PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

# WELCOME TO THE PMS PATIENT **INFORMATION PACKET**

PMSNM.ORG

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# Welcome to Presbyterian Medical Services

Thank you for choosing Presbyterian Medical Services (PMS) for your care. We are proud to serve as your primary care health home to provide and coordinate the health care services you need. A primary care health home is a team-based approach to providing health care with the patient as the central focus. As our patient, you will have access to a skilled team of medical, dental, and behavioral health professionals, specialty care and programs. At PMS, our goal is to help you improve your health and well-being.

Enclosed in this booklet, you will find listings of locations and services, important documents and other helpful information.

We are excited to have you as our patient and look forward to caring for you.

Sincerely,
Your Health Care Team
Presbyterian Medical Services

Presbyterian Medical Services (PMS) is a non-profit network of community health centers serving thousands of patients in counties across New Mexico. PMS is a Federally Qualified Health Center and is certified by the Joint Commission as a Primary Care Medical Home (PCMH). It 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).

# CALL For An Appointment

**To request, reschedule or cancel an appointment, call your health center location or call 800-477-7633.**

Alamogordo Family Health Center
(575) 434-2960

Alamogordo Behavioral Health
(575) 437-7404

Artesia Family Health Center
(575) 746-9848

Carlsbad Family Health Center
(575) 887-2455

Carlsbad Behavioral Health
(575) 885-4836

Carlsbad School-Based Health
(575) 234-3319

Catron County Medical Center
(575) 533-6456

Chaparral Family Health Center
(575) 824-8100

Counselor Clinic
(575) 568-4328

Cuba Health Center
(575) 289-3291

Cuba School Based Health
(575) 289-2082

Deming Health Center
(575) 546-4663

Deming Behavioral Health
(575) 546-2174

Espanola Family Wellness Center
(505) 443-2800

Esperanza Family Health Center
(505) 384-2777

Express Care (Carlsbad)
(575) 628-1081

Farmington Community Health
(505) 327-4796

Gallup Family Counseling
(505) 863-3828

Gallup School Based Health Center
(505) 721-2681

Grants Family Counseling
(505) 876-1890

Grants Family Health Center
(505) 287-2958

Hobbs Family Health Center
(575) 391-0270

Hopewell Family Health Center
(505) 443-3100

Loving Health Center
(575) 745-3573

Magdalena Area Health Center
(575) 854-3162

Mountainair Family Health Center
(505) 847-2271

Ojo Encino Clinic
(505) 731-2268

Ortiz Mountain Health Center
(505) 471-6266

Pecos Valley Medical Center
(505) 443-3200

PMS Family Health Center
(505) 896-7100

Quay County Family Health Center
(575) 461-2200

Quemado Health Center
(575) 773-4610

Questa Health Center
(575) 586-0315

Rio Rancho Family Health Center
(505) 896-0928

Ruidoso Behavioral Health Center
(575) 630-0571

Sacramento Mountain Medical
(575) 682-2542

Santa Fe Family Health Center
(505) 989-4500

Socorro Community Health Center
(575) 835-4444

Socorro High SchoolTeen Health Center
(575) 838-3199

Socorro Mental Health
(575) 835-2444

Teen Health Center - Capital High
(505) 467-1081

Teen Health Center - Santa Fe High
(505) 467-2439

Thoreau Family Health Center
(505) 862-7417

Torreon Health Clinic
(505) 731-2284

Totah Behavioral Health
(505) 564-4804

Tularosa Medical Center
(575) 585-1250

Valley Community Health Center
(505) 747-7400

Veguita Health Center
(505) 443-7701

WNM Medical Group - Gallup
(505) 863-3120

# After Hours Assistance - Medical/Dental

In the event that you have a medical or dental question after normal business hours, please call our nurse advice line. The registered nurses at Call 4 Health guide our patients to the appropriate level of care, whether it be home care, referral to the emergency room, or setting up an appointment.

Call 4 Health
The Compassionate Call Center

**1-855-741-3400**

# Where to Call for Behavioral Health Crises

If you or someone you care about is experiencing any kind of emotional crisis, mental health or substance use concern, you can find help 24 hours a day, seven days a week, by calling your PMS location from the list below. If there is not an appropriate PMS location listed, you can contact the Suicide & Crisis Lifeline at 988, the New Mexico Crisis and Access Line or the Peer to Peer Warmline.

- 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 Family Health Center: 1-855-223-7111
- Socorro: 1-855-207-1628
- Torrance: 1-855-817-5058
- Totah: 1-855-279-7507
- Valley/Espanola Wellness Center: 1-855-738-3680
- NM Crisis Line: 1-855-662-7474
- NM Warmline: 1-855-466-7100

## We recommend you utilize this service if you are:

- Thinking about wanting to die, hurt or kill oneself
- Concerned about use of drugs or alcohol, substance use, gambling, or other addiction
- Behaving in ways you know aren't safe, but continue anyway
- Having a hard time keeping your anger under control
- Withdrawing or becoming isolated
- Talking about being a burden to others
- Sleeping too little or too much
- Seeking support for someone struggling with mental health
- Just needing someone to talk to

# Our Services

**From prenatal to geriatric, family care and beyond, PMS provides care that's advanced, affordable, and most importantly, accessible.**

## Adult Health

- Immunizations and health screenings
- Treatment of acute and chronic conditions
- Family planning and birth control
- STI testing, treatment, and protection
- Sick visits
- Substance use treatment

## Women's Health

- Well Woman Exams
- Free pregnancy testing
- Prenatal care, postpartum care, and case management*
- Family planning and birth control

## Pediatrics & Adolescent Health

- Well baby and child physicals
- Immunizations
- Adolescent reproductive health, including STI testing, treatment, and protection
- Sports physicals
- Sick visits

## Psychiatry

- Diagnostic evaluation
- Comprehensive treatment planning
- Medication management
- Substance use treatment

## Behavioral Health

- Counseling for couples, individuals, families, children, and adolescents
- Intake, Assessment, and Treatment Planning
- Comprehensive Community Support Services (CCSS)
- Substance use counseling
- Group therapy
- Crisis intervention
- Psychosocial Rehabilitation (PSR)

## Dental

- Emergency Dental Care
- Comprehensive Exams and X-rays
- Cleanings
- Fillings
- Extractions
- Crowns, Bridges and Dentures

*Service may not be available at all locations

# Insurance

## Don't have insurance?

Depending on your family size and income, you may qualify for a sliding fee discount. The Sliding Fee Discount Application is found inside this packet in the forms section.

To access this benefit, please 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

## Patient Assistance

Our Certified Medicaid Determiners can work with you and your family to help you enroll into the health plan that best fits your needs. We can connect patients with community based resources such as housing, transportation, food, etc. If you have questions, or would like to set up an appointment, speak to a front desk team member.

## Paying for Care

We accept Medicare, Medicaid, and most insurance plans. Please remember to bring your insurance ID card and any co-payments to every appointment.

# Billing and Payment Information

Our Care Teams will see all patients regardless of their ability to pay. We do ask patients to bring their current insurance or member ID cards to every appointment. Patients can contact the billing department at (877) 222-4521 for any billing and/or payment questions.

Depending on your insurance or health plan, PMS may require payment at the time of service; however, you can be billed for services provided. Billing statements are mailed monthly.

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

# Personal Health Records

To request copies of your medical records, you can download the form at the link below or scan the QR code below to be taken directly to the release form on our website. Print, complete, and submit to the health center where you receive services.

https://www.pmsnm.org/patients/patient-registration-forms/ or scan the QR code:

SCAN ME

# Patient Portal

The Patient Portal gives you safe and secure access to your personal health information records from anywhere with an internet connection.

Features include:

- Send and receive messages with your primary care provider
- Access your health records
- Request appointments
- Search health and wellness information
- View latest test results
- Request medication refills
- View, download, and/or share your personal health records
- Manage your information through NextGen Patient Portal App
- Access billing statements and make payments

**To Log-in or Enroll in the Patient Portal, use our QR Code.**

SCAN ME

# Prescription Refill & Pharmacy

## RX Refill

There are several ways to request medication refills. Please note the following:

- Patients can call the pharmacy directly and request a refill
- If no refills remain on your medication, you can submit a request via the Patient Portal, contact your health center, or contact the pharmacy
- We require 72 hours for processing

NOTE: If your prescription is from a provider outside the PMS system, we cannot approve the refill. If you want a refill from a PMS provider, please make an appointment with us.

## Pharmacy

With four in-house pharmacies statewide, PMS makes it easy to get the medications you need. As a Federally Qualified Health Center, PMS participates in the 340B program that allows us to provide important medications to our patients, regardless of their ability to pay.

If you are having trouble obtaining your medication at any local pharmacy, you can have your prescription transferred to one of our in-house pharmacies closest to you. Our in-house pharmacies are listed below:

- Farmington Community Health Center, 505-443-4253
- Cuba Health Center, 505-443-6799
- Pecos Valley Medical Center, 505-443-3200
- Carlsbad Family Health Center, 575-887-2455

# 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 CAREFULLY ]

## Protection of Medical Information

We understand that your medical information is personal and we are committed to protecting your medical information. 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 accouting 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 circumstance 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 dislose 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 instituition 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 perfom 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 or 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 our 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 s crime. Federal law does not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

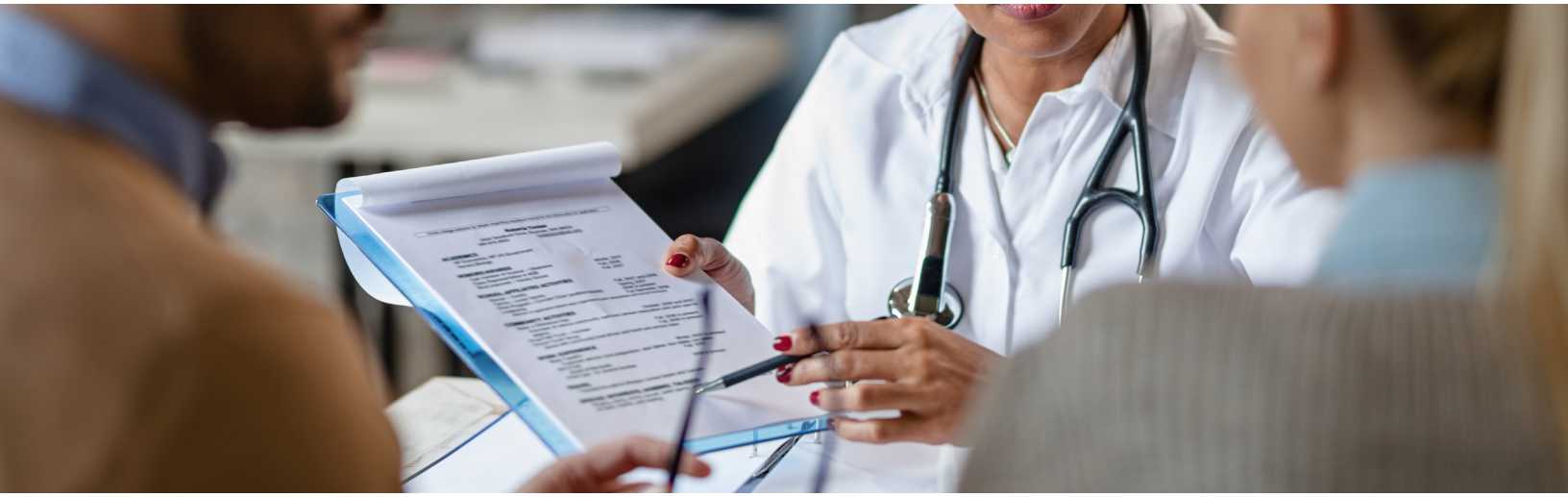
## Changes to this Notice

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, 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 complaint 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 US Attorney for the district where the violation occurs. Reports of violations by an opioid treament 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 in this information packet. We will not retaliate against you for filing a complaint.



# 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 Mexcio 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 Advance 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 require three things: 1) you must sign the Advance Directives, 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 include the acceptance as part of your Advance Directive.

We have some samples of Advance Directive forms available. If you are interested, please ask your doctor or provider for a copy. You have the right to revoke (cancel) or replace an Advance Directive at any time. If you complete an Advance 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 Managment Department, and/or the state survey and certification agency, the New Mexico Department of Health.

# Notice of PMS Policies & Procedures on Reporting of Abuse, Neglect & Misappropriation of Property

This notice describes how PMS reports abuse, neglect or exploitation of 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 PMS to prohibit the use of physical, verbal, sexual or psychological abuse, neglect and exploitation. To protect the rights of consumers, PMS 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 service 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 or 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 reported to DOH/DHI
  - Notify the parent(s) or legal guardian(s) of minor consumers 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 avilable 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 number 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 Compliance at (800) 477-7633 or (505) 982-5565.

# Responding To Your Needs & 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

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.

**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.

This procedure does not prevent you from filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability within 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 Ave. SW, Room 509F, HHH Building, Washington, DC 20201 or phone 1-877-696-6775.

# Consumer Rights

**PMS believes consumers or their legal guardians have the right to:**

- Be treated fairly, with dignity, and with respect for their right to privacy.
- To receive all health care services in a caring, non-judgmental way.
- For those with communication-related disabilities, receive any information in a format that meets your needs.
- Get services in a way that respects your culture, including having an interpreter if you do not speak English.
- Take part in making all health care decisions. This includes making treatment plans. You also have the right to refuse treatment.
- Decide on treatment after being informed of your options.
- Choose someone to help with care choices.
- Make a complaint about your care or decisions about the care you are receiving without worrying about retaliation.
- 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 not want to make choices on your behalf if you are ill.
- 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.
- Get information about PMS, including its services, how to access services and other information to help with your PMS health care needs.
- 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:**

- To treat service providers with dignity and respect.
- Provide, when able, information needed for our providers to serve you.
- Understand your health issues and take part in planning treatment goals.
- Follow the plans for care that you have agreed on.
- Let your provider know if changes to your care are needed.
- Notify your provider if medications change by another practitioner.
- To receive a medication refill, call 1 week prior to running out and expect up to 3-business days after request is made.
- Make sure PMS has your current contact information so we can reach you if necessary.
- To provide a safe environment for care to be provided.
- To attend appointments sober.
- No weapons are allowed on the premises.
- Please change or cancel an appointment rather than not showing up.

# Forms

Telling us your ethnicity, race, language, sexual orientation, and gender identity allows us to deliver the best care possible.

Why do we ask? The information enables us to address any gaps in access, equity, and quality of care.

Is it safe? The information you provide will be kept confidential and is legally protected. It is seen only by our registration staff, administrators, and employees involved in quality improvement and oversight.

Thank you for giving us the opportunity to serve you better.

PLEASE COMPLETE THE FOLLOWING FORMS AND RETURN TO A FRONT DESK TEAM MEMBER.

**PLEASE PRINT** **NEW CLIENT REGISTRATION FORM** **Date:** _____

| | | |
|---|---|---|
| **Patient Last Name:** | **First Name:** | **Middle Initial:** |
| **Social Security:** | **Birth Date:** __/__/___ | **Birth Sex:** ☐ Male ☐ Female ☐ Unknown ☐ Undifferentiated<br>**Gender Identity:** ☐ Male ☐ Female ☐ FTM/Transgender Male/Trans Man<br>☐ MTF/Transgender Female/ Trans Woman ☐ Choose not to disclose<br>☐ Genderqueer, neither exclusively male or female ☐ Other |
| **Preferred contact:** ☐ **Cell Phone:** _____<br>☐ **Home Phone:** _____ ☐ **No Phone**<br>☐ **Alternate Phone:** _____ | | |
| **Address:** | | **City, State, Zip Code** |
| **Mailing Address, if different:** | | **City, State, Zip Code** |
| **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** |
|---|---|---|
| **Parent's Name** | **Day Phone (  )** | ☐ |
| **Parent'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/a** **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 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 (Car, 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**

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 purpose 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 _____

## STATEMENT OF FINANCIAL RESPONSIBILITY

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

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

Patient/Legal Guardian's Signature _____ Date _____

# SLIDING FEE
# DISCOUNT APPLICATION

## APPLICANT

Name (First MI Last): _____ Date of Birth: _____
Street Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Applicant's relationship to patient: _____

## FAMILY MEMBERS AND INCOME

- 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 and include their income.

| Name (First and Last): | Gross Monthly Income (if any) | Pay Cycle (Please Circle) |
|---|---|---|
| | | Weekly, Biweekly, Monthly, Yearly, Semi Monthly |
| | | Weekly, Biweekly, Monthly, Yearly, Semi Monthly |
| | | Weekly, Biweekly, Monthly, Yearly, Semi Monthly |
| | | Weekly, Biweekly, Monthly, Yearly, Semi Monthly |
| | | Weekly, Biweekly, Monthly, Yearly, Semi Monthly |
| | | Weekly, Biweekly, Monthly, Yearly, Semi Monthly |

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 _____, 20__ 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 (PMS) 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 PMS at my next visit.

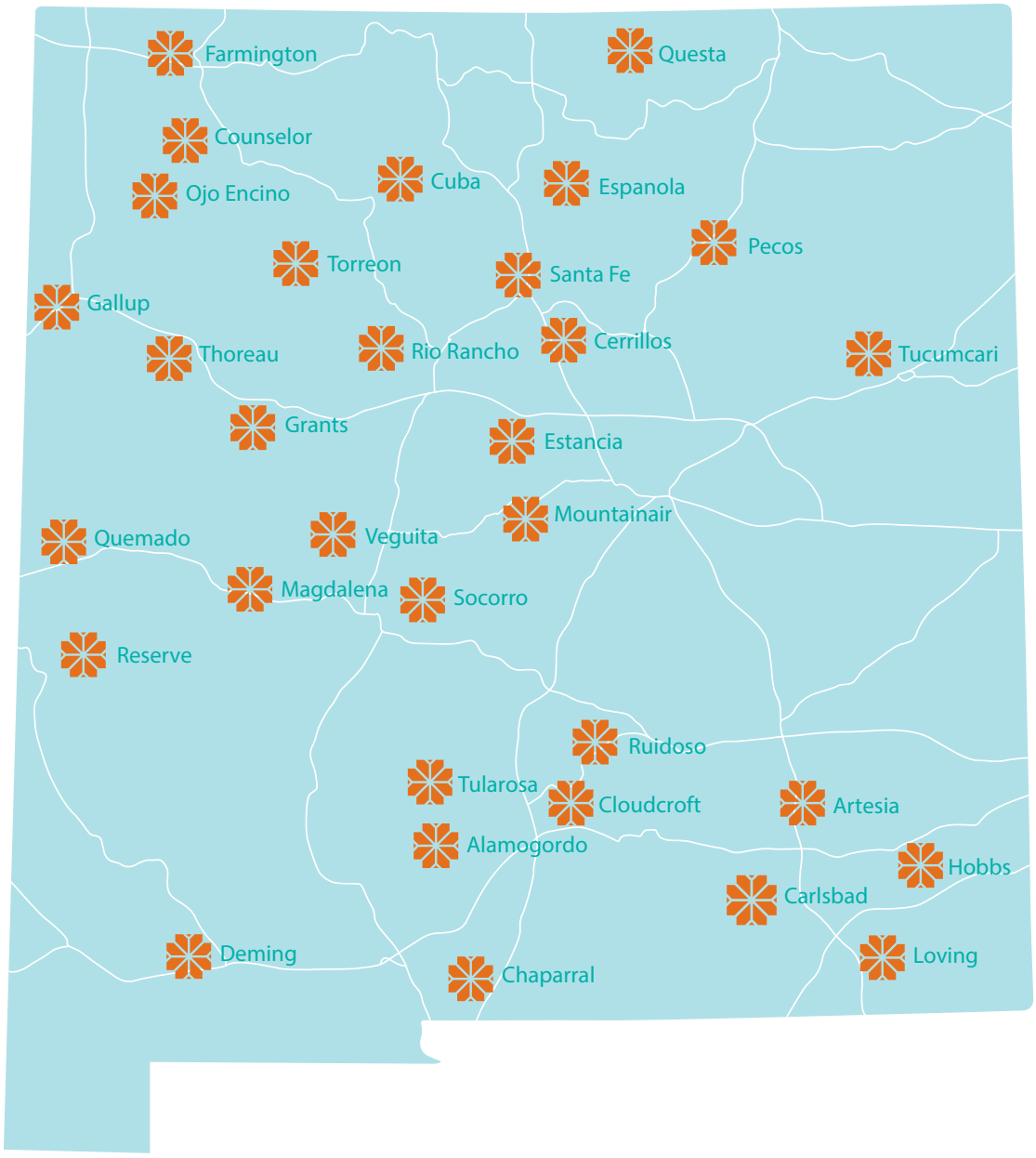
Patient/Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

PMS STAFF ONLY

| | |
|---|---|
| Weekly Calculations = (Income x 52) | |
| Bi-Weekly Calculations = (Income x 26) | |
| Monthly Calculations = (Income x 12) | |
| Yearly Calculations = (Income x 1) | |
| Semi-Monthly = (Income x 24) | |
| Household Size | |

# Visit us at any of our convenient LOCATIONS

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