



New Patient Registration Form

Please complete all the information and bring it with you to your office visit.

Personal Information

Last Name:	First Name:	Middle:	Suffix:
Date of Birth:	SSN:	Preferred Language:	
Sex: Female () Male () Marital Status: Divorced () Married () Separated () Single () Widow/Widower ()			
Ethnicity: American Indian/Native American () White () Black/African American () Asian () Pacific Islander () Hispanic or Latino () Don't know or Declined to answer ()			
Email:	Place of Birth:		
Do you have an Advanced Directive? Yes () No () Do you have a Power of Attorney? Yes () No ()			
Would you like information regarding an Advanced Directive? Yes () No ()			
Internet Access? Yes () No () If yes, where at? Home () Work () School () Other ()			
Religious Preference:			

Demographics

Physical Address:	City:	State:	Zip:
Mailing Address (If different):	City:	State:	Zip:
Present Community:	Date moved to community:		
Home Phone:	Cell Phone:	Message Phone:	
Do we have permission to send text message regarding appointments reminders and clinic updates? Y / N			

Emergency Contact:

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone:	Work Phone:		

Next of Kin:

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone:	Work Phone:		

Employment History

Employer Name:	Work Phone:		
Address:	City:	State:	Zip:
Status: Full-time () Part-time ()	Estimated Monthly Family Income: \$		#In Household:

Parent/Legal Guardian:

Parent/Legal Guardian #1:	Birthdate:	Birthplace:
Employer :	Phone #:	
Type of Guardian: Biological () Adoptive () Foster () Other:		
Parent/Legal Guardian #2:	Birthdate:	Birthplace:
Employer:	Phone#:	
Type of Guardian: Biological () Adoptive () Foster () Other:		
Mother's Maiden Name:		

Native American Descendancy

Are you of Native American descendancy? Yes () No () Indian Blood Quantum:		
Tribal Membership:	Tribe Quantum:	Tribal Enrollment Number:

*******BRING ALL TRIBAL IDENTIFICATION WITH YOU TO YOUR APPOINTMENT – WE WILL NEED TO SCAN THEM INTO OUR RECORD******* To Prove Descendancy: Parents Indian Verification/Patient Birth Certificate Tribal Documentation: Grandparents Indian Verification/Parents County Birth Certificates/Patient Birth Certificate

Veteran Status:

Are you a Veteran? Yes () No ()	If yes, which branch?
Valid VA Card? Yes () No ()	Please give card to registration clerk.

Migrant/Homeless:

Migrant worker? Yes() No()	Migrant Worker Type: Migrant Ag Worker() Seasonal Migrant Worker ()
Are you Homeless? Yes() No()	Homeless Type: Homeless Shelter() Street() Transitional() Other()

Insurance/Guarantor:

#1 Company Name:		Phone:	
Address:	City:	State:	Zip:
Policy Holder Name:	Relationship:		
Policy Number:	Coverage Type:		
Eligibility Start Date:	Member Number:		
#2 Company Name:		Phone:	
Address:	City:	State:	Zip:
Policy Holder Name:	Relationship:		
Policy Number:	Coverage Type:		
Eligibility Start Date:	Member Number:		

******* BRING ALL INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT – WE WILL NEED TO SCAN THEM INTO OUR RECORD *******

Print Name:
Signature: Date:
Relationship to Patient:

By signing here you are agreeing that the details given on this form are true and correct.

Office use Only:

Received by: _____ Date: _____

Scanned by: _____ Date: _____



Patient Financial Responsibility Agreement

We feel that a part of good health care is having a clear financial policy that is shared with our patients. Please take time to review this policy. We want to make sure you understand it. Financial details can be confusing. Let us know if you need us to explain anything.

If you are Native American /Alaskan Native you may qualify for special benefits and some of this information will not pertain to you.

Payment: Here are some details that you should know about our payment policy.

Any fees that you need to pay are due at the time of your visit. This policy is for patients with or without health insurance.

We will take cash check or credit card.

If you have insurance, your payment includes any unpaid:

- *Deductibles
- *Co-insurance
- *Co-payment amount
- *Non-covered fees from your insurance company

We ask for a copy of an ID card or license to help protect you from identity theft.

Self-Pay, Sliding fee scale:

Did you know that we have a sliding fee for patients that qualify? Please ask for more information.

Insurances: Here are some details that you should know about insurance.

We are participating provider or considered "in-network" with a few insurance plans; find out if we are with your plan by contacting your insurance company.

Learn what services and clinicians are covered before you visit by calling your insurance benefits department.

If our clinicians or services are not listed in your plan's network (on their list of clinicians or services they have a contract with):

- *You may have to pay for part of, or the entire bill.
- *We will send the claim to your insurance for you.
- *Your insurance might send the payment for you to bring and pay at your PRHS visit.

You must bring your insurance card to every visit. We will need to copy both sides.

If you have insurance, we will send them a bill.

If the insurance does not cover the fees the patient will need to pay. If we get a payment from insurance you pay, we will refund what is due to you.

If you are a member of a HMO or managed care plan:

You must see your primary care provider (the clinician you see for your general health care).

If your insurance does not cover part of your fee:

You might qualify for our sliding fee discount program for the things that are not covered Medical and dental have different rules.

Other Notes: Here are some things to think about:

Diagnostic test are billed separately.

If you are referred to another provider or other services, any bills or fees you get from them will be between you and them. They may bill differently than we do at PRHS.

If you have any question about your bill or fees. Our billing team is willing to help you. Call 530-335-3651

Sign Here: By signing you are saying that you agree to the statement in the box.

I have read and understand the details of the PRHS Financial Policy and authorize PRHS to bill my insurance.

Patient Name: _____ Date: _____

Sign (patient or account holder): _____ Print Name: _____



YOUR PRIVACY OPTIONS Receipt of Privacy Practices & HIPAA Authorization

This form is to help us know what details, if any, you would like us to share with the people in your life. You can also tell us how you want information shared. Telling PRHS how you want to share information is called HIPAA Authorization and it's from the Health Insurance Portability and Accountability Act (HIPAA). This form also helps us to know that we have asked to give you our privacy practices.

Personal Details: Tell us about yourself or the person this form is for.

Last Name: _____	First Name: _____	Middle Initial: _____
Nickname: _____		Date of birth: _____
Name of Parent, Legal Guardian, or Conservator: (Only if any of these apply to you.) _____		

Messages: This is where you tell us if we can leave you voice messages and what we can share.

You allow PRHS To:	_____ Leave voice messages at the phone number you've given us.
	_____ Leave voice messages about your appointments at the phone numbers you've given us.
	_____ Leave voices messages about labs or tests results at the phone numbers you've given us.

If you do not want ANYTHING told or shared with ANYONE check and sign here: _____

Signature: _____

Who to share with and what we can share: This is where you tell PRHS who you would like us to share, or release information with. Each box is for different person.

Who can we share your information with? (Optional)

Person #1: _____	DOB: _____	Relationship: _____
With this person, you allow PRHS to:		
_____ We can tell this person any and all of my medical information.		
_____ We can give this person today's chart notes at the time of the visit.		
_____ We can give this person all of your test results.		
_____ This person is allowed to pick up your prescription medication.		
This patient is under 18years old and this person is allowed to give permission and make decisions for: Medical/Dental visits Immunizations(This person must bring ID in at the time of visit)		

Who can we share your information with? (Optional)

Person #2: _____ DOB: _____ Relationship: _____

With this person, you allow PRHS to:

- We can tell this person any and all of my medical information.
- We can give this person today's chart notes at the time of the visit.
- We can give this person all of your test results.
- This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: Medical/Dental visits Immunizations(This person must bring ID in at the time of visit)

Who can we share your information with? (Optional)

Person #3: _____ DOB: _____ Relationship: _____

With this person, you allow PRHS to:

- We can tell this person any and all of my medical information.
- We can give this person today's chart notes at the time of the visit.
- We can give this person all of your test results.
- This person is allowed to pick up your prescription medication.

This patient is under 18years old and this person is allowed to give permission and make decisions for: Medical/Dental visits Immunizations(This person must bring ID in at the time of visit)

Sign & Initial Here:

Print name here _____

Sign: _____ Date: _____

I was asked if I wanted a copy of PRHS's Notice of Privacy Practices. _____ (Initial)

Parent/Guardian/Conservator:

Sign: _____ Date: _____

*****This approval ends one year from the date signed or updated in writing*****

Office use Only:

Received by: _____ Date: _____

Scanned by: _____ Date: _____

MRN: _____

PIT RIVER HEALTH SERVICE

36977 PARK AVE
BURNEY, CA. 96013

MEDICAL/DENTAL CLINIC

(530) 335-3651
(800) 843-7447



ADMINISTRATIVE OFFICE

(530) 335-5090
FAX (530) 335-5241

PRC DEPARTMENT

Boqueta (530) 335-0662
Lori (530) 335-0328
Carol (530) 335-0325
FAX (530) 335-5064

Acknowledgement of Receipt of PRHS Notice of Privacy Practices

I hereby acknowledge that I received Pit River Health Service Notice of Privacy Practices

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

Signature of Patient or Patient Representative: _____

Relationship if Patient is a minor: _____

.....

Signature of PRHS Employee: _____

Date: _____

HRN: _____

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

(RPMS AOB & ROI) 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 or home 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 given 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 and is 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: _____

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Fax: (530) 335-5241

Pit River Health Service Medical Appointment and Failed Appointment Policy

The Pit River Health Service Medical Clinic is here to serve the needs of the community. We ask you to please arrive 15 minutes early to update your information and to fill out any necessary paper-work. If you are 10 minutes late, your appointment we will have to be rescheduled and will count as a failed appointment. By showing up to your appointment early you will help us in providing you with the very best quality health care.

When appointments are cancelled, without at least 4 hours advance notice, we are unable to offer this time to another patient who is in need of our services. A less than 4 hour cancel notice or not showing up for a scheduled appointment would be considered a failed appointment. Our failed appointment policy will be enforced as follows:

The receptionist may contact a nurse to triage each request for urgent care to determine whether there is a true urgency for medical care exists and to assure that chronic health issues receive proper continued care. The nurse will determine if there is a valid excuse for missing an appointment in which case this policy may be waived.

You will not receive another scheduled medical appointment until you have attended a clinic session for standby care at 8:00 a.m. and 1:00 p.m. to standby for your missed medical visit. When another patient fails to show up, you will be given the appointment visit. If the last patient of the morning or afternoon session arrives and you have not already been seen, an appointment will be made for you. Thank you for assisting us in keeping all Pit River Health Service appointment times filled.

Walk-in emergency times are 8:00 a.m., 1:00 p.m. and 4:00 p.m. If possible, please call before you come in so that we can prepare for your arrival.

To assist Pit River Health Service in maximizing your services to the community, I hereby agree to give 4-hour notice of a cancelled appointment by phone or by voice message. I understand the scheduling restrictions if I fail to give adequate notice of cancellation.

Patient Signature: _____

Date: _____

CEO: Loren Ellery

Date: 7/10/24

Board Approved: Sam Hayward

Date: 7/3/2024

Legislative History: Amended by the PRHS Board of Directors On May 28, 2024



Medical History

Patient Name: _____ **Date** _____

Age: _____ **Sex:** _____ **Date Of Birth** _____

Allergies: Are you allergic to any to any medicine or food? No () Yes ()
 If Yes, Please list your medicine and food allergies.

Medicine or Food	What happened when you take or eat it?
1.	
2.	
3.	
4.	
5.	

Past Medical History: Do you have or have you been diagnosed and/or treated for the following?

Anemia / Blood disorder Type: _____	Kidney / Urinary tract problems Type: _____
Arthritis Type: _____	Liver problems or Hepatitis Type: _____
Blood clots	Lung problems Type: _____
Bone / joint disease Type: _____	Mental health problems Type: _____
Cancer Type: _____	Skin problems Type: _____
Diabetes Type: _____	Stomach or bowel problems Type: _____
Epilepsy / seizure disorder Type: _____	Stroke
Eye or ear disease Type: _____	Thyroid disease
Heart problems Type: _____	Tuberculosis
High blood pressure	Women's health problems Type: _____
High cholesterol	Other: _____
HIV/AIDS	Other: _____

Surgical History: Please list any surgeries you have had and the year they took place.

Gallbladder Year:	Appendix Year:	Tonsils Year:
Other:		Year:
Other:		Year:
Other:		Year:
Other:		Year:

Family History: Have your close family members had any of the following?

Family Member	Medical Condition
Mother ___ Alive ___ Passed Age: _____	___ Heart problems ___ Stroke ___ High Blood Pressue ___ High Cholesterol ___ Alchol/Drug Abuse ___ Mental Illness ___ Cancer,type _____ ___ Diabetes, type: _____ ___ Genetic disorder (run in family) ___ Other: _____
Father ___ Alive ___ Passed Age: _____	___ Heart problems ___ Stroke ___ High Blood Pressue ___ High Cholesterol ___ Alchol/Drug Abuse ___ Mental Illness ___ Cancer,type _____ ___ Diabetes, type: _____ ___ Genetic disorder (run in family) ___ Other: _____
Sister(s) #Alive: _____ #Passed: _____ Age(s): _____	___ Heart problems ___ Stroke ___ High Blood Pressue ___ High Cholesterol ___ Alchol/Drug Abuse ___ Mental Illness ___ Cancer,type _____ ___ Diabetes, type: _____ ___ Genetic disorder (run in family) ___ Other: _____
Brother(s) #Alive: _____ #Passed: _____ Age(s): _____	___ Heart problems ___ Stroke ___ High Blood Pressue ___ High Cholesterol ___ Alchol/Drug Abuse ___ Mental Illness ___ Cancer,type _____ ___ Diabetes, type: _____ ___ Genetic disorder (run in family) ___ Other: _____
Grandmother(s) #Alive: _____ #Passed: _____ Age(s): _____	___ Heart problems ___ Stroke ___ High Blood Pressue ___ High Cholesterol ___ Alchol/Drug Abuse ___ Mental Illness ___ Cancer,type _____ ___ Diabetes, type: _____ ___ Genetic disorder (run in family) ___ Other: _____
Grandfather(s) #Alive: _____ #Passed: _____ Age(s): _____	___ Heart problems ___ Stroke ___ High Blood Pressue ___ High Cholesterol ___ Alchol/Drug Abuse ___ Mental Illness ___ Cancer,type _____ ___ Diabetes, type: _____ ___ Genetic disorder (run in family) ___ Other: _____

Past Immunizations (Shot): Have you had any of the following shots?

Clinic Name

	Date:	Have the record?	No	Yes
Flu		Have the record?	No	Yes
Hepatitis A	Date:	Have the record?	No	Yes
Hepatitis B	Date:	Have the record?	No	Yes
Pneumonia	Date:	Have the record?	No	Yes
Tetanus	Date:	Have the record?	No	Yes
Tuberculosis skin test	Date:	Have the record?	No	Yes
Shingles	Date:	Have the record?	No	Yes
Whooping Cough	Date:	Have the record?	No	Yes

Social History:

Current Employment Status	Alcohol Use
<input type="checkbox"/> Work, Full-time <input type="checkbox"/> Work, part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled Other: _____ Current job? _____ Past job? _____	Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Former – Year Quit: _____ Type: <input type="checkbox"/> Beer <input type="checkbox"/> Hard Liquor <input type="checkbox"/> Wine <input type="checkbox"/> Other: _____ How often? _____ How much? _____ Last Drink? _____

Tobacco & Drug Use

Have you ever actively used tobacco products? No Yes
 Former smoker or chewer? No Yes Age started? _____ Age stopped? _____
 Are you currently using? No Yes Average Daily Use: _____
 Have you ever used marijuana? No Yes
 If yes, are you currently using? No Yes
 Have you ever used drugs such as meth, cocaine, or IV drugs? No Yes
 If yes, are you currently using? No Yes

PHQ2: Over the past 2 weeks, how often have you been bothered by and of the following problems?

	Not at all	Several days	More then half the day	nearly ever day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Office uses Total: _____

Reproductive Health History

Have you ever had a sexually transmitted disease (STD)? If yes, what kind?	No	Yes
Are you taking hormone replacement therapy?	No	Yes
Are you having periods? If yes, date of last menstrual period? If no, when did they stop? (age) or (year)	No	Yes
How old were you when you started having periods?	Age: _____	
Are you currently pregnant?	No	Yes
Have you ever been pregnant? If yes. how many times? _____ If yes, how many times carried to full term? _____ If yes, how many abortions or miscarriages? _____ If yes, how many children do you have?	No	Yes
Have you had a mammogram? If yes, when and where?	No	Yes
Have you had a pap smear? If yes, when and where?	No	Yes
Have you had a hysterectomy? If yes what year? _____ If yes, Was it to remove cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what type? Cervical Ovarian Uterine	No	Yes

Medication:

Please bring all current medications (pills, inhalers, creams, patches) to your first visit. This includes over the counter medications, vitamins, and supplements. **Please bring your medication to year appointment!** If you did not bring them, please list them below. You can also provide a medication list.

Medication Name	Dose (include strength & number of pills per day)
<i>Example: aspirin</i>	81mg tablet once daily
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

If there is any other medical issues that you may have or need addressed please take the time to list them below!

Print Name: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

Office Use Only:
Medical Assistant Reviewed: _____ Date: _____
Provider Reviewed _____ Date: _____
Scanned By _____ Date: _____

MRN: _____



Pit River Health Service Inc
Medical/Dental/Behavioral Health Clinics
36977 Park Ave Burney CA 96013
(530)-335-3651
Release of Information

PLEASE FAX ALL COPIES TO PRHS MEDICAL RECORDS (530)335-3221

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

I hereby authorize: _____

Address: _____

Phone: _____ **Fax:** _____

To disclose my protected health information listed below to: (clinic/hospital, person, etc.)

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

INFORMATION TO BE RELEASED

Dates of Service: _____

- History and physical exam
- Lab report
- X-ray report
- Consultation report Must Initial
- Behavioral Health/Psych _____
- Other _____

PURPOSE OF DISCLOSURE:

- Changing physicians
- Second Opinion
- Continuing Care Legal
- At patient request Insurance
- Workers' Comp School
- Other _____

1. I understand that this authorization will expire two years from date signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer, in writing, at Pit River Health Service, Inc. and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

- 3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- 4. My health care will not be affected if I do not sign this form. My PRC and/or 3rd party funds can be affected if I choose not to sign this form.
- 5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

6. I request that the records identified above be handled in the following manner:

Mail to Address Listed Above I will pick Fax# above/Attn: _____

A Representative will pick-up on my behalf. (Valid ID is required)

Representative Name: _____ DOB: _____

7. I understand that I will get a copy of this form after I sign it upon request.
By signing below, I acknowledge that I have read and understand this Authorization.

OR

Signature of Patient	Date	Parent/Legal Guardian/Authorized Person	Date	Relationship to Patient

PLEASE FAX ALL COPIES TO PRHS MEDICAL RECORDS (530)335-3221

Please note: The Information contained in this report may be privileged, confidential and protected from disclosure. If the reader of this is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited by law. If you have received this communication in error, please notify the sender immediately and destroy his copy. Call 530-335-0323 if you have received this in error.

For Office Use Only

Date Request Filled _____	By _____			
			Printed Name	Title
Identification Presented: <input type="checkbox"/> yes <input type="checkbox"/> no			_____	RPMS Account #: _____
Date of Release _____, See line 6			IF PICKED UP Signature required _____	
HIM Signature _____				