MOSAIC

MRN: _____

Patient Information

Legal Information (as shown on ID)

Full Legal Name: *(As shown on ID)*	**Legal Sex:** *(As shown on ID)*	**Date of Birth:**
Name on Insurance Card: *(if different from ID)*	☐ Female ☐ Male ☐ X	

Preferred Name:	**Sex Assigned at Birth:** ☐Female ☐Male ☐Intersex ☐Unknown

Gender identity: ☐ Female ☐ Male ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman ☐ Two Spirit ☐ Questioning ☐ Non-binary /Genderqueer ☐ Other:

Sexuality: ☐ Heterosexual/Straight ☐ Bisexual ☐ Unsure ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Omnisexual ☐ Asexual ☐ Other:_____

Pronouns: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ Patient's name ☐ Other:

This information helps us to improve patient services and provide the lowest cost care you're eligible for.

Marital Status:
☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Domestic Partnership ☐ Significant Other ☐ Widowed

Veteran Status: Have you ever served in the US Military? ☐ Yes ☐ No

Ethnic Group:	**Race:** (Choose all that apply)
☐ Hispanic	☐ White ☐ Asian ☐ Native American ☐ Alaskan Native ☐ African American
☐ Non-Hispanic	☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal/Temporary ☐ Self Employed ☐ Retired ☐ Unemployed ☐ Full time Student ☐ Part time Student ☐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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

Yes = this person and their family can be classified as migratory/Seasonal workers.

Housing Status: *(Check the closest option)*	**Do you live in public housing?**	**Have you applied for Medicaid (OHP)?**
☐ Not homeless ☐Homeless ☐ Living with others ☐ Living in a shelter ☐ Transitional housing ☐ Street, camp, bridge, vehicle	*Public housing is defined as low-income or section 8 housing.* ☐ Yes ☐ No	☐ No ☐ Yes, date:_____

Estimated yearly household income: **Number of people living in your household**:_____

☐ $0–5,000	☐ $25,001–30,000	☐ $50,001–55,000	☐ $75,001–80,000	☐ $100,001-110,000
☐ $5,001–10,000	☐ $30,001–35,000	☐ $55,001–60,000	☐ $80,001–85,000	☐ $110,001-120,000
☐ $10,001–15,000	☐ $35,001–40,000	☐ $60,001–65,000	☐ $85,001–90,000	☐ $120,001-130,000
☐ $15,001–20,000	☐ $40,001–45,000	☐ $65,001-70,000	☐ $90,001–95,000	☐ $130,001-140,000
☐ $20,001–25,000	☐ $45,001–50,000	☐ $70,001–75,000	☐ $95,001-100,000	☐ 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 - Minor

Patient Name: _____ **Date of Birth:** _____

SECTION 1

Biological or legal parents or guardian(s) contact information *(please provide proof if legal guardian, legal representative, medical power of attorney, etc.):*	
Name:	**Name:**
Relationship:	**Relationship**:
Phone: _____ ☐ Mobile ☐ Home ☐ Other: _____	**Phone:** _____ ☐ Mobile ☐ Home ☐ Other: _____

SECTION 2

Mosaic Medical may leave a voicemail for the following reasons using the above numbers: (check all that apply)

□ Medical Information □ Billing □ Automated Appointment Reminders □ ***No*** Messages of any kind

Use: □ Preferred Number on file **ONLY** □ Any Personal Number on file (not including emergency contact)

SECTION 3

Patient Contact Information *(if applicable). Patients who are minors (Under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by Mosaic Staff.*

Patient's Phone Number: _____ ☐ Mobile ☐ Home ☐ Other: _____

Mosaic Medical may *(please check all that apply)***:**

1. Leave **medical** information on voicemail: ☐ YES ☐ NO
2. Use for automated appointment reminders*: ☐ YES ☐ NO

SECTION 4

Please complete this section if there is anyone besides the parent/guardian that may regularly seek and authorize medical care for the patient AND/OR with whom a Mosaic Medical representative may share healthcare information about the patient [step parents, grandparents, etc. *(NOTE: This is not an authorization to release medical records.)]*

☐ **None**

Name: _____ **Relationship:** _____ **Phone:** _____

Regarding: *(please check all that apply)*

☐ Schedule or cancel appointments ☐ **All** Information ☐ Seek medical care ☐ Other: _____

Name: _____ **Relationship:** _____ **Phone:** _____

Regarding: *(please check all that apply)*

☐ Schedule or cancel appointments ☐ **All** Information ☐ Seek medical care ☐ Other: _____

SECTION 5

Signature required

This authorization may be changed or revoked in writing at any time, it will remain in effect until that time or the patient turns 18.

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 (Parent/Legal Guardian): _____ **Date:** _____

Print name (Parent/Legal Guardian): _____ **Relationship:** _____

MOSAIC

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 _____

MosaicMedical
Quality Care For All

MRN: _____

Health History - Minor

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

HOME ENVIRONMENT / Who lives with patient? *Please write in and/or circle the answers below.*				
Mother's name:	Biological / Step / Adoptive / Foster	Lives with child:	Yes	No
Father's name:	Biological / Step / Adoptive / Foster	Lives with child:	Yes	No
Other (name & relationship):				
Siblings (at home, first name and age/s):				
What type of residence? Single family / Apartment / Trailer / Temporary		Was it built before 1978?	Yes	No
Tobacco users/smokers at home?			Yes	No
Is there a child or adult at home who uses alcohol or drugs often?			Yes	No
Are there guns in the home?			Yes	No
Is anyone at home being hurt or touched in a bad way?			Yes	No
Does anyone at home have a problem with their mood?			Yes	No
Does your family have a hard time paying bills or for food?			Yes	No

ALLERGIES *Please write in or circle the answers below.*		
Does the patient have allergies?	Yes	No
Was allergy testing done?	Yes	No
To medications:		
To foods/other (bees, latex):		

MEDICINES *(list medication/s taken regularly)*

IMMUNIZATIONS *Please write in and/or circle the answers below.*			
Do you think the patient is up-to-date on recommended vaccines?	Not Sure	Yes	No
Do you have a current record of vaccines?		Yes	No
Any reactions or problems? (if yes, please describe):		Yes	No

PAST MEDICAL HISTORY *Please write in and/or circle the answers below.*		
Birth: Full term / Early / Late Pregnancy lasted: weeks (full term is 40) Birth Weight: pounds ounces		
Pregnancy complications? (if yes, please describe):	Yes	No
Tobacco / Alcohol / Drug use in pregnancy?	Yes	No
Birth complications? (if yes, please describe):	Yes	No
Hearing screen passed?	Yes	No
Hospital stay lasted: 1-3 days & routine / more than 3 days due to:		
Hospitalizations (list with date/s):		
Surgeries (list with date/s):		
Chronic illness/es (asthma, diabetes, allergy, eczema):		
Developmental delays / developmental therapies (speech, physical, occupational):		
Psychiatric care / hospitalization/s:		

MosaicMedical
Quality Care For All

FAMILY HISTORY *Please write in and/or circle the answers below.* Please note only affected blood relatives: Mother, Father, Brother/s, Sister/s, Grandparents, Aunts, Uncles, Cousins		
Alcohol or substance abuse:	Yes	No
Allergies (hay fever, other):	Yes	No
Arthritis (rheumatoid, lupus, other):	Yes	No
Asthma:	Yes	No
Abnormal bleeding or blood clotting:	Yes	No
Cancer (where:):	Yes	No
Mental health (Depression / Anxiety / Bipolar / Suicide):	Yes	No
Diabetes (Type 1, Type 2):	Yes	No
Digestive tract (Crohn's / Ulcerative colitis / Irritable bowel / Constipation / Hepatitis):	Yes	No
Genetic disease, birth defects:	Yes	No
Reproductive or Urinary problems:	Yes	No
Headaches / Migraine:	Yes	No
Heart disease:	Yes	No
High cholesterol:	Yes	No
High blood pressure:	Yes	No
Kidney disease (Stones / Infections / Kidney failure):	Yes	No
Muscle or skeletal problems:	Yes	No
Nervous system disorder (M.S., seizures):	Yes	No
Skin problems: (Eczema / Psoriasis)	Yes	No
Osteoporosis (bone loss):	Yes	No
Blood disorder (Sickle cell, thalassemia):	Yes	No
Stroke:	Yes	No
Thyroid disease:	Yes	No
Tuberculosis:	Yes	No
Learning problems or disability (ADHD / speech/ or language delay / dyslexia):	Yes	No
Vision problems:	Yes	No

REVIEW OF SYSTEMS *(please check if you have any of these problems now; let us know if you have any questions)*					
	Fever or chills		Chest pain		Joint stiffness or swelling
	Loss of appetite		Abnormal heart beat		Limp
	Weight gain or loss		Passing out		Abnormal gait or stance
	Fatigue		Spitting up frequently		Pain in back, arms or legs
	Trouble sleeping		Nausea / Vomiting		Worrisome or changing moles
	Depressed feelings		Abdominal pain		Hives
	Anxious or worried feelings		Diarrhea		Rash
	Thoughts of death or suicide		Constipation or irregularity		Blood clots
	Abnormal gaze or eye movements		Heartburn		Easy bruising or bleeding
	Vision loss or problems		Painful or difficult swallowing		Swollen lymph nodes or bumps
	Eye pain or redness		Blood in the stool		Headache
	Frequent nosebleeds		Pain or burning with urination		Weakness
	Ear pain		Frequent urination		Numbness
	Hearing loss		Blood in urine		Abnormal sensations
	Pain in mouth or teeth		Incontinence (can't control urine)		Females: Painful periods
	Hoarseness		Urinate too much		Females: Heavy periods
	Snoring nightly		Excessive thirst		Females: Irregular periods
	Shortness of breath		Excessive hunger		Females: Vaginal discharge
	Cough		Can't tolerate cold or heat		Males: Discharge from penis
	Wheezing		Sweat too much		Males: Testicle pain or swelling

Reviewed by _____ Date_____

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 of 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