



Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Dear Patient:

Welcome!

Thank you for choosing Northern Valley Indian Health, Inc. for your oral health care needs. Our team is dedicated to providing you with the personalized, gentle care that you deserve. This letter answers some of the most commonly asked questions by new patients. We hope you find this information useful.

Will I get a reminder of my appointment?

We use an automatic calling system for appointment reminders. The automatic system will call you two days in advance of your appointment or send a text message to your cell phone one day prior.

Can I stop the appointment reminders?

Patients are automatically signed up for both of these reminders during new patient registration. However, you may choose to stop either one or both reminders. This change can be completed by speaking with our reception staff.

What if I can't make it to my appointment?

We understand that situations may come up in today's busy world that are beyond your control. If you need to reschedule or cancel your scheduled appointment, it is our policy that we receive notification by 12:00pm one business day prior to your appointment. This notice allows us to operate efficiently and use the time that was reserved for you to help other patients in need. Notifications received after 12:00pm will be considered a no-show.

What if I missed my appointment?

Missed appointments or appointments that are canceled on the same day of the appointment are documented as a "no-show." Future "no-shows" may put you in risk of being dismissed altogether.

When should I arrive to my appointment?

We ask that you arrive 30 minutes prior to your new patient appointment with all paperwork completed. This allows us sufficient time for the new patient registration process.

What if I can't arrive 30 minutes prior to my appointment?

If you are unable to arrive 30 minutes prior to your new patient appointment, please give us a call. Please note: if enough time is not given due to a non-early arrival, the appointment may need to be rescheduled to another date and time.



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What should I bring to my appointment?

Please bring the following to your appointment:

- Completed Paperwork
- Completed Health History Forms (list of current medications)
- Dental Insurance Card and I.D. Card (required)
- Doctor Release, if needed (ex. Recent surgery or replacement surgery)

What will I need to pay for services at the appointment?

Fees for services are due at the time of service. We will bill your dental insurance company as a courtesy to you, however, any portion not paid by your insurance company is your responsibility at the time of service. If your insurance company reimburses you directly, you will be requested to pay at the time of service.

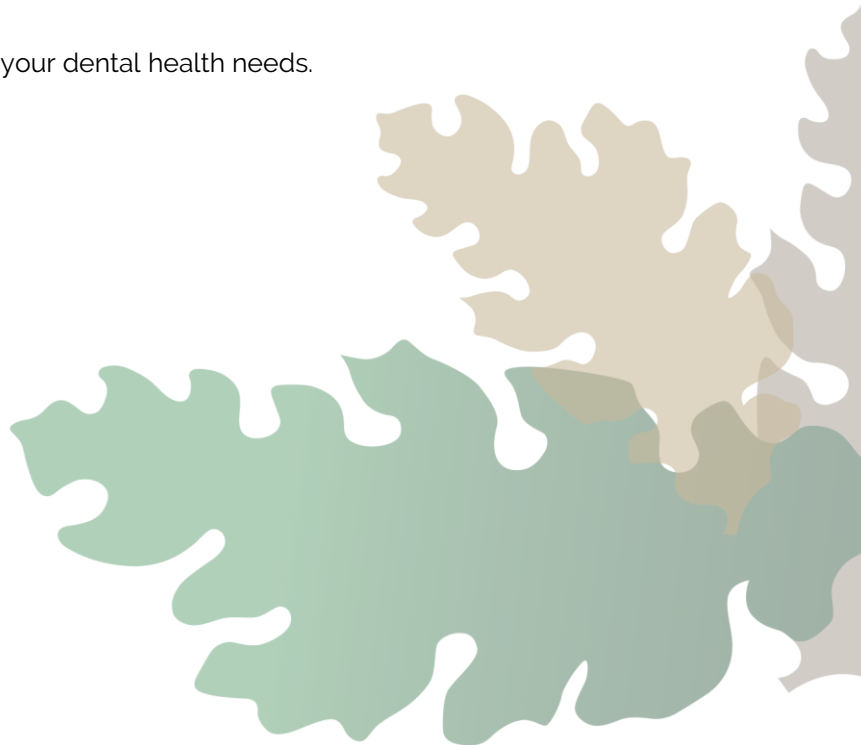
Do you offer discounts for uninsured patients??

If you are a self-pay patient, please inquire options for Sliding Fee Scale discounts and/or Care Credit services from the receptionist.

Minor Patients: A parent/legal guardian needs to accompany minor patients.

Thank you

for choosing Northern Valley Indian Health, Inc. for your dental health needs.
It is a great pleasure to welcome you!



PATIENT REGISTRATION FACESHEET

Patient Information:	
Last Name:	First Name: Middle Initial:
Patient's Previous Name:	
Patient's Preferred Name:	
Patient's Home Phone:	Cell Phone:
Mailing Address:	Physical Address (If different than mailing address):
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
County:	County:
Email:	Are you currently unhoused? <input type="checkbox"/> Yes or <input type="checkbox"/> No Are you a Veteran? <input type="checkbox"/> Yes or <input type="checkbox"/> No
Would you like to be Web enabled for the patient portal? <i>If yes, we will use your email above unless otherwise indicated.</i> <input type="checkbox"/> Yes or <input type="checkbox"/> No	
How would you like us to notify you for appointment reminders? PLEASE SELECT AT LEAST ONE OPTION: <input type="checkbox"/> Voice: Number to call: _____ <input type="checkbox"/> Text: Number to receive messages: _____ <input type="checkbox"/> Do not send appointment reminders	
Patient's date of birth: / /	Sex/Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Is the patient transgender?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/Other <input type="checkbox"/> Trans MTF <input type="checkbox"/> Trans FTM	
Current Legal Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/Other	
Patient's Social Security Number:	
Patient Marital Status:	
<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	
Preferred Language:	Interpretation Services Requested: <input type="checkbox"/> Yes or <input type="checkbox"/> No
Patient's Race:	
<input type="checkbox"/> American Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Declined to Specify <input type="checkbox"/> White	Or: _____ (Please fill in blank)
Are you Native American? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Tribe of Membership:
(NVIH Use Only) Patient Name: _____ HRN: _____	

**Parent/Guardian Information If Patient Is a Minor or Dependent Adult:**

Name:	Circle One: Father / Mother / Other	Phone:
Name:	Circle One: Father / Mother / Other	Phone:
Guardian's Name:	Phone:	

Patient Emergency Contact Information:

Relationship to patient:		
First Name:	Last Name:	MI:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Ext:
Cell Phone:		

Patient Employer Information:

Employer Name:		
Employer Address:		
City:	State:	Zip:

Insurance Information:

Please fill in information below and provide a copy of: Medicare, Medi-Cal, or Private Insurance Card(s)		
#1 Primary Insurance:		
Sub No:	Group No:	
Policy Holder Name:	<input type="checkbox"/> Self	Policy Holder's DOB:
Medicaid ID No:		
#2 Secondary Insurance:		
Policy Holder Name:	<input type="checkbox"/> Self	Policy Holder's DOB:
Group No:		
#3 (Tertiary)- Third Policy:		

Guarantor/Person Responsible for Payment

<input type="checkbox"/> SELF <input type="checkbox"/> Another patient or person <i>if so, complete this portion. If not, mark SELF</i>	
Name:	DOB:
Address:	
Phone:	Work:
Relationship to Patient:	

(NVIH Use Only) Patient Name: _____ **HRN:** _____

Terms and Conditions of Service

Consent for Treatment and Financial Agreement

1. NVIH: Northern Valley Indian Health, Inc. (NVIH) is a non-profit 501(c)(3) tribal organization and Tribal Federally Qualified Health Center (FQHC) system with federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. 25 U.S.C. 5301 et seq.
2. **CONSENT FOR TREATMENT:** I wish to receive health care services at NVIH. I consent to the medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment related photographs, videotaping, laboratory procedures, dental services, clinical services, behavioral health services, care and case management services or other services rendered to me under the general and special instructions of the provider or other health care professionals assisting in my care. I am aware that the practice of medicine, surgery, and therapy is not an exact science. I acknowledge that NVIH has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my provider or other health care professionals any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.
3. **TEACHING ACTIVITIES:** I understand that residents, interns, medical students, associate behavioral health clinicians, students of ancillary health care professions (e.g., nursing, social work), post-graduate fellows, and other learners and trainees may observe, examine, treat, and participate in my care at NVIH under the supervision of the attending health care professional as part of an approved external education/training program.
4. **CONSENT FOR COMMUNICATIONS:** I understand that I may receive messages and calls from or on behalf of NVIH, at the contact information provided, including my cell phone number and email address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I understand that if I email or text NVIH providers and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods as unencrypted messages could be intercepted. I acknowledge that all such communications may become part of my medical records.
5. **ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT:** In consideration of the health care services provided, I the undersigned, whether signing as a patient or legal guardian, irrevocably (without the right to revoke) and expressly assigns and transfers to NVIH all insurance benefits including government programs, private insurance, and any other health plan otherwise payable to or on my behalf for NVIH services. I hereby authorize the release of all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid

(NVIH Use Only) Patient Name: _____ **HRN:** _____

accounts referred to outside agencies for collection bear interest at the current legal rate.

6. **TELEHEALTH CONSENT:** Telehealth visits involve the use of telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering services. I understand that during my care at NVIH, I may be offered a telehealth visit if clinically appropriate. These services may include consultation, diagnosis, treatment recommendation, prescriptions, and/or referral to in-person care if further evaluation is needed. This service is offered to me as a convenience. I understand that I always maintain the option of choosing an in-person appointment if I prefer. If I am experiencing difficulty in accessing in-person services due to transportation, Medi-Cal provides coverage to beneficiaries for transportation services to in-person services when other resources have been reasonably exhausted. I understand that not all services will be clinically appropriate to complete via a telehealth visit and the option may be limited as determined by my provider. Should I agree to a telehealth visit, I consent to have my insurance billed for the services and will pay any relevant copays, coinsurances or for services not covered by insurance. I understand that during the telehealth visit, sensitive personal health information may be discussed, and it will be my responsibility to locate myself in a location that ensures privacy. I will also be expected to participate in a location that will not cause danger to myself or those around me (such as while driving). If my provider is concerned about my safety, they may terminate the visit. Telehealth visits are not appropriate for medical emergencies. If I believe I am having an emergency, I will call 911 and/or go to my nearest emergency room.
7. **BEHAVIOR:** NVIH has a zero tolerance for abuse, intimidation, harassment, or violence in our facilities. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. NVIH is committed to maintaining a safe workplace that is free from threats and acts that are disrespectful, discriminatory, hostile, or harassing. It is the expectation of NVIH that you and your visitors conduct yourselves in a respectful, non-violent, non-discriminatory, and non-abusive manner. I understand that any violation of NVIH's patient rights and responsibilities with unwelcome words or actions may lead to removal from NVIH premises and immediate termination as a patient of NVIH.
- I also understand that under California law I and my visitors cannot film, record, or disclose any images or sounds of our/my conversation with a NVIH employee or provider without the written consent of NVIH and all parties to the conversation, and that violation of this law may result in criminal and/or civil liability, and immediate removal/termination as a patient of NVIH.
8. **AUDIO/VIDEO RECORDING CONSENT:** I hereby consent to the use and transcription of audio and video recordings by NVIH and its providers and staff for treatment and service purposes. I understand that NVIH uses recording technology to capture and record my visits and other communications with NVIH and its providers and staff for treatment and services. I understand that NVIH uses third-party vendor(s) to process the recordings to generate clinical documentation and related activities. I expressly consent

(NVIH Use Only) Patient Name: _____ **HRN:** _____

to NVIH and its third-party vendor(s) to audio or video record my visits, transcribe and document my treatment and services, and permanently destroy the recordings. I understand that any use of my medical information will be in accordance with applicable law, including all applicable laws and regulations governing patient confidentiality, in the manner outlined in the NVIH Notice of Privacy Practices. I understand that I may request cessation of recordings at any time by written request to NVIH. I understand that my withdrawal of consent will not affect recordings made prior to receipt of the written request to stop recording.

9. **RELEASE OF MEDICAL INFORMATION:** I understand that my medical information, photographs, and/or video in any form may be used for other NVIH purposes, such as quality improvement, patient safety and education. NVIH will obtain my written authorization to release information about my medical treatment, except in those circumstances when NVIH is permitted or required by law to release information (see NVIH Notice of Privacy Practices for a description of the specific circumstances under which NVIH may release this information). I understand that any use of my medical information will be in accordance with applicable state and federal law, including all applicable laws and regulations governing patient confidentiality, in the manner outlined in the NVIH Notice of Privacy Practices. I understand that NVIH providers are mandated to report to the appropriate authorities, as required by State and/or Federal laws, when (1) my provider believes I may hurt myself or someone else, (2) my provider suspects child, dependent adult, or elder abuse, (3) or by a specific order of the Courts.
10. **NOTICE OF PRIVACY PRACTICES:** I have received and reviewed a copy of the Notice of Privacy Practices of NVIH which is also available at <https://nvih.org>. I understand that NVIH reserves the right to change its practices and the terms of this Notice of Privacy Practices for all medical information that NVIH maintains. NVIH will make available the revised Notice of Privacy Practices by posting it in all patient registration areas, where copies will also be available. The revised Notice of Privacy Practices will also be posted on our website at <https://nvih.org>.

Signature of Agreement: I have read this Terms and Conditions of Service agreement. On my own behalf, or on behalf of the patient, I accept and agree to be bound by all of the terms in this agreement until I revoke my agreement, consent, or authorization in writing to NVIH.

Signature of Patient or Patient Representative Date Time _____ ☐ AM ☐ PM

Signature of Representative to Patient

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Assignment of Benefits and Financial Agreement (Paragraph 5) set forth above.

Signature of Patient or Patient Representative Date Time _____ ☐ AM ☐ PM

Signature of Representative to Patient

(NVIH Use Only) Patient Name: _____ **HRN:** _____

Physician _____ Office Phone _____ Date of Last Exam _____

Patient Name _____ DOB _____ HRN _____

		Yes	No		
1.	Are you under medical treatment now?	Y	N		
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain: _____	Y	N		
3.	Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	Y	N		
4.	Is your child taking fluoride supplements?	Y	N		
5.	Have you ever taken Phen-Fen/Redux?	Y	N		
6.	Do you use tobacco in any form?	Y	N		
7.	Do you use a controlled Substance	Y	N		
8.	Do you drink alcohol	Y	N		
9.	Have you ever taken Bisphosphonate medications?	Y	N		
10.	Are you allergic to or have you had any reactions to the following:	Yes	No		
	Local Anesthetic (e.g. Novocain)	Y	N		
	Penicillin or other Antibiotics	Y	N		
	Sulfa Drugs	Y	N		
	Barbituates	Y	N		
	Iodine	Y	N		
	Sedatives	Y	N		
	Aspirin	Y	N		
	Any Metals (e.g. nickel, mercury, etc.)	Y	N		
	Latex Rubber	Y	N		
	Other _____				
11.	Women Only:	Yes	No		
	Are you pregnant or think you may be pregnant?	Y	N		
	Are you nursing?	Y	N		
	Are you taking oral contraceptives?	Y	N		
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:					
	Yes	No	Yes	No	
Developmentally delayed	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N
Low Blood Pressure	Y	N	Kidney Disease	Y	N
Heart Attack	Y	N	Leukemia	Y	N
Cardiac Pacemaker	Y	N	Aids or HIV	Y	N
Heart Murmur	Y	N	Thyroid Problem	Y	N
Heart Trouble	Y	N	Frequently Tired	Y	N
Angina/Chest Pain	Y	N	Anemia/Sickle Cell	Y	N
Rheumatic Fever	Y	N	Bleeding disorder	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N
Fainting/Seizures	Y	N	Arthritis	Y	N
Epilepsy/Seizures	Y	N	Liver Disease	Y	N
Stroke	Y	N	Cancer	Y	N
Swollen Ankles	Y	N	Hay Fever/Allergies	Y	N

NORTHERN VALLEY INDIAN HEALTH, INC.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING continued:

	Yes	No		Yes	No
Joint Replacement of Implant	Y	N	Glaucoma	Y	N
Hepatitis A B C (circle)	Y	N	Recent Weight Loss	Y	N
Sexually Transmitted Disease	Y	N	Easily Winded	Y	N
Stomach Troubles/Ulcers	Y	N	Respiratory Problems	Y	N
Tuberculosis	Y	N	Mental/Nervous Disorder	Y	N
Radiation Therapy	Y	N	Dementia	Y	N
Other _____					

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

Have you ever experienced any of the following problems in your jaw?	Yes	No		
Clicking	Y	N		
Pain (joint, ear, side of face)	Y	N		
Difficulty in opening or closing	Y	N		
Difficulty in Chewing	Y	N		
Do your gums bleed while brushing or flossing?	Y	N		
Are your teeth sensitive to hot or cold liquids/food?	Y	N		
Are your teeth sensitive to sweet or sour liquids/food?	Y	N		
Do you have any sores or lumps in or near your mouth?	Y	N		
Have you had any head, neck, or jaw injuries?	Y	N	Yes	No
Do you have frequent headaches?			Y	N
Do you clench or grind your teeth?			Y	N
Do you bite your lips or cheeks frequently?			Y	N
Have you ever had any difficulty or any prolonged bleeding with extractions in the past?			Y	N
Have you had any orthodontic treatment?			Y	N
Do you wear dentures or partials? (circle)?			Y	N
Have you ever received oral hygiene instructions regarding the care of your teeth?			Y	N
YOUR CHILDS HABITS:				
	Yes	No		
Used a Pacifier now or in the past?	Y	N		
Thumb sucking now or in the past?	Y	N		

Authorization and Release:

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect answers can be dangerous to my health.

X _____ X _____
 Signature of patient (or parent/guardian if minor) Date Signature of Dentist Date

Patient Name _____ DOB _____ HRN _____



Chico Clinic

845 W. East Avenue
Chico, CA 95926
(530) 896-9400
Fax: (530) 896-9407

Dental and Maternal Health Center

500 Cohasset Rd. Ste 15
Chico, CA 95926
(530) 433-2500
Fax: (530) 433-2510

Children's Health Center

1515 Springfield Dr. Ste 175
Chico, CA 95928
(530) 781-1440
Fax: (530) 342-1663

Red Bluff Clinic

2500 N. Main Street
Red Bluff, CA 96080
(530) 529-2567
Fax: (530) 529-2552

Willows Clinic

207 N. Butte Street
Willows, CA 95988
(530) 934-4641
Fax: (530) 934-4081

Woodland Clinic

175 West Court Street
Woodland, CA 95695
(530) 661-4400
Fax: (530) 661-4416

Northern Valley Indian Health, Inc.

Mobile Dental Clinic

530-520-6913

www.nvih.org

DENTAL MATERIALS FACT SHEET

The Dental Board of California is required by law* to make this Dental Material Fact Sheet available to every licensed dentist in the State of California. Your dentist, in turn, must provide this Dental Material Fact Sheet to every new patient of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling material being considered for your particular treatment.

(*Business and Professions Code 1648.10-1648.20)

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge I have been given the opportunity to receive from Northern Valley Indian Health, Inc., a copy of the Dental Materials Fact Sheet.

(Patient/Parent/Guardian Signature) Date: _____

(Patient Name-Printed) DOB: _____

Northern Valley Indian Health, Inc.



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 THE FOLLOWING INFORMATION
CAREFULLY.**

Understanding Your Health Information

Each time you visit a Northern Valley Indian Health (NVIH) facility for services, a record of your visit is made. If you are referred by NVIH through the Purchased Referred Care (PRC) program, NVIH also keeps a record of your PRC visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your 'health record,' serves as a:

- Plan for your care and treatment, and as a communication source between health care professionals.
- Tool we can use to check results and continually work to improve care.
- Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
- Tool for education of health care professionals.
- Source of information for public health authorities charged with improving health.
- Source of data for medical research, facility planning, and marketing.
- Legal document that describes your care.

Understanding what is in your health record and how the information is used helps you to:

- Ensure its accuracy.
- Better understand why others may review your health information.
- Make an informed decision when authorizing disclosures.

Your Health Information Rights

Although your health record is the physical property of NVIH, the information belongs to you. You have the following rights with respect to your health information:

To Inspect and Copy. You have the right to inspect and copy certain health information. If you request a copy of the information, we may, as permitted by applicable law, charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information you may, with limited exceptions, request that the denial be reviewed by submitting a written request to the Chief Executive Director or HIPAA Privacy Officer.

To an Electronic Copy of Electronic Records. If your health information is maintained in an electronic form, such as an electronic health record, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the form or format you request, if it is readily producible in such form or format. If it is not, then your information will be provided to you in our standard electronic format (unless you prefer a hard copy).

To Notice of Breach. You have the right to be notified if there was unauthorized access to or disclosure of your health information.

To Request a Restriction. You have the right to request a restriction on information we use or disclose about you: (1) for treatment, payment, or health care operations; or (2) to someone who is involved in your care, such as a family member or friend. NVIH is not required to agree to your request, but if we do we will comply with your request unless the information is needed to provide you with emergency services. Also, if you paid out-of-pocket in full for a specific item or service, you may ask that your health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

To Request Amendment. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as it is kept by us. To request an amendment, your request must be made in writing and submitted to the Chief Executive Director or HIPAA Privacy Officer, along with a reason that supports your request. We may deny your request for an amendment in certain limited situations. If we deny your request, you have the right to file a statement of disagreement with us.

To Request Confidential Communications. You have a right to ask to receive confidential communications in a different manner or at a different place (for example, you may ask that we communicate with you at a location other than your home or by a different means of communications such as telephone or mail). Such a request must be submitted in writing to the Chief Executive Director or HIPAA Privacy Officer.

To a List of Disclosures. You have the right to request a list and description of certain disclosures by NVIH of your health information. Such request must be made in writing. The first list you request within a 12-month period will be provided free of charge, but subsequent requests within the same period may be subject to a fee (in which case we will notify you of the cost and you may choose to withdraw or modify your request.) This information is maintained for six years or the life of the record, whichever is longer.

To Obtain a Paper Copy of the NVIH Notice of Privacy Practices one will be available upon request, even if you have agreed to receive this Notice electronically.

NVIH's Responsibilities

NVIH is required by law to:

- Maintain the privacy of your health information.
- Inform you about our privacy practices regarding health information we collect and maintain about you.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternate means or at alternate locations.
- Honor the terms of this Notice or any subsequent revisions of this Notice.

NVIH reserves the right to change its privacy practices and to make the new provisions effective for all health information it maintains. NVIH will post any revised Notice of Privacy Practices at public places in its health care facilities and on its web site at www.nvih.org.

How NVIH may use and disclose health information about you:

We may use and disclose your health information without your permission to facilitate your medical treatment, payment of any medical treatment, and for any other health care operation, as described in this Notice. We may also use and disclose your health information without your permission as allowed or required by applicable law. Otherwise, we must obtain your written authorization for any other use and disclosure of your health information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given. The following categories describe how we may use and disclose health information about you:

For Treatment. We will use and disclose your health information to provide medical treatment or help other providers to treat you. For example:

- Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider will document in your health record his/her instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your health record so your health care provider will know how you are responding to treatment.
- If NVIH refers you to another health care facility, NVIH may disclose your health information to that health care provider for treatment decisions.
- If you are transferred to another facility for further care and treatment, NVIH may disclose information to that facility to enable them to know the extent of treatment you have received and other information about your condition.

- Your health care provider(s) may give copies of your health information to others to assist in your treatment.

For Payment Purposes. We will use and disclose your health information for payment purposes. For example:

- If you have private insurance, Medicare, or Medicaid coverage, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
- If NVIH refers you to another health care provider, NVIH may disclose your health information with that provider for health care payment purposes.

For Health Care Operations. We will use and disclose your health information for health care operations. For example, we may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under PRC program.

Health Information Exchange (HIE) HIE services are planned in the future for NVIH and once active HIE may make your health information available electronically through an information exchange network to other providers involved in your care who requests your electronic health information. Participation in the national eHealth Exchange network is voluntary. If you want your health information to be accessible to authorized health care providers through the HIE to the national eHealth Exchange, you must authorize this use and disclosure. More information is available at <http://www.ihs.gov/hie/>

Personal Health Record. The ability for you to access to your Personal Health Record electronically is planned in the future. Personal Health Record (PHR) is a secure web based application that provides patient access to their health care information. The PHR is accessible to any patient who receives care at an NVIH and requests a PHR account.

Direct. NVIH may share your health information between healthcare providers, patients and/or patients' authorized representatives, using the DIRECT secure, web-based messaging service.

To Business Associates: NVIH provides some healthcare services and related functions through the use of contracts with business associates. For example, NVIH may have contracts for medical transcription. When these services are contracted, NVIH may disclose your health information to business associates so that they can perform their jobs. We require our business associates to protect and safeguard your health information in accordance with all applicable federal laws.

To Persons Involved in Your Care: NVIH may notify your family of your location or general condition. NVIH may also provide your health information to a person involved in your care or who helps pay for your care, such as a family member or friend, unless you notify us that you object, or when you are incapacitated or in an emergency. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. We may also make similar professional judgments about your best interests that allow another person to pick up such things as your filled prescriptions, medical supplies, and x-rays. There may also be circumstances when we can assume, based on our professional judgment, that you would not object, such as when your spouse comes with you into an exam room during treatment.

Adults and Emancipated Minors With Personal Representatives or Legal Guardians: NVIH shall treat a personal representative or legal guardian of an individual, who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction, as the individual for the purposes of the use and disclosure of the individual's health information, as such use and disclosure relates to such personal representation.

Interpreters: In order to provide you proper care and services, NVIH may use the services of an interpreter. This may require the use or disclosure of your personal health information to the interpreter.

Research: NVIH may use or disclose your health information for research purposes that has been approved by an NVIH Institutional Review Board that has reviewed the research proposal and established protocols to ensure

the privacy of your health information. NVIH may also use or disclose your health information for research purposes based on your written authorization.

Uses and Disclosures about Decedents: When an individual is deceased, NVIH may disclose health information about the decedent when required by applicable law, and to the following categories of individuals:

- A family member, personal representative, or other authorized person(s) responsible for the decedent's care, as relevant to his or her responsibility for such care, unless we know that doing so would be inconsistent with the decedent's prior-expressed preferences.
- A coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- Funeral directors consistent with applicable law as necessary to carry out their duties.

Organ Procurement Organizations: Consistent with applicable laws, NVIH may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of facilitating organ, eye, or tissue donation and transplant.

Appointment Reminders, Treatment Alternatives and Other Health-related Benefits and Services: We may contact you to remind you that you have an appointment with us or to discuss a missed appointment, and to provide information about treatment alternatives or other types of health-related benefits and services that may be of interest to you. For example, we may contact you about the availability of new treatment or services for diabetes.

Food and Drug Administration (FDA): NVIH may use or disclose your health information to the FDA in connection with an FDA-regulated product or activity. For example, we may disclose to the FDA information concerning adverse events involving food, dietary supplements, product defects or problems, and information needed to track FDA-regulated products, or to conduct product recalls, repairs, replacements, or lookbacks (including locating people who have received products that have been recalled or withdrawn), or post marketing surveillance.

Worker's Compensation: NVIH may use or disclose your health information for workers compensation purposes as authorized or required by applicable law.

Public Health: NVIH may use or disclose your health information for public health activities as follows:

- To a public health authority authorized by applicable law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions.
- To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect.
- To a government authority authorized by applicable law to receive reports of other abuse, neglect, or domestic violence (other than child abuse).
- To an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, where authorized by applicable law.
- To the individual's employer (for example, if you are employed by NVIH, or if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public), concerning a work-related illness or injury or a workplace-related medical surveillance, or as otherwise required or permitted by applicable law.
- To the individual's school or prospective school for proof of immunization, if such proof is required by applicable law, and we obtain the agreement of either a parent, guardian, or other person legally responsible for the individual (or from the individual if he or she is an adult or emancipated minor).

Correctional Institution: If you are an inmate of a correctional institution, NVIH may use or disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement: NVIH may use or disclose your health information for law enforcement activities as required or authorized by applicable law. Such situations include the following:

- To report certain types of wounds or injuries.
- In response to a court order, subpoena, warrant, or other similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- If you are believed to be a victim of a crime and a law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency and if we determine that such disclosure would be in your best interests.
- About a death we believe may have been the result of criminal conduct.
- To report a crime committed on NVIH premises.
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description, or location of the person who committed the crime.

Military and Veterans: If you are a member of the armed forces, NVIH may use or disclose your health information, if necessary, to the appropriate military command authorities or to determine eligibility for benefits, as authorized by applicable law.

Health Oversight Authorities: NVIH may use or disclose your health information to health oversight agencies for activities authorized by applicable law. These oversight activities include: investigations, audits, inspections, and other actions. These are necessary for the government to monitor the health care system and government benefit programs, among other requirements. NVIH is required by applicable law to disclose health information to the Secretary of HHS to investigate or determine compliance with the HIPAA privacy standards.

Compelling Circumstances: NVIH may use or disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances:

- We may disclose health information we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person.
- We may use or disclose health information in the course of judiciary and administrative proceedings if required or authorized by applicable law.
- We may use or disclose health information during a disaster and for disaster relief purposes.
- We may release health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by applicable law.
- We may make any other disclosures that are required by applicable law.

For Data Breach Notification Purposes. We may use or disclose your health information to provide legally-required notices of unauthorized access to or disclosure of your health information.

Authorization Required. NVIH will use or disclose your health information only with your written authorization in the following circumstances:

- Any use or disclosure of your psychotherapy notes; except that we do not need your written authorization to use such notes for treatment, payment, or health care operations, nor in other limited circumstances required or permitted by applicable law.
- Any use or disclosure of your health information for marketing; except that we do not need your written authorization for face-to-face communications or to give you promotional gifts with nominal value.
- The sale of your health information.

Non-Violation of this Notice: NVIH is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses protected health information under the following circumstances:

- *Disclosures by Whistleblowers:* If an NVIH employee or contractor (business associate) in good faith believes that NVIH has engaged in conduct that is unlawful or otherwise violates clinical and professional

standards, or that the care or services provided by NVIH has the potential of endangering one or more patients, members of the workplace, or the public, and discloses such information to:

- A Public Health Authority or Health Oversight Authority authorized by applicable law to investigate or otherwise oversee the relevant conduct, conditions, or suspected violations, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by NVIH; or
- An attorney on behalf of the workforce member, or contractor (business associate), or hired by the workforce member or contractor (business associate) for the purpose of determining their legal options regarding the suspected violation.
- *Disclosure by Workforce Member Crime Victims:* Under certain circumstances, a NVIH workforce member (either an employee or contractor) who is a victim of a crime, on or off the NVIH premises, may disclose information about the suspect to law enforcement official provided that the information disclosed is about the suspect who committed the criminal act and the information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures not described in this Notice will be made only with your written authorization, which you may later revoke in writing at any time. To revoke your authorization, deliver a written revocation to the Chief Executive Director or HIPAA Privacy Officer. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent we have already used or disclosed your health information in reliance on your authorization, or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

To exercise your rights under this Notice, to ask for more information, or to report a problem contact the Chief Executive Director or HIPAA Privacy Officer at:

Chico W. East Ave
(530) 896-9400

Children's Health Center
(530)781-1440

Dental and Maternal Health Center
(530) 433-2500

Willows
(530) 934-4641

Red Bluff
(530) 529-2567

Woodland
(530) 661-4400

If you believe your privacy rights have been violated, you may file a written complaint with the above individual(s) or the Secretary of Health and Human Services, U.S. Department of Health and Human Services, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

Effective Date: [September 2013, January 27, 2014]



Chico Clinic

845 W. East Avenue
Chico, CA 95926
(530) 896-9400
Fax: (530) 896-9407

Dental and Maternal Health Center

500 Cohasset Rd. Ste 15
Chico, CA 95926
(530) 433-2500
Fax: (530) 433-2511

Children's Health Center

1515 Springfield Dr. Ste 175
Chico, CA 95928
(530) 781-1440
Fax: (530) 342-1663

Red Bluff Clinic

2500 N. Main Street
Red Bluff, CA 96080
(530) 529-2567
Fax: (530) 529-2552

Willows Clinic

207 N. Butte Street
Willows, CA 95988
(530) 934-4641
Fax: (530) 934-4081

Woodland Clinic

175 West Court Street
Woodland, CA 95695
(530) 661-4400
Fax: (530) 661-4416

Northern Valley Indian Health, Inc.

Mobile Dental Clinic
530-520-6913
www.nvih.org

Acknowledgement of Receipt of NVIH Notice of Privacy Practices

I hereby acknowledge receipt of Northern Valley Indian Health (NVIH)
Notice of Privacy Practice information.

☐ I, the Patient/Legally Authorized person am able to communicate effectively in English.

Signature of Patient

DOB

Date

Signature of Patient Representative
(State relationship to patient)

Date

Signature and Title of NVIH Employee

Date

For Patients unable to Acknowledge Receipt or Refuses NVIH Notice of Privacy Practices

I hereby certify that the patient was unable to acknowledge receipt of the NVIH Notice of Privacy Practices
because: _____

Signature and Title of NVIH Employee

Date

Signature of NVIH Employee (Witness)

Date

Patient Name _____ HRN _____



Northern Valley Indian Health

Your Health. Our Mission.

Clinic Appointment Policy

PURPOSE

In order to maintain quality patient care and timely access to care, the following established guidelines regarding appointments with NVIH healthcare clinics are to be followed:

POLICY

New Patient Appointments:

1. New patients unable to keep their scheduled initial appointment must notify the Clinic staff. Notification must be made by no later than 12:00 p.m. one business day in advance of the intended cancellation. Failure to do so is considered a missed (no-show) appointment.
2. New patients who miss their scheduled initial appointment twice will not be rescheduled. *(Exceptions may be authorized by the Lead Provider or Department Director.)

Established Patient Appointments:

1. Patients unable to keep a scheduled appointment must notify the Clinic staff no later than 12:00 p.m. one business day in advance of the scheduled appointment of the intended cancellation. Failure to do so is considered a missed (no-showed) appointment.
2. Arriving more than ten minutes late for a scheduled appointment may result in the Clinic Provider determining the patient has missed (no-showed) the scheduled appointment.
3. Late arrival for any same day appointment scheduled for 15 minutes or less will not be seen by the provider due to limited length of time and will be considered a no-show.
4. Patients will be considered a high risk no-show patient if patient misses two appointments within a 12-month period and may receive a notification from NVIH with information of future inability to reserve individual scheduled appointments time slots. Notification will inform patient the option of being seen as a stand-by or same-day patient appointment as available.
5. If after three missed appointments in a 6-month period a patient continues to miss appointments, the patient may be dismissed from the associated clinical services altogether as a direct result of being “noncompliant to treatment,” at the Clinic Provider’s discretion. A stand-by or same-day work-in option will be considered for Native American patients. **



Northern Valley Indian Health

Your Health. Our Mission.

Clinic Appointment Policy

6. If patient is allowed to continue after three missed appointments in a 6-month period and continues to miss future appointments, patient will be dismissed from the associated clinical services at the discretion of the Department Director. A stand-by or same-day work-in option will be considered for Native American patients. **

DEFINITIONS

New Patient: A person who has not previously been registered within the NVIH system; or, a patient who has been registered within the NVIH system but has not had an established care visit; or, a patient who has been registered within the NVIH system but has not been an active patient for at least three years.

Stand-by: Patient will be scheduled in a time slot that would be considered a double-booked space. Staff will work efficiently to seat/room the patient in a timely fashion. Patient should expect to have some delay in seeing the provider. Visit type will likely be limited in focus depending on available time (e.g.: Dental treatment may be limited to limited exam/minor treatment).

Same-day: Patient will call in the same day and be advised on availability/arrival time for a same-day work in appointment as available at associated site. Staff will work efficiently to seat/room the patient in a timely fashion but minor delays may occur.

* Native American patients will be placed on a stand-by or same day work-in option.

**Dismissal of patients will be considered, in accordance with the Patient Termination Policy.

Patient Acknowledgement:

I hereby acknowledge that I have been given the opportunity to review the Clinic Appointment Policy and receive a copy if requested.

Patient Printed Name: _____ Patient DOB: _____

Patient/Parent Signature: _____ Date: _____

NVIH Use Only:

HRN: _____