOH/DHI) within 24 hours of knowledge of the incident and documented utilizing the Department of Health's Incident Report Form.
- In addition to the above listed practices, all community based service providers must complete the following within 24 hours or the following business day:
    - Notify the consumer's case manager that an incident has occurred and has been report to DOH/DHI
    - Notify the parent(s) or legal guardian(s) of minor consumers of any reportable of any reportable incidents, unless the parent(s) or legal guardian(s) are suspected of the alleged abuse, neglect or exploitation
    - If PMS is not the responsible provider of the consumers, the site must notify the responsible provider that an incident has occurred and has been reported

Your Rights: If you wish to report abuse, neglect or exploitation, you may contact the DOH/DHI directly, or you may access the PMS reporting process.

Reports made directly to DOH/DHI can be made by telephone, written correspondence or through other forms of communication utilizing the DOH/DHI Incident Report Form. Access to the DOH/DHI Incident Report Form and instructions for its completion are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained by calling the Department's toll free at (800) 445-6242.

To make a report to DOH/DHI through PMS please contact the administrator of the PMS site at which you receive care or services, or contact the PMS Director of Corporate Compliance at (800)477-7633 or (505)982-5565.

Questions?: If you have any questions about this Notice or need additional information, please contact our Director of Corporate Compliance at (800)477-7633 or (505)982-5565.

PMS
PRESBYTERIAN MEDICAL SERVICES

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Questions? If you have questions about this Notice or need additional information, please contact our Corporate Compliance Officer at (505) 982-5565 or (800) 477-7633.

Protection of Medical Information. We understand that your medical information is personal and we are committed to protecting your medical information. Presbyterian Medical Services ("PMS") creates records of the care and services provided to you. We need these records to provide you with quality care and services and to comply with certain legal requirements.

Purpose of Notice. This Notice describes how we may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your legal rights to access and control your medical information.

Who Will Follow this Notice? This Notice describes the privacy practices of PMS, its clinics and other programs, as well as its affiliated health care professionals. We will share information with each other as necessary to carry out our respective treatment obligations, payment activities and health care operations.

Your Rights. Although the records containing your medical information are the physical property of PMS, the information belongs to you. By law, you have the right to:

- Inspect and obtain a copy of your medical information. Generally, we will respond to your request within 30 days but, under certain circumstances, we may deny your request.
- Request a restriction on certain uses and disclosures of your medical information; however, we are not required to agree to a requested restriction.
- Request that we communicate with you by using alternative means or at an alternative location.
- Request an amendment of your medical information, if you believe it is inaccurate; however, we may deny your request for amendment if we believe your medical information is accurate.
- Request an accounting of certain disclosures we have made, if any, of your medical information.
- Restrict disclosures to health plans where you have paid out-of-pocket and in full for care.
- Opt out of receiving fundraising communications from PMS.
- Revoke any authorization you have provided to use or disclose your medical information except to the extent that action has already been taken in reliance on such authorization.
- Obtain a paper copy of this Notice upon request.

You can exercise any of these rights by speaking with the administrator of the PMS site at which you received care or services, or by contacting the PMS Corporate Compliance Officer at (505) 982-5565 or (800) 477-7633.

Our Duties. We are required by law to:

- Maintain the privacy of your medical information.
- Not sell your medical information without your consent.
- Notify you following a breach of unsecured medical information.
- Provide you with a copy of our Notice of Privacy Practices.
- Abide by the terms of our Notice of Privacy Practices.

How We May Use and Disclose Your Medical Information. The following are *examples* of the types of uses and disclosures of your medical information that are permitted:

Treatment. We may use and disclose your medical information to provide, coordinate or manage your health care and any related services. For example, we may disclose your medical information to the doctors or technicians that care for you, even if the doctors or technicians are not affiliated with PMS.

Payment. Your medical information may be disclosed, as needed, to obtain payment from your insurance company or other person/party responsible for payment for services we provide to you. For example, we may disclose your medical information to your health plan to determine your eligibility or coverage for insurance benefits.

Health Care Operations. We may use or disclose your medical information for our internal operations, which include activities necessary to operate the PMS sites or programs from which you receive services. For example, we may use your medical information for quality improvement services to evaluate the care or other services provided to you. We may also use your medical information to evaluate the skills and qualifications of our health care providers, or to resolve grievances within our organization.

Appointment Reminders and Treatment Alternatives. We may use and disclose your medical information to provide a reminder to you about an appointment you have with us for treatment or medical care. We may also use or disclose your medical information to tell you about or recommend possible treatment options or alternatives, or inform you of other health-related benefits and services, that may be of interest to you.

Other Permitted Uses and Disclosures. We may use and/or disclose your medical information in a number of circumstances in which it is not required that we obtain your consent or authorization, or provide you with an opportunity to agree or object. Those circumstances include:

- Unless you object, we may disclose your medical information to a family member, relative, close personal friend or other person that you identify.
- We may be required by law to disclose your medical information.
- We will make your medical information available to you and the Secretary of the Department of Health and Human Services.
- We may disclose your medical information to a public health agency to help prevent or control disease, injury or disability. This may include disclosing your medical information to report certain diseases, death, abuse, neglect or domestic violence or reporting information to the Food and Drug Administration, if you experience an adverse reaction from any of the drugs, supplies or equipment that we use.
- We may disclose your medical information to government agencies so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.
- We may disclose your medical information as authorized by law to comply with workers' compensation laws.
- We may disclose your medical information in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request, or other lawful process.
- We may disclose your medical information to law enforcement officials to report or prevent a crime, locate or identify a suspect, fugitive or material witness or assist a victim of a crime.
- We may use or disclose medical information for research purposes when the research received approval of an institutional review board that has

reviewed the research proposal and established protocols to ensure the privacy of your medical information.

- If you are a member of the armed forces, we may disclose your medical information as required by military command authorities or to evaluate your eligibility for veteran's benefits, for conducting national security and intelligence activities, including providing protective services to the President or other persons provided protective services under Federal law.
- We may disclose your medical information to coroners, medical examiners and funeral directors so that they can carry out their duties or for purposes of identification or determining cause of death.
- We may disclose your medical information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.
- We may use or disclose your medical information to prevent or avert a serious threat to your health or safety, or the health or safety of other persons.
- We may disclose your medical information to a health oversight agency that is authorized by law to oversee our operations.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your medical information to the law enforcement official or correctional institution. This disclosure is required for the institution to provide health care to you, to protect the health and safety of others, or to protect the health and safety of law enforcement personnel or correctional facility staff.
- We may share your medical information with third party "business associates" that perform various services for us. For example, we may disclose your medical information to third parties to provide billing or copying services. To protect your medical information, however, we require our business associates to safeguard your medical information.

Other Uses and Disclosures of Medical Information Other uses and disclosures of your medical information not covered by this Notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your medical information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care or services that we have provided to you.

New Mexico Law In the event that New Mexico law requires us to give more protection to your medical information than stated in this Notice or required by Federal law, we will provide that additional protection. For example, we will comply with state law confidentiality provisions relating to communicable diseases, such as HIV and AIDS. We will also comply with additional state law confidentiality protections relating to treatment for behavioral health and substance abuse. Those laws generally require that we obtain your consent before we disclose your information related to behavioral health or substance abuse, subject to certain exceptions permitted by law.

Protection of Substance Use Disorder Information If you apply for and receive substance use disorder services from us, Federal law (42 CFR Part 2) requires that we obtain your written consent before we may disclose information that would identify you as having a substance use disorder or a patient for substance use disorder services. There are exceptions to this general requirement. We may disclose such information to our workforce as needed to coordinate your care, to agencies or individuals who help us carry out or services to you; when the disclosure is allowed by a court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Federal law does not protect any information about a crime committed by a patient either at the program or against any person who works for a program or about any threat to commit such a crime. Federal law does not protect any information about suspected child abuse or neglect form being reported under State law to appropriate State or local authorities.

Changes to this Notice We reserve the right to change our privacy practices and/or this Notice. If we revise this Notice, the revised Notice will be effective for all medical information we maintain. Any revised Notice will be available by accessing our website, http://www.pmsnm.org/ or you can obtain a copy of the revised Notice by requesting that we send you a copy by mail or by requesting a copy upon your next visit to one of our sites.

Complaints If you believe your privacy rights have been violated, you may file a written compliant with our Corporate Compliance Officer or the Secretary of the Department of Health and Human Services. Reports of violations of confidentiality of substance use disorder diagnosis or treatment information may be directed to the United States (US) Attorney for the district where the violation occurs. Reports of violations by an opioid treatment program may also be directed to the US Attorney as well as to the SAMHSA office responsible for opioid treatment program oversight.

You may submit your written complaints to PMS at P.O. Box 2267, Santa Fe, NM 87504-2267, or you may call us at the phone numbers listed at the top of this Notice. We will not retaliate against you for filing a complaint.

Revisions:
May 2011
July 2013
September 2018