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:____________________

Pit River Health Service Inc
Medical/Dental/Behavioral Health Clinics
Form: HIM106
MRN:____________
Office Use Only

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 include 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 yor 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:_____________________

MRN:________________

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:___
Signiture:________________________

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 you 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 you 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 you 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:____________________

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
(530) 335-0662
(530) 335-0328
(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:____

Date:____

- -

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: ______________________ Relation to patient:__________________________

Updated 1/16/2025 BG

Medical/Dental Clinic
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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: [signature] Date: 7/3/2024

<u>Legislative History:</u> 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

	Flu	Date:	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
__Work, Full-time __Work, part-time __Self-employed __Unemployed __Retired __ Disabled __Other:______________________________________ Current job?__________________________________ Past job?_____________________________________	Do you drink alcohol? __No __Yes __Former – Year Quit:_______________ Type: __Beer __Hard Liquor __Wine __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? ___No ___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
Example: *aspirin*	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:** _______________

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: ___________ to ____________

- ☐ History and physical exam
- ☐ Lab report
- ☐ X-ray report
- ☐ Consultation report
- ☐ Behavioral Health/Psych — Must Initial: ________
- ☐ Other _________________

PURPOSE OF DISCLOSURE:

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

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 to:________________
   ☐ 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: ☐ yes ☐ no ______________________________ RPMS Account #:_________________
Type of Identification

Date of Release___________ ,See line 6 IF PICKED UP Signature required ____________________________________

HIM Signature_____________________________________