Northern Valley Indian Health

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:
_____

City: _____ State: _____ Zip: _____

County:

Physical Address (If different than mailing address):
_____

City: _____ State: _____ Zip: _____

County:

Email:

Are you currently unhoused? □ Yes or □ No
Are you a Veteran? □ Yes or □ No

Would you like to be Web enabled for the patient portal? *If yes, we will use your email above unless otherwise indicated.* □ Yes or □ No

How would you like us to notify you for appointment reminders? PLEASE SELECT AT LEAST ONE OPTION:
□ Voice: Number to call: _____ □ Text: Number to receive messages: _____
□ Do not send appointment reminders

Patient's date of birth: / / Sex/Gender assigned at birth: □ Male □ Female

Is the patient transgender?: □ Yes □ No

Gender Identity: □ Male □ Female □ Non-Binary/Other □ Trans MTF □ Trans FTM

Current Legal Gender: □ Male □ Female □ Non-Binary/Other

Patient's Social Security Number:

Patient Marital Status:

□ Divorced □ Married □ Partner □ Single □ Unknown □ Widowed □ Legally Separated

Preferred Language: Interpretation Services Requested: □ Yes or □ No

Patient's Race:

□ American Indian □ Black or African American □ Declined to Specify □ White Or: _____
(Please fill in blank)

Are you Native American? □ Yes or □ No Tribe of Membership:

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

Parent/Guardian Information If Patient Is a Minor of 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:	□ Self	Policy Holder's DOB:
Medicaid ID No:		
#2 Secondary Insurance:		
Policy Holder Name:	□ Self	Policy Holder's DOB:
Group No:		
#3 (Tertiary)- Third Policy:		
Guarantor/Person Responsible for Payment		
□ SELF □ Another patient or person *if so, complete this portion. If not, mark SELF*		
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.

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

_____
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.

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

_____
Signature of Representative to Patient

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

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Pediatric Medical History

Patient Name: _____ DOB: _____

Mother's Full Name: _____ DOB: _____

Mother's Maiden Name: _____ DOB: _____

Father's Full Name: _____ DOB: _____

Legal Guardian Name (if applicable): _____

Relationship to Child: _____

Is child currently in Foster Care? ☐ Yes ☐ No Has child ever been in Foster Care? ☐ Yes ☐ No

Who all lives with your child? _____

List all siblings' names (first and last) and DOB

Name	DOB
Name	DOB
Name	DOB
Name	DOB

List Current Medications and dosage and frequency of medication

Any allergies? ☐ Yes ☐ No If Yes, please identify below:

☐ Food: _____

☐ Medication: _____

☐ Insects: _____

☐ Other: _____

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Pediatric Medical History

Patient Name:_____HRN: _____

Birth History:

Birth Weight: _____ ☐ Vaginal birth ☐ C-Section ☐ Birth Hospital: _____

Problems: ☐ Jaundice ☐ Respiratory distress and/or needing oxygen ☐ Breech delivery

☐ Greater than 3 day Nursery Stay ☐ Other: _____

☐ Ongoing Diagnosis: _____

Medical History of Child (please check positive illness/conditions):

☐ ADHD/behavior problems	☐ Eye/Seeing problems
☐ Anemia (low iron)	☐ Eczema (dry skin)
☐ Allergies - Seasonal	☐ Seizures with or without fever
☐ Asthma/wheezing	☐ Kidney/bladder/bowel issues
☐ Diabetes	☐ Heart problem/heart murmur
☐ Developmental Delay	☐ Other
☐ Ear/Hearing problems	☐ Other

Overnight hospital stays/surgeries: ☐ Yes ☐ No If yes, please list reason and date:

1.
2.
3.

Family History (please check all that apply):

	Father	Mother	Paternal grandfather	Paternal grandmother	Maternal grandfather	Maternal grandmother	Sibling
Asthma							
Allergies							
Birth Defects							
Cancer							
Seizures							
Heart Disease							
High Blood Pressure							
Kidney Disease							
ADHD							
Anxiety/Depression							
Substance abuse							
Thyroid disease							
Diabetes							
Other							

Completed by: _____ Date: _____

Clinic Appointment Policy Acknowledgement

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 who are unable to keep their scheduled initial appointment must notify clinic staff no later than one business day in advance of the intended cancellation. Failure to do so will be 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 who are unable to keep a scheduled appointment must notify clinic staff no later than one day in advance of the scheduled appointment. Failure to do so will be considered a missed (no-show) appointment.
2. Arriving more than ten minutes late for a scheduled appointment may result in the Clinic Site Manager determining the appointment has been missed (no-show).
3. Late arrival for any same day appointment scheduled for 15 minutes or less may result in not being seen by the provider due to limited length of time and will be considered a no-show.
4. Patients will be considered high-risk no-show patients if they miss two appointments within a 12-month period. Patients may receive written notification from NVIH outlining the following potential actions: (1) inability to reserve individual scheduled appointment time slots; (2) limitation on the number of future appointments scheduled; and/or (3) cancellation of scheduled future appointments. Notification will also inform the patient of the option to be seen as a stand-by or same-day patient, as available.
5. If a patient misses three appointments within a six-month period and continues to miss appointments, the patient may be dismissed from associated clinical services as a result of noncompliance with treatment, at the rendering provider's discretion. For Native American patients, a stand-by or same-day work-in option will be considered in lieu of dismissal. **
6. If a patient is allowed to continue care after three missed appointments within a six-month period and continues to miss future appointments, the patient may be dismissed from associated clinical services at the discretion of the Department Director. For Native American patients, a stand-by or same-day work-in option will be considered in lieu of dismissal. **
7. Patients who exhibit a pattern of chronic appointment cancellations, despite providing appropriate notice, may be subject to the following: (1) limitation on the number of future appointments scheduled; (2) cancellation of

scheduled future appointments; or (3) transition to same-day appointment status. This measure ensures equitable access to care by reducing unused reserved appointment time slots.

Definitions

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

Stand-by: A patient scheduled in a double-booked time slot. Staff will work efficiently to room the patient in a timely manner. The patient should expect potential delays in seeing the provider, and visit services may be limited based on available time. (e.g.: Dental treatment may be limited to limited exam/minor treatment).

Same-day: A patient who calls on the same day and is advised regarding availability and arrival time for a same-day work-in appointment. Minor delays may occur.

Chronic appointment cancellations: Patients who cancel three or more appointments within a 6-month period.

*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 acknowledge that I have been given the opportunity to review the Clinic Appointment Policy and that a copy has been provided to me upon request.

Patient Printed Name: _____ Patient DOB: _____

Patient/Parent Signature: _____ Date: _____

****

NVIH Use Only:

HRN: _____

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

AUTHORIZATION TO SEEK MEDICAL CARE

Date: _____

As the parent or legal guardian of _____**, I authorize**
(Print Minor Patient's Name)

_____**to seek healthcare attention for my child from**
(Print Name of Family Member or Friend)

_____ **to** _____**. I also consent to any medical treatment or procedures,**
(start date) **(end date)**

to be performed for my child by a licensed medical provider, that are necessary or advisable in the interest of my child's wellbeing.

This form is valid for a maximum of one year. It is the parent or legal guardian's responsibility to notify **Northern Valley Indian Health of any changes that might apply.**

Under the circumstances set forth above, I elect not to be informed in advance of the nature character of the proposed treatments, its results, possible alternatives, and the risks, complications, and anticipated benefits involved in the proposed treatments, and the alternative forms of treatment, including non-treatment.

Parent/Guardian Name (please print):_____

Parent/Guardian Signature: _____Date:_____

FOR NVIH USE ONLY:

_____ **HRN** _____

Patient Name

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, hereby voluntarily authorize the disclosure of information from my record.

Patient Name: _____ Patient Date of Birth: ____-____-____

I.

The information is to be disclosed by: NAME OF FACILITY	**And is to be provided to/or discussed with**: NAME OF PERSON/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE
Phone Number:	Phone Number:
FAX Number:	FAX Number:

II. The purpose or need for this disclosure is:_____

III. The information to be disclosed from my health record: *(Check appropriate box(es)*

☐ Default includes all in this box	**☐ Immunizations**	**☐ Chart notes: Last 1 Year**
☐ Newborn Records	**☐ CHDP/PM 160**	**☐ Laboratory: Last 1 Year**
☐ Growth Charts	**☐ Radiology:_____**	**☐ Medication List**

☐ Other:_____	**☐ All procedure notes**	**☐ Specialist Notes Last 3 Years**
☐ Entire record	**☐ Only information related to (specify):**	
☐ Date Range: _____to _____	**_____**	
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any Psychotherapist-patient privilege)		

How do you prefer the information be disclosed: ☐ e-mail ☐ Fax ☐ Paper ☐ Verbally
Provide e-mail address if disclosure is by e-mail_____
If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

Name_____HRN_____

IV. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one-year from the date of my signature unless I have specified a different expiration date or expiration event.____

I understand that NVIH will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that according to the California Confidentiality of Medical Information Act (CMIA) [Civil Code Section 56.13] the recipient of my health information may not further disclose the released information unless the recipient obtains another authorization from me or unless the disclosure is required by law. In instances where the CMIA doesn't apply, information disclosed by this authorization may be subject to a redisclosure by the recipient and may no longer be protected by the Health Insurance and Portability Accountability Act Privacy Rules [45cfr Part 164].

All Alcohol and Substance abuse health information is protected by the Public Health Service Act (42 CFR 2.1-2.67). The recipient of Alcohol or Substance abuse health information is bound by the regulations in the Public Health Service Act (42 CFR 2.1- 2.67). Specifically these regulations state that further disclosure of this information is prohibited except with the express written consent of the person it pertains to, unless otherwise permitted by the Public Health Service Act (42 CFR 2.1-2.67). Express written consent must meet the standards of the Public Health Service Act (42 CFR 2.1-2.67). A court order is required for any Alcohol or Substance abuse health information that is to be used for criminal investigation of a patient.

_____Date_____
Signature of Patient or Signature of Authorized Representative (*State relationship to patient*)

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual under false pretenses shall be guilty of a misdemeanor (5 USC 552a (I) (3)

Disclosure Processed by NVIH Staff:_____Date Completed:_____

Each patient has a right to a copy of this authorization
NAME_____HRN_____