PATIENT WELCOME FORM

Sunrise Clinics
Providing Exceptional Rural Healthcare

DATE ___/___/_____ **CLINIC** ☐Las Vegas ☐Raton ☐Santa Rosa ☐Tucumcari ☐WLVHS ☐NMHU ☐Belen Schools ☐Other

First Name _____ Middle Initial ____ Last Name _____ Preferred Name _____

First, middle, and last names must match your insurance card

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone ____-____-____ Cell ____-____-____ Email _____

Preferred method of communication
☐Home Phone ☐Cell ☐Text ☐Email

May we leave a voicemail?
☐Yes ☐No

Date of birth ____/____/____ Sex ☐M ☐F ☐Unknown Social Security # ____-____-____

Emergency Contact _____ Relationship _____ Phone ____-____-____

Marital Status _____ Language _____ Do you need a translator? ☐Yes ☐No

Occupation _____ Employer _____

Preferred Pharmacy_____ Phone ____-____-____ Address _____

Primary Insurance Company _____ Policy ID _____ Group # _____

Policy Holder Name _____ Relationship _____

Secondary Insurance Company _____ Policy ID _____ Group # _____

Policy Holder Name _____ Relationship _____

THIS SECTION REQUIRES INITIALS, NAME, SIGNATURE, AND DATE

Patient Financial Obligation Agreement

☐ I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Sunrise Clinics for services rendered. I authorize representatives of Sunrise Clinics to release pertinent medical information to my insurance company when requested to facilitate payment of a claim.

Notice of Privacy Practices:

☐ Acknowledgement of receipt. I acknowledge that I was provided with a copy of the Sunrise Clinics Notice of Privacy Practices (NOPP).

Consent to Treatment

☐ I consent to allow the providers of Sunrise Clinics to perform necessary medical examinations and tests to diagnose and treat my health conditions.

Name _____ Signature _____ Date ____/____/____

☐ **I acknowledge that I received Sliding Fee Discount information and was offered an opportunity to complete the application form.**

- ☐ Yes, I would like to see if I qualify for the Sliding Fee discount. I have completed the application and returned it to the front desk.
- ☐ No, I am not interested in the Sliding Fee discount. I do understand that Sunrise Clinics is under obligation to provide me with information regarding the Sliding Fee discount every twelve (12) months.

☐ **I acknowledge that I received information regarding Advance Directives. Please check one:**

- ☐ I have an Advance Directive and have provided a copy to the front desk.
- ☐ I do not have an Advance Directive at this time.

HEALTHCARE FOR ALL

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

As a result, we are required to obtain the following information to comply with government regulations. This information is for statistical reporting purposes only. Your personal information will not be shared with anyone or any company.

Completion of this section allows us to serve all members of our community with the professionalism and compassion we here at Sunrise Clinics embrace.

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown

Transgender ☐ Yes ☐ No

Pronouns ☐ he/him/his/himself ☐ she/her/hers/herself ☐ another pronoun (please specify) _____

Sexual Orientation ☐ Lesbian, Gay, or Homosexual ☐ Straight or Heterosexual ☐ Bisexual
☐ Do not know ☐ Choose not to disclose ☐ Other (please specify) _____

Gender Identity ☐ Male ☐ Female
☐ Female-to-Male (FTM) / Transgender Male / Trans Man
☐ Male-to-Female (MTF) / Transgender Female / Trans Woman
☐ Genderqueer / Neither Exclusively Male nor Female
☐ Choose not to disclose
☐ Additional gender category OR other (please specify) _____

Race ☐ Black or African American ☐ White (including Hispanic, Latino, and Anglo)
☐ Native American ☐ Other (please specify) _____

Ethnicity ☐ Hispanic or Latino ☐ Mexican ☐ Mexican American
☐ Not Hispanic or Latino ☐ Decline to Specify

Are you a Veteran? ☐ Yes ☐ No

Are you here seasonally? ☐ Yes ☐ No

Are you a migrant worker? ☐ Yes ☐ No

Are you homeless? If yes, please check one:
☐ Living on Street ☐ Doubling Up ☐ Transitional Housing ☐ Homeless Shelter
☐ Permanent Supportive Housing ☐ Other (please specify) _____

How Many Dependents Do You Claim? _____

Gross Household Income Per Year _____

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Sliding Fee Discount Program Application

Sunrise Clinics offers discounted fees based on household income and size. Eligibility is determined using the Federal Poverty Guidelines. This program applies to all patients, regardless of insurance status.

Section 1: Patient Information

Full Name: _____

Date of Birth: _____ Phone Number: _____

Home Address: _____

City / State / Zip: _____

Section 2: Household Information

Total Household Size (including yourself): _____ Estimated Gross Household Income: $ _____

Income Frequency (circle one): Daily / Weekly / Biweekly / Monthly / Annually

Proof of Income Provided (circle one): Paystubs / Tax Return / Other / Self-Attestation

Section 3: Program Acknowledgment

☐ Yes, I would like to be considered for the Sliding Fee Discount.

☐ No, I decline the discount and accept full financial responsibility for all charges.

I certify that the information provided above is true and complete to the best of my knowledge. I understand that Sunrise Clinics may require additional information or may contact me for clarification. I also understand that this form is valid for up to 12 months, and I must inform Sunrise Clinics if my income or household size changes.

Print Name: _____ Signature: _____ Date: _____

Staff Use Only

If the patient qualifies for a discount, circle A–E. If not, circle F. (circle one): A B C D E F

Proof of income provided (circle one): Paystubs / Tax Return / Other / Self-Attestation

Reviewed By (Initials): _____ Staff Name: _____ Date: _____

Family Size	A		B		C		D		E		F
	100% & Below		101% - 125%		126% - 150%		151% - 175%		176% - 200%		Above 200%
	No Fee		$1		$5		$8		$10		No Discount
	From	To	From	To	From	To	From	To	From	To	Equal to or Above
1	$ -	15,960.00	15,961.00	19,950.00	19,951.00	23,940.00	23,941.00	27,930.00	27,931.00	31,920.00	31,921.00
2	$ -	21,640.00	21,641.00	27,050.00	27,051.00	32,460.00	32,461.00	37,870.00	37,871.00	43,280.00	43,281.00
3	$ -	27,320.00	27,321.00	34,150.00	34,151.00	40,980.00	40,981.00	47,810.00	47,811.00	54,640.00	54,641.00
4	$ -	33,000.00	33,001.00	41,250.00	41,251.00	49,500.00	49,501.00	57,750.00	57,751.00	66,000.00	66,001.00
5	$ -	38,680.00	38,681.00	48,350.00	48,351.00	58,020.00	58,021.00	67,690.00	67,691.00	77,360.00	77,361.00
6	$ -	44,360.00	44,361.00	55,450.00	55,451.00	66,540.00	66,541.00	77,630.00	77,631.00	88,720.00	88,721.00
7	$ -	50,040.00	50,041.00	62,550.00	62,551.00	75,060.00	75,061.00	87,570.00	87,571.00	100,080.00	100,081.00
8	$ -	55,720.00	55,721.00	69,650.00	69,651.00	83,580.00	83,581.00	97,510.00	97,511.00	111,440.00	111,441.00
9	$ -	61,400.00	61,401.00	76,750.00	76,751.00	92,100.00	92,101.00	107,450.00	107,451.00	122,800.00	122,801.00
10	$ -	67,080.00	67,081.00	83,850.00	83,851.00	100,620.00	100,621.00	117,390.00	117,391.00	134,160.00	134,161.00

Sunrise Clinics
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Sunrise Clinics Administrative Office | 575.472.4311
117 Camino De Vida #500 Santa Rosa, NM 88435

Patient Bill of Rights

Your Rights

You have the right to:
✓ Be informed and involved in your care.
✓ Request an interpreter or communication assistance.
✓ Receive respectful, non-discriminatory care.
✓ Privacy and confidentiality of your health information.
✓ Pain assessment and management.
✓ Be informed about financial assistance options.

Your Responsibilities

- **Appointments**: Cancel at least 1 business day in advance. Cancelling less than 2 hours in advance will be considered a "no-show." Three no-shows in 12 months may affect future scheduling.
- **Clinic Rules**: No smoking, vaping, or weapons allowed.
- **Insurance & Fees**: Bring your insurance card; co-pays/fees due at the time of service.
- **Visitors**: Limit to two guests; bring an adult to supervise children if needed.
- **Medications**: Bring an updated list to each visit and follow treatment plans.
- **Immunizations**: Bring records for child appointments.
- **Forms & Records**: Allow 30 days for paperwork requests.
- **Medication Refills**: Request refills at least 3 business days in advance.

By signing below, you acknowledge and agree to follow these guidelines.

Name: _____ Date of Birth: _____ Phone: _____

Signature: _____ Date: _____

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117 Camino De Vida #300 | Santa Rosa, NM 88435

Notice of Privacy Practices

Effective Date: May 1, 2025

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice.
- Not use or share your information other than as described here unless you give us written permission. If you do give us permission, you may revoke it at any time.

How We May Use and Share Your Information

- Treatment: To provide, coordinate, or manage your healthcare and related services.
- Payment: To bill and collect payment from you, your insurance company, or a third party.
- Healthcare Operations: To run our practice, improve your care, and contact you when necessary.

Other Ways We May Use or Share Your Information

- Public health and safety issues (e.g., reporting disease, injury, or vital events).
- Research (with necessary approvals).
- Compliance with the law (e.g., responding to legal requests or law enforcement).
- Health oversight activities (e.g., audits, inspections).
- Organ and tissue donation.
- Workers' compensation claims.
- Prevention of serious threats to health or safety.

Your Rights Regarding Your Health Information

- Get a copy of your medical record.

- Request corrections.
- Request confidential communications.
- Ask us to limit what we use or share.
- Get a list of those with whom we've shared information.
- Get a copy of this privacy notice.
- File a complaint.

Contact Information

- If you have any questions, need more information, or want to file a complaint, please contact:
- Privacy Officer
  Deanna Sandoval
  2020 7th Street
  Las Vegas, NM 87701
  505-587-1050
  deanna.sandoval@sunrisenm.org
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights at www.hhs.gov/ocr/privacy/hipaa/complaints/.

We reserve the right to change the terms of this notice, and the changes will apply to all information we have about you. We will make a new notice available upon request, in our office, and on our website.