

Patient Information

<i>Legal Information (as shown on ID)</i>				
Full Legal Name: <i>(As shown on ID)</i>		Legal Sex: <i>(As shown on ID)</i>		Date of Birth:
Name on Insurance Card: <i>(if different from ID)</i>		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X		
Preferred Name:		Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown		
Gender identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/Trans Man <input type="checkbox"/> Transgender Female/Trans Woman <input type="checkbox"/> Two Spirit <input type="checkbox"/> Questioning <input type="checkbox"/> Non-binary /Genderqueer <input type="checkbox"/> Other: _____				
Sexuality: <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Unsure <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer <input type="checkbox"/> Omnisexual <input type="checkbox"/> Asexual <input type="checkbox"/> Other: _____				
Pronouns: <input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/them/theirs <input type="checkbox"/> Patient's name <input type="checkbox"/> Other: _____				
<i>This information helps us to improve patient services and provide the lowest cost care you're eligible for.</i>				
Marital Status:				
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Significant Other <input type="checkbox"/> Widowed				
Veteran Status: Have you ever served in the US Military? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Ethnic Group:		Race: (Choose all that apply)		
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other: _____		
Employment Status:				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/Temporary <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Full time Student <input type="checkbox"/> Part time Student <input type="checkbox"/> Other: _____				
Migrant/ Seasonal Worker:				
a. In the past two years have you or another member of your family worked in agriculture as your principal employment? <input type="checkbox"/> Yes <input type="checkbox"/> No **Agricultural is defined as work on farms, ranches, orchards, nurseries, feedlots.				
b. Have you or a member of your family stopped migrating to work in agriculture because of a disability or old age? <input type="checkbox"/> Yes <input type="checkbox"/> No				
c. In the past two years have you or a member of your family established a temporary home in order to work in agriculture? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<i>Yes = this person and their family can be classified as migratory/Seasonal workers.</i>				
Housing Status: <i>(Check the closest option)</i>		Do you live in public housing?		Have you applied for Medicaid (OHP)?
<input type="checkbox"/> Not homeless <input type="checkbox"/> Homeless <input type="checkbox"/> Living with others <input type="checkbox"/> Living in a shelter <input type="checkbox"/> Transitional housing <input type="checkbox"/> Street, camp, bridge, vehicle		Public housing is defined as low-income or section 8 housing. <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____
Estimated yearly household income:				
Number of people living in your household: _____				
<input type="checkbox"/> \$0–5,000	<input type="checkbox"/> \$25,001–30,000	<input type="checkbox"/> \$50,001–55,000	<input type="checkbox"/> \$75,001–80,000	<input type="checkbox"/> \$100,001-110,000
<input type="checkbox"/> \$5,001–10,000	<input type="checkbox"/> \$30,001–35,000	<input type="checkbox"/> \$55,001–60,000	<input type="checkbox"/> \$80,001–85,000	<input type="checkbox"/> \$110,001-120,000
<input type="checkbox"/> \$10,001–15,000	<input type="checkbox"/> \$35,001–40,000	<input type="checkbox"/> \$60,001–65,000	<input type="checkbox"/> \$85,001–90,000	<input type="checkbox"/> \$120,001-130,000
<input type="checkbox"/> \$15,001–20,000	<input type="checkbox"/> \$40,001–45,000	<input type="checkbox"/> \$65,001-70,000	<input type="checkbox"/> \$90,001–95,000	<input type="checkbox"/> \$130,001-140,000
<input type="checkbox"/> \$20,001–25,000	<input type="checkbox"/> \$45,001–50,000	<input type="checkbox"/> \$70,001–75,000	<input type="checkbox"/> \$95,001-100,000	<input type="checkbox"/> Other _____



THIS CONSENT DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND RELEASED AND WHERE TO FIND MORE DETAILS ABOUT THIS. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES:

Mosaic’s Notice of Privacy Practices gives information about how Mosaic may use, and release protected health information about you.

I understand that:

- I have the right to receive a copy of Mosaic’s Notice of Privacy Practices.
- I may request a copy at any time.
- This notice may be revised.
- I am entitled to a copy of any revised Notice of Privacy Practices.

By signing below, I acknowledge the above and that I have received or have been offered a paper copy of Mosaic’s Notice of Privacy Practices. Mosaic’s Notice of Privacy Practices is also available on Mosaic’s website.

CONSENT TO TREATMENT:

By signing below, I agree to receive Health care from Mosaic.

I understand that:

- This consent to treatment will be in effect as long as I am a Mosaic patient.
- I may cancel this consent in writing.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION:

My protected health information is made up of my health history, testing and treatment(s).

By signing this form, I understand and agree that Mosaic may use or release my protected health information for purposes of:

- Providing treatment;
- Payment;
- Healthcare operations;
- As is reasonably necessary to comply with any court order, subpoena, or any other legal requirement(s) or regulation(s) as long as a separate authorization is not required under HIPAA regulations; or
- As is otherwise permitted under HIPAA regulations.

By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Print Patient's Name

Patient's Date of Birth

Signature of Patient (or Parent/Legal Guardian)

Date

Relationship to patient



MRN: _____

Communication Permissions - Adult

Patient Name: _____

Date of Birth: _____

SECTION 1

Mosaic may leave a voicemail for the following: *(check all that apply)*

- General information regarding your care
- Billing
- No** Messages of any kind
- Use: Preferred Number on file **ONLY**
- Any Personal Number on file (not including emergency contact)

Mosaic will use automated calls or texts for appointment reminders and other clinic notifications such as clinic closures, etc. **By checking this box** you agree to receive these automated reminders and notices at your preferred number on file.

SECTION 2

Let us know who we may communicate with regarding your care. Specify what type of information we may share. (Examples: caregiver/care facility, spouse, family member who is not a legal representative, guardian, power of attorney, etc.)

I authorize Mosaic Medical to communicate with the following people in person or by telephone in order to: (check all that apply)

Name: _____ Relationship: _____ Phone: _____

- Discuss **ALL** information
NOTE: this is not an authorization to release records.
- Pick up items from clinic. (Including medication, correspondence, hardcopy scripts, etc.)
- Appointment Management
- Other: _____

Name: _____ Relationship: _____ Phone: _____

- Discuss **ALL** information
NOTE: this is not an authorization to release records.
- Pick up items from clinic. (Including medication, correspondence, hardcopy scripts, etc.)
- Appointment Management
- Other: _____

NOTE: If you would like to add more people to this section, please do so on the back of the page.

SECTION 3

Does the patient have a legal representative, guardian, medical power of attorney, etc.?

If so, please list them and provide the legal documentation for our records.

None

Name: _____ Relationship: _____ Phone: _____

SECTION 4

Signature required (below):

The authorization may be changed or revoked in writing at any time. It will remain in effect until that time.

By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature (Patient/ Legal Guardian): _____ Date: _____

Print name (Patient/ Legal Guardian): _____ Relationship: _____



Financial Agreement

Mosaic expects all patients pay co-pays (Sliding Scale or insurance) and other payments **at the time of service**.

Overview

- All services provided by Mosaic are charged to the patient.
- Forms will be completed to help expedite insurance payments.
- The patient is responsible for all charges, whether or not paid by insurance.
- Any copays (sliding scale or insurance) identified in advance, are due at the time of service and may be considered partial payment for services provided. The total cost to the patient will only be known after insurance has been processed.
- We accept cash, checks, and VISA or MasterCard. **There will be a \$15.00 charge for any returned check.**

Insurance

We cannot guarantee your insurance will cover our services. We suggest you verify coverage options with your insurance before your appointment. It is the patient’s responsibility to notify Mosaic of any insurance coverage changes. We ask that the patient’s insurance card be presented at every visit. This ensures that our records are kept current.

Sliding Scale

Mosaic offers a Sliding Scale Program to all patients. If you qualify, your copay may be discounted. To apply, please complete the application and provide proof of income for every person (18 years of age or older) in the household.

This application and financial information is required before we can determine any eligibility. If you are missing any pieces of this application process, your application will be returned to you until you have all required information. In the meantime, you may receive a bill and are responsible for the full price of services provided.

PLEASE NOTE: charges are for services provided by Mosaic. Any lab work, imaging, and referrals to specialists are NOT covered under this sliding scale. You will be responsible for any and all charges/costs associated with non-Mosaic organizations.

I hereby authorize the provider to provide my insurance company all information which the insurance company requests concerning my present illness/injury. I hereby assign to the provider all money to which I am entitled for medical and/or surgery expense relative to the services, but not to execute indebtedness to the provider/surgeon. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. If all or part of the claims for service provided to myself or my dependents are denied by our insurance company, I will be responsible for payment in full to Mosaic. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. Should it become necessary to pursue collection efforts for an unpaid balance due for services provided to me or my family, I/we agree to pay reasonable attorney’s fee or other such costs as the court determines proper. It is agreed that payment will not be delayed or withheld because of insurance coverage or the length of time it takes to process claims. All proceeds of insurance are assigned to Mosaic where applicable, but without their assuming responsibility for the collection thereof. Mosaic is an equal opportunity provider.

By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Print Patient Name

Date of Birth

Signature of Patient (or Parent/Legal Guardian)

Date

Relationship to patient

MRN: _____

Health History - Adult

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Personal Medical History (please check all that apply in box to the right)			
Abuse (physically)		Cataracts	Pacemaker
Abuse (sexually)		Chemical dependency	Abnormal Heart Rhythm
HIV/AIDS		Colon Polyp	Atrial Fibrillation
Alcoholism		Depression	Hepatitis
Anemia		Diabetes	Hernia
Anorexia/Bulimia		Epilepsy/ seizures	Herpes
Bladder problems		Gall stones	High blood pressure
Blood Transfusion		Glaucoma	
Bleeding disorders		Gonorrhea	High cholesterol
Deep Vein Thrombosis (blood clot)		Gout	Irregular periods
Pulmonary Embolism (blood clot)		Headaches	Kidney problems
Breast lump		Heart disease	Liver disease
Cancer		Coronary Artery Disease	Lung disease
			COPD/Emphysema
			Chronic Bronchitis
			Asthma
			Mental illness
			Multiple sclerosis
			Pneumonia
			Rheumatic fever
			STD/STI
			Stomach ulcers
			Stroke
			Suicide Attempt
			Thyroid Problems
			Tuberculosis

SAFETY / SOCIAL HABITS (please circle or write the answer)			
1. Do you use tobacco?	Yes	No	Used to
If yes, how many cigarettes a day? If you used to, how many cigarettes a day? Quit date:			
Do you use chewing tobacco?	Yes	No	
2. Are you exposed to second hand smoke?	Yes	No	
3. Are you sexually active?	Yes	No	
If yes, what gender/s are you sexually active with? (circle all that apply below)			
Male	Female	Both	Other:
4. Is your household aware of gun safety?	N/A	Yes	No
5. Are the firearms in your house secured?	N/A	Yes	No

FAMILY HISTORY (please circle or mark which member of your family has or had the problem listed)			
Problem	Family Relationship	Age of Onset	Type (circle one)
Arthritis	Mother/Father/Brother/Sister/Mom's mom Mom's dad/Dad's mom/Dad's Dad		Rheumatoid / Lupus / other:
Cancer	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		
Mental health	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		History of Mental Illness / Anxiety / Bipolar / Suicide
Diabetes	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		Type 1 / Type 2
Heart disease	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		
High blood pressure	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		
Kidney disease	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		Stones / Infections / Kidney failure
Stroke	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		
Other	Mother/Father/Brother/Sister/Mom's mom/Mom's dad/Dad's mom/Dad's Dad		

Reviewed by _____ Date _____

Patient Name: _____

Date of Birth: _____

Please check YES if you have a frequent or continuous problems related to the following systems or NO if you do not.
Please explain any YES answers in the space provided.

Constitutional Symptoms (General)	Yes	No
Fevers		
Chills		
Weight Loss		
Malaise/ fatigue		
Heavy sweating		
Weakness		
Explanation:		
Skin	Yes	No
Rash		
Itching		
Explanation:		
Head/Ears/Nose/Throat	Yes	No
Headaches		
Hearing loss		
Noise/ringing in ear		
Ear pain		
Ear discharge		
Nosebleeds		
Congestion		
Wheezing coming from throat		
Sore throat		
Explanation:		
Eyes	Yes	No
Blurred vision		
Double vision		
Sensitivity to light		
Eye pain		
Eye discharge		
Eye redness		
Explanation:		
Cardiovascular (Heart and Blood Vessels)	Yes	No
Chest pain		
Palpitations		
Difficulty breathing while lying flat		
Pain in back of legs when walking		
Leg swelling		
Trouble breathing or wheezing at night		
Explanation:		
Respiratory	Yes	No
Cough		
Coughing blood		
Phlegm		
Shortness of breath		
Wheezing		
Explanation:		

Gastrointestinal	Yes	No
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Black sticky stool		
Explanation:		
Genitourinary (Urinary and Reproductive)	Yes	No
Painful urination		
Urgency		
Frequency		
Blood in urine		
Flank pain		
Explanation:		
Musculoskeletal (Muscles and Joints)	Yes	No
Muscle pain		
Neck pain		
Back pain		
Joint pain		
Falls		
Explanation:		
Endocrine/Hematology (Blood)/Allergies	Yes	No
Easy bruise/bleed		
Environmental allergies		
Thirsty often		
Explanation:		
Neurological	Yes	No
Dizziness		
Tingling		
Tremor		
Sensory changes		
Speech changes		
Weakness in one area		
Seizures		
Pass out		
Explanation:		
Psychiatric	Yes	No
Depression		
Suicidal ideas		
Substance abuse		
Hallucinations		
Nervous/Anxious		
Insomnia		
Memory Loss		
Explanation:		

PATIENT RIGHTS & RESPONSIBILITIES



MOSAIC

OUR PATIENTS HAVE THE RESPONSIBILITY TO:

- Arrive on time for appointments
- Provide at least 24 hours notice of appointment cancellation.
- Bring all medications, over the counter drugs, and herbal supplements to every appointment.
- Participate in development of mutually agreed-upon treatment plans.
- Follow agreed-upon treatment plans
- Inform your medical provider if you become worse or you have an unexpected reaction to a medication.
- Comply with signed patient contracts/agreements including, but not limited to:
 - Controlled substance treatment agreement.
 - Relationship agreement.
- Give written permission to release your health records to other providers.
- Let us know if you are dissatisfied with services.

- Let us know of changes in address, phone number, or other requested information.
- Follow all insurance company guidelines about how to access services.
- Take financial responsibility for payment of all charges including:
 - Bring in your insurance card each time you come to the clinic for services if you are insured.
 - Pay all co-payments and deductibles at the time of your visit if you are insured.
 - Pay at the time of your visit for services rendered if you are uninsured.
 - Bring in documentation of eligibility for a discount in a timely manner if you are uninsured.
 - Bring in documentation of eligibility for the Oregon Health Plan (OHP), if requested by clinic staff, in a timely manner.
- Prescription drug renewals: It is your responsibility to contact your pharmacy to request a prescription renewal two or more business days prior to when you need the medication. The pharmacy will fax or electronically submit the prescription renewal request to our office. Once received, our office will review and address the prescription request within two business days. Delays at the pharmacy for filling, payment, or delivery are between you and the pharmacy.

OUR PATIENTS HAVE THE RIGHT TO:

- **Service** – Service regardless of your race, sex, religion, age, ethnic background, linguistic preference, education, social class, economic status, sexual orientation, or disability.
- **Respect** – Expect that our workers will be sensitive to your needs and feelings, and to be treated with respect and dignity as a human being.
- **Privacy** – Consideration for your privacy. Treatment is confidential and should in all cases be conducted discreetly.

- **Information** – Know your diagnosis, treatment options, likely course of your illness, and likely consequences of treatment options. To know any other significant information that would enable you to give informed consent.
- **Choice** – Be involved in planning the services you are to receive, consent to or refuse treatment, get a second opinion about your illness or treatment and/or change providers.
- **Confidentiality** – Confidentiality in personal matters, interpersonal relations, and written records, and access to your medical records.
- **Continuity of Care** – Referral to other services and agencies that are necessary for continuity of care.
- **Billing** – Obtain, question, and discuss a full accounting of charges for your care regardless of the source of payment.
- **Rules and Regulations** – Know what rules and regulations apply to your conduct as patients/clients, and to have representation in the formulation of rules and regulations that will govern you as patients/clients.
- **Communication** – Have all communications in a language that you can clearly understand.
- **Grievances** – File a complaint about service-related issues or the treatment being provided. To request assistance in filing a complaint.
- **Know your care team** – Know the names of the people caring for you.

If you have any questions, please tell your medical provider or clinic manager.

use or disclose PHI to your family members or friends if verbal agreement is obtained from you, or if you have been given an opportunity to object to such a disclosure and you do not raise an objection. Mosaic Medical may also use or disclose PHI to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

Marketing - Mosaic Medical will not use your information for marketing purposes without your written authorization. Mosaic Medical will not sell your PHI to another organization for marketing or any other purposes.

In situations where you are not capable of giving consent due to incapacitation or a medical emergency, Mosaic Medical may, using our professional judgment, use or disclose PHI to a family member or friend if it is in your best interest.

YOUR PHI PRIVACY RIGHTS

You have the following rights regarding your PHI:

Right to Inspect and Copy - With certain exceptions, you have the right to inspect and copy your health information. You may request an electronic copy of your records. You must make the request in writing. Mosaic Medical reserves the right to charge a fee to cover the costs of labor, supplies, and mailing. Mosaic Medical may deny your request to inspect and/or copy your records in certain circumstances. If you are denied access to your PHI, you may request that the denial be reviewed. The second reviewer will be a licensed healthcare provider not involved in the first decision to deny access.

Right to Amend - You have the right to request that an amendment to your record be made if you think the information is incorrect or there is information missing. Your request must be in writing and must include a reason for the request. Mosaic Medical may deny your request for an amendment if the information to be corrected was not originally created by Mosaic Medical, is not part of PHI that we maintain, was not permitted to be inspected and/or copied, or is already accurate and complete. A copy of your amendment request will be put in your record even if we do not agree to amend the record itself.

Right to a List of Disclosures - You have the

right to an "accounting of disclosures" of your PHI. This is a list of disclosures of PHI about you for purposes other than treatment, payment, healthcare operations, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. The list will exclude any disclosures we have made based on your written authorization. To obtain this list, you must submit your request in writing to the Compliance Officer. It must state a time period which may not be longer than six years and may not include requests for information prior to April 14, 2003. The request must indicate how you would like the information (paper or electronically). For list requests after the first one, Mosaic Medical reserves the right to charge a fee for the costs of providing the lists.

Right to Request Restrictions - You have the right to request a restriction or limitation on the use of your PHI. The request must be in writing and describe what information you wish to be restricted and to whom Mosaic Medical may deny a request. If the request is approved, the restrictions may be terminated either in writing or verbally at any time in the future.

Right to Request Restrictions to Health Plan - You have the right to request a restriction of disclosure to your health plan for treatments you pay cash for. The request must be in writing and describe what information you wish to be restricted and the name of your health plan. This restriction does not extend to follow-up care or disclosures authorized to another provider, unless the restriction request specifies. Mosaic Medical does have the right to bill your health plan if Mosaic Medical is unable to obtain payment from you.

Right to Request Confidential Communications - You have the right that we communicate with you about your PHI in a certain way or at a certain location. For example, you may request that we contact you only at work, or only by mail. The request must be in writing. No reason is necessary. We will accommodate all reasonable requests.

Right to Receive Notification of a Breach If there is a breach involving your PHI, Mosaic Medical will contact you in writing with a description of the breach, the type of information involved, the steps you should take to protect yourself, a brief summary of what is being

done and the person you can contact for further information.

Right to File a Complaint - You have the right to file a complaint if you feel your privacy rights have been violated. You will not be penalized for filing a complaint. You may contact the Compliance Officer listed at the bottom of this notice, or the Office for Civil Rights at:

Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW
HHH Building, Room 509H
Washington, D.C. 20201
Toll free phone: 877-696-6775
866-627-7748 (phone)
886-788-4989 (TTY)
www.hhs.gov/ocr (e-mail)

Right to a Paper Copy of This Notice - You have the right to a paper copy of this notice at any time. This notice is also available online at www.mosaicmedical.org

If you have any questions about this information please contact:

Compliance Officer
600 SW Columbia, Street 6210
Bend, OR 97702
541-383-3005 (phone)
541-647-2921 (fax)



MOSAIC

PRIVACY OF YOUR INFORMATION

LEARN HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PURPOSE

This Notice of Privacy Practices describes established privacy practices followed by our staff in relation to your protected health information (PHI). This notice will explain how and when we may use and disclose your PHI, but may not include every possible situation. Please address any questions to the Compliance Officer as at the end of this notice.

YOUR PROTECTED HEALTH INFORMATION (PHI)

This notice addresses information and records we maintain regarding your health, health status, and the healthcare services provided at our office. This information may include information collected and recorded in this office, as well as information received from other healthcare providers. The information may be in written, electronic or spoken form. It may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity, and similar types of health-related information.

We are required by law to give you this notice. It will explain how we may use and disclose PHI about you and explains your rights regarding the use of that information.

HOW WE MAY DISCLOSE YOUR PHI WITHOUT YOUR WRITTEN CONSENT

For Treatment - Mosaic Medical may use or disclose information with healthcare providers who provide healthcare services to you. This may include, but is not limited to, doctors, nurses, technicians, office staff, or other personnel who are involved in your care. Personnel in our office may share information in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work, and ordering x-rays. Family members and other healthcare providers may be part of your medical care outside of this office and may require information about you in order to improve your treatment.

For Payment - Mosaic Medical may use or disclose PHI in order to bill for services provided and receive payment from an insurance company or other third party. Insurance companies may need information regarding a specific visit or procedure or require information in order to pre-

approve future services. Mosaic Medical may use or disclose this information for these purposes.

For Healthcare Operations - Mosaic Medical may use or disclose PHI in order to operate and/ or improve the office, its programs, and services. Mosaic Medical may, for example, use PHI to review the quality of services you have received.

Health Information Exchange (HIE) - Mosaic Medical participates in the Central Oregon Health Information Exchange (COHIE).

- HIE is a computer-based, secure method of exchanging or disclosing patient health information with other organizations, for the purposes of healthcare treatment, payment, and operations (TPO).

Benefits of HIE:

- Helps coordinate your care among all your health care providers
- Reduces duplicative tests and associated costs
- Improves the quality and safety of your treatment by providing more complete information to your health care providers
- Increases the privacy of your health care information through encryption, authentication, access controls, and other security mechanisms

Certain information, in certain cases, can be specially protected by law and require additional authorization. Mosaic Medical may ask you to provide authorization or "opt-in" to disclose the following:

- Mental health treatment information
- Substance abuse treatment information (NOTE: Mental health and substance abuse treatment information is only specially protected information for certain federally funded substance abuse and mental health providers within Mosaic. These providers will be designated and will be the only ones that need to obtain the additional authorization).

Mosaic Medical also participates in and is part of an HIE that includes participants in OCHIN Inc.

- A current list of OCHIN participants is available at www.ochin.org/our-members/ochin-members/. As a business associate of Mosaic Medical, OCHIN supplies information technology and related services to Mosaic Medical and other OCHIN participants.

OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Mosaic Medical with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

Business Associates - Mosaic Medical may contract with Business Associates who may perform certain functions and activities on our behalf. Our Business Associates are required to safeguard your PHI.

Appointment Reminders - Mosaic Medical may contact you directly or leave messages as a reminder of your appointment for services.

Insurance Verification - Mosaic Medical may contact your insurance company via telephone or their website to verify your insurance enrollment status.

Treatment Alternatives - Mosaic Medical may contact you regarding possible treatment alternatives.

Health-Related Products and Services - Mosaic Medical may contact you regarding health-related products or services that may be of interest to you.

OTHER SITUATIONS IN WHICH MOSAIC MEDICAL MAY RELEASE PHI WITHOUT CONSENT

As Required by Law - Mosaic Medical will use and disclose PHI when required by federal, state, or local law or by a court order. Mosaic Medical may disclose PHI in response to a subpoena, warrant, summons, or similar process subject to all applicable legal requirements.

For Abuse Reports or To Avert a Serious Threat to Health or Safety - Mosaic Medical may use or disclose PHI in order to meet its legal mandatory reporting requirements, or to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Research - Mosaic Medical may use and disclose PHI for research projects, if you have consented to participate in the study. If you have voluntarily consented to participation in a research study, researchers will be subject to the same PHI restrictions as Mosaic Medical.

Organ and Tissue Donation - If you are an organ donor, Mosaic Medical may use or disclose PHI to organizations that handle organ procurement to facilitate organ donation, transport, and transplantation.

Military, Veterans, National Security, and Intelligence - If you are or were a member of the armed forces, or part of the national security or intelligence communities, Mosaic Medical may use or disclose PHI to military command or other government authorities as required. Mosaic Medical may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers Compensation - Mosaic Medical may use or disclose PHI for workers compensation or similar programs. Such programs provide benefits for work-related injuries or illness.

Public Health Risks - Mosaic Medical may use or disclose PHI for public health reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities - Mosaic Medical may use or disclose PHI to a health oversight agency for audits, investigations, inspections, or licensing purposes.

Lawsuits and Disputes - Mosaic Medical may use or disclose PHI in response to a court administrative order due to your involvement in a lawsuit or dispute. Mosaic Medical may release PHI in response to a subpoena subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors - Mosaic Medical may use or disclose PHI to a coroner or medical examiner when requested.

De-Identified Information - Mosaic Medical may use or disclose PHI in a way that does not identify who you are.

Family and Friends - Mosaic Medical may