PIT RIVER HEALTH SERVICE

36977 PARK AVE
BURNEY, CA 96013
530-335-3651

If you are new to the Pit River Health Service please be sure to bring the following items to your first appointment.

- Insurance cards
- Picture Id
- Tribal verification, if you are Native-American:

  To show descendancy you must provide:

  1. Your grandparents Indian Verification
  2. Your parents County Birth Certificate & County of Birth
  3. Your own County Birth Certificate

  To show descendancy from an Indian parent you must provide:

  1. Your parents Indian Verification
  2. Your own County Birth Certificate

Please note: Dental now accepts children under 21 with Medi-cal or private insurance and adults with Medi-cal. Native Americans must have their tribal certification on file when being seen in dental or they cannot be seen without meeting the other two criteria.

Thank you

Intake Eligibility Clerk

Pit River Health Service, INC.
Patient Registration

Name: ____

Last *First* *Middle*

Sex: M / F SSN: ________________ *DOB:* ______________ *Indian / Non-Indian*

Name of Tribe: ____________________ *State Enrolled:* ______________

Tribal/BIA Roll #: __________________ *Indian Blood Degree:* ____________

Present Community: ______________ *Date moved to the community:* ________

Marital Status: ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Place of Birth: City __________________________ *State* ______________

Do you have internet access? Y / N If yes from where? Home / Work / School / Library

Mailing Address: ____

____

Physical Address: ____

____

Home Phone (___) __________ *Cell (___)* __________ *Msg.(___)* __________

Employer Name: ______________________ *Work Phone(___)* ____________

Employment Status: Full Time / Part Time

Number of People in the household ______

Estimated Family Income: __________ *Monthly / Annually*

Emergency Contact: Name: ______________________________________

Address: ______________________________________

____

Phone: (___) ____________ *Relationship:* ____________

Next of Kin: Name: ________________________________

Address: ________________________________

____

Phone: (____) ______________ Relationship: __________

Insurance Information:

Name of Insurance Company: ________________________________

Policy Holder: ________________________________

Policy Number: ______________________ Effective Date: __________

PLEASE BRING YOUR INSURANCE CARD WITH YOU SO WE CAN MAKE A COPY OF IT

Religious Preference: ________________________________

Father's Name: ________________________________

Last First

Father's City of Birth: ______________________ State: __________

Father's Employer: ________________________________

Father's Phone Number: (____) ______________

Mother's Maiden Name: ________________________________

Last First

Mother's City of Birth: ______________________ State: __________

Mother's Employer: ________________________________

Mother's Phone Number: (____) ______________

Are you a veteran? Y / N If Yes Branch: ______________________

Do you (Patient) have any liability claims pending? ______________

Do you (Patient) have any workers compensation claims pending? __________

The following optional questions are used for statistical information for IHS

Are you of Hispanic descent? Hispanic / Not Hispanic

Race: ________________________________

Are you a migrant worker? Y / N Are you homeless? Y / N

What language do you speak most at home? ______________________

Do you speak any other languages? If yes which one(s)? ______________

I herby certify that the information provided is true and correct to the best of my knowledge

Signature: ______________________________ Date: ______________

Relationship to Patient: ______________________________

MEDICAL HISTORY FORM

Name: ____________________ Age____ Sex____ Date of Birth____________

Address: ____

1. **Medical History: Read carefully. Mark "Yes" or "No" for each item.**

YES	NO		YES	NO	
____	____	Measles, Mumps	____	____	High Blood Pressure
____	____	Rheumatic Fever	____	____	Venereal Disease
____	____	Scarlet Fever	____	____	Heart Disease
____	____	Arthritis, Rheumatism	____	____	Stroke
____	____	Diabetes	____	____	Ulcer
____	____	Tuberculosis	____	____	Alcoholism
____	____	Bleeding Disorder	____	____	Cancer
____	____	Joint Replacement	____	____	Transfusions
____	____	Sinus Infection	____	____	AIDS
____	____	Asthma/Hay Fevers	____	____	Anemia
____	____	Cirrhosis	____	____	Epilepsy or Seizures
____	____	Hepatitis	____	____	Nervous or Mental Disorders
____	____	Kidney Disease or Infections			

2. **Do you have or have you ever had:**

YES	NO		YES	NO	
____	____	Bleeding Tendencies	____	____	Paralysis
____	____	Loss of Vision	____	____	Chest Pain
____	____	Ear Pain or Deafness	____	____	Swelling of Ankles
____	____	Bleeding from Ears	____	____	Heart Flutter(Palpitation)
____	____	Urinary Problems	____	____	Breathing Difficulties
____	____	Frequent Indigestion	____	____	Toothache
____	____	Nausea and Vomiting	____	____	Uncomfortable Bite
____	____	Abdominal Pain	____	____	Pain while Chewing
____	____	Coughing up Blood	____	____	Hereditary Disease
			____	____	Tremor

3. List any medications/drugs/herbal products you are taking at this time.

____________________ ____________________

____________________ ____________________

____________________ ____________________

4. Are there any disease you have had not mentioned above?

If yes what? ____________________________________

5. Are you allergic to penicillin or any other medications? Yes____ No ____
   If "Yes" please Indicate: ____

6. Do you use Alcohol or Drugs Y / N If "Yes" do you want to quit? Y / N
   If "No" are you in recovery? Y / N

7. Do you use tobacco products? Y / N If "Yes" do you want to quit? Y/ N

8. List any Operations, Hospitalizations or Serious Injuries: _______________
   ____

9. Are you Pregnant at this time? Y / N

10. Do you have any special Medical or Dental concern? __________________
    ____

11. When did you last see a Dentist? _____________ What for? ____________

12. Dentist Name: ________________________________

13. When did you last see a Physician? _________________

14. Physicians Name: ______________________________

15. Who referred you to this clinic? ___________________________________

Signature: __________________________________ Date: _______________

Update: ____________ Signature/Initials: ____________ Doctors Review: ___________

Pit River Health Service Inc.

Medication List

Date	Name of Medication	Dose	Route	Interval

Medical/Dental Clinic
36977 Park Avenue
Burney, CA 96013
(530) 335-3651
(800) 843-7447

Administrative Office
369977 Park Avenue
Burney, CA 96013
(530) 335-5090
Fax: (530) 335-5241
FTS: (530) 551-5091

Patient Consent:

This agreement is entered into by and between Pit River Health Service, Inc. and ________________________________, the patient or guardian in order for the patient/minor to obtain:

1. **Health Care:** including medical examination, routine laboratory studies, x-ray procedures and skin tests.
2. **Dental Care:** including dental examinations, preventative use of fluorides, x-rays and necessary emergency dental care.
3. **Mental Health Service:** including evaluation and treatment as necessary.
4. **Transportation:** to and/or from another health facility for their services.

Terms of Agreement:

1. **The Treatment Authorization:** The patient, responsible relative or agent authorizes the health care providers at Pit River Health Service to treat him/her as required and appropriate under California Administrative Code, Title 16, section 1399.510.
2. **Authorization to Pay:** The Patient gives permission to Pit River health Service to bill or receive direct payment for services renders from appropriate and available payment sources. Charges will not exceed that which is reasonable and customary.
3. **Release of Information:** The patient gives permission to Pit River Health Service to release information concerning him/her to insurers, other agencies or individuals that may provide medical or social services to the patient in the future.
4. **Patients Rights:** The patients' rights have been read and explained to the patient by the Pit River Health Service staff.
5. **Contact by Phone:** The Patient gives express consent for Pit River Health Service to contact them by telephone regarding their care or appointments.
6. **Certification:** The patient, responsible relative or agent, certifies that he/she has read the foregoing, received a copy and willing to abide by these agreements.

A minor is a person under the age of 18 and must have the signature of a parent or legal guardian prior to receiving treatment.

Patient: ________________________________ Signature: __________________________

(If Patient is under 18, the above signature is that of parent or legal guardian of minor who has primary responsibility for care; gives consent for the above services.)

Date: ______________________ ____

Relationship to patient

PATIENT RIGHTS AND RESPONSIBILITIES

A. Patients are treated with respect, consideration and dignity.

B. Patients are provided appropriate privacy.

C. Patient disclosures and records are treated confidentially and patients are given the opportunity to approve or refuse their release except when release is required by law.

D. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically unadvisable to give such information to a patient the information is provided to a person designated by the patient or to a legally authorized person.

E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

F. Information is available to patients and staff concerning:

1. Patient rights, including those specified in A, B, C, D and above
2. Patient conduct and responsibilities
3. Services available at Pit River Health Service
4. Provisions for after-hours and emergency care
5. Fee for services
6. Payment policies
7. Patient's right to refuse to participate in experimental research
8. Advance directive as required by state or federal law and regulations
9. The credentials of health care professionals

G. Prior to receiving care patients are informed of patient responsibilities. These responsibilities require the patient to:

1. Provide complete and accurate information to the best of his/her ability about his/her health, any medications including over the counter products and dietary supplements and any allergies or sensitivities
2. Follow the treatment plan prescribed by his/her provider.
3. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by the provider.
4. Inform his/her provider about any living will, medical power of attorney or other directive that could affect his/her care
5. Accept personal financial responsibility for any charges not covered by his/her insurance.
6. Be respectful of all the health care providers and staff was well as other patients

H. Patients are informed of their right to change their provider if other qualified providers are available.

I. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

J. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.

K. Patients are informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.

Patient Signature: ______________________________ Date ____________________

Acknowledgment of Receipt of PRHS Notice of Privacy Practices

I hereby acknowledge receipt of the Pit River Health Service (Indian Health Service) Notice of Privacy Practices at:

Pit River Health Service
36977 Park Avenue
Burney, CA 96013

Name of Patient _______________ Date _______________

Signature of Patient Representative (State relationship to patient)
Or witness (If signature is by thumb print or mark) _______________

Relationship to Patient is a Minor _______________

Signature of PRHS Employee _______________ Date _______________

Signature of PRHS Employee _______________ Date _______________

For Patients Unable to Acknowledge Receipt

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

____

PIT RIVER HEALTH SERVICE

INDIAN HEALTH SERVICE

PATIENTS'
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 IT CAREFULLY."

APRIL 14, 2014

- Request an amendment on your health record if you believe the health information we have about you is incorrect or incomplete.

We will use and disclose your health information to provide your treatment.

For example: Your person 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 take and the observations made by the member 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 PRHS refers you to another health care facility under the Contract Health Service (CHS) program, PRHS may disclose your health information with that health care provider for treatment decisions.

If you are transferred to another facility for care and treatment, PRHS may disclose information with that facility to enable them to know the extent of treatment you have received and other information about your condition.

Your health care provider may give copies of your health information to others to assist with your treatment.

We will 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 PRHS refers you to another health care provider under the Contract Health Service (CHS) program, PRHS may disclose your health information with that provider for health care payment purposes.

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 outcome with our quality improvement team. This information will be to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under the Contract Health Services (CHS) program.

Law Enforcement: PRHS may disclose health information for law enforcement purposes as required by law or in response to an order from a court of competent jurisdiction or in response to a valid request from an authorized law enforcement official as permitted under the federal law.

Members of the Military: If you are a member of the military services PRHS may disclose your health information to your military command authorities.

Health Oversight Authorities: Where required by law or necessary for an employee of the Department of Health and Human Services to perform his/her official duties PRHS may disclose your health information to health oversight agencies for activities authorized by law. These oversight activities include:

a.) The information disclosed is about the suspect who committed the criminal act.

b.) The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization which you may later revoke in writing at anytime. (Such revocation would not apply where the health information has already been disclosed, used or in circumstances where PRHS has taken action 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 Health Service Administrator or the Pit River Health Service Privacy official in writing at:

Pit River Health Services
Administrative office
36977 Park Avenue
Burney, CA 96013

If you believe your privacy right have been violated you may file a written complaint with the above individuals 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. Or Call:

1-800-554-0350
HIPPA COMPLAINT HOTLINE

Effective date: April 14 2014

Medical/ Dental Clinic
36977 Park Avenue
Burney, CA 96013
(530) 335-3651
(800) 843-7447

Administrative Office
36977 Park Avenue
Burney, CA 96013
(530) 335-5090
Fax (530) 335-5241
FTS (530) 551-5091

PERMISSION TO DISCUSS

Date: ______________________________

To: Pit River Health Service, Inc., Providers and/ or Staff Members

I, ______________________________, by way of my signature below, do hereby give Pit River Health Service, Inc., its providers, staff members and representatives therein, permission to discuss scheduling, pertinent information, prescriptions and medications and any other medical and/ or dental issues or concerns with my appointee, ______________________________, until such time that I deem it unnecessary.

____
Patient Signature

____
Date

CONFIDENTIALITY NOTICE: This email or fax communication and any attachments or further pages may contain confidential and privileged information, i.e. protected health information for the use of the designated recipient(s) named. If you are not the intended recipient (or authorized to receive for the recipient), you are HEREBY NOTIFIED THAT YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR and that any review, disclosure, dissemination, distribution or copying of it or its contents is PROHIBITED. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects and secures the privacy of an individual's medical information. Therefore, if you have received this communication IN ERROR, PLEASE DESTROY all copies of this communication, any and all attachments and pages and CONTACT the sender via telephone, email or fax.