18 year old PACKET

**NOTE:** This packet is for 18 year olds that are already a Registered Patients here at FRTH

**PLEASE TAKE ONE COPY** of the Patient Hand Book, HIPAA (Notice of Privacy Practices) and clinic information.

Please complete the Registration Form - bold areas only. This packet is for patients who are already a patient here and have just turned 18 years old.

**DO NOT COMPLETE THE SHADED AREA.**

For updating your information as an 18 year old you will need the following:

1. Picture ID
2. Verify Social Security Number.
3. Marriage license, if applicable.
4. Insurance, Medi-cal, CMSP or Covered CA card (we need to make a copy).
5. If you are on PRC (CHS) you will need to update your information and schedule an appointment with Linda at ext 247 for Education on the PRC program.
6. FRTH does not accept Medical discount cards.

Mikki  Registration Clerk  10/2016
REGISTRATION FORM

Scanned Date:_______ Initials:_______ REGISTRATION NUMBER:_______

CLIENT COMPLETES QUESTIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Maiden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthday</td>
<td>Soc. Sec. #</td>
<td>City of Birth</td>
<td>State of Birth</td>
<td></td>
</tr>
</tbody>
</table>

When did you move to your current community?______________________

☐ Married  ☐ Single

Religious preference:______________________ Household income:____________

☐ Yearly  ☐ Monthly

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

| Street Address: | Street | City | State | Zip |

<table>
<thead>
<tr>
<th>Phone#:</th>
<th>Home</th>
<th>Work</th>
<th>Cell</th>
<th>Message</th>
</tr>
</thead>
</table>

| ( ) | ( ) | ( ) | |

☐ American Indian  ☐ African American  ☐ White  ☐ Asian  ☐ Pacific Islander  ☐ Hispanic or Latin

Internet Access: ☐ Yes  ☐ No

If yes, from: ☐ Work  ☐ Home  ☐ School  ☐ Health Care Facility  ☐ Library  ☐ Tribal/Community Center

Insurance Information: ☐ Medicare  ☐ Medi-cal  ☐ CMSP  ☐ Prescription Ins  ☐ Private Ins  ☐ Other

<table>
<thead>
<tr>
<th>Father’s Last Name:</th>
<th>First</th>
<th>MI</th>
<th>Birthplace (City/State)</th>
<th>Tribe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Last Name:</td>
<td>First</td>
<td>MI</td>
<td>Birthplace (City/State)</td>
<td>Tribe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Employer:</th>
<th>Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouses: Employer:</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
<tr>
<td>If child, Father’s Employer:</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
<tr>
<td>If child, Mother’s Employer:</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

If you are Native American, please fill out the following:

Tribe:______________________ Blood Degree:_________ Roll#:_________ Tribal Roll#:_________

NOTE: You must provide Indian Verification upon registration, i.e., CDIB card, Federally recognized tribal card, or be able to link yourself by birth and/or death certificate(s) to a lineal descendant who has a CDIB card or tribal card or be on the California Rolls or Dawes Final Roll.

FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Tribal Code</th>
<th>CHS</th>
<th>Eligibility</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>I D C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Department</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ MM</td>
<td>☐ Oro</td>
<td>☐ YC</td>
<td>☐ Patient Services</td>
</tr>
</tbody>
</table>
CONSENT TO DISCUSS HEALTH ISSUES

Patient or Minor Name: ____________________________ DOB: ________________

☐ I decline for FRTH to discuss my health care issues.

☐ I give my permission to FRTH to discuss my health care issues with the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone/Cell Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form is not a release of records. This form will be used for discussion only and applies to the following departments (must initial to be valid):

- Medical, Dental, Pharmacy, Outreach, Patient Services, PRC, Billing and Referrals
- BHS ______ (must initialed to be valid)

Unless otherwise revoked, this consent expires _____________(insert applicable date).

If no date is indicated, this consent will expire 12 months after the date of signing this form.

Signed: ____________________________ Date: ____________________________

Printed Name: ____________________________

Witness: ____________________________ Date: ____________________________

Printed Name: ____________________________
AUTHORIZED TO BILL & TREAT

Patient Name: ____________________________

Birth Sex:  □ Male  □ Female  □ Undifferentiated  □ None

Current Gender:  □ Male  □ Female  □ Undifferentiated  □ None

Home Address: ____________________________

Date of Birth: ____________________________

Social Security #: ____________________________

City/State/Zip: ____________________________

Day Phone: ____________________________

Mailing Address: ____________________________

Cell Phone: ____________________________

City/State/Zip: ____________________________

Other/Message Phone: ____________________________

- I authorize, to the extent permitted under applicable law, the release of any information necessary to process claims for payment on my behalf. I also authorize any third party payments to be sent payable to Feather River Tribal Health, Inc.
- I authorize Feather River Tribal Health, Inc. to deposit checks received on account from my Insurance Company, when made out in my name.
- I understand that I am responsible for any balance not covered by a third party.
- I understand that it is my responsibility to pay co-payments at time of visit if applicable.
- This authorization for billing will remain in effect for one (1) year unless revoked by me in writing.
- Feather River Tribal Health, Inc. has my permission to provide routine and emergency medical care for myself or the minor child listed above.
- PLEASE NOTE: This includes ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES. I hereby acknowledge receipt of Feather River Tribal Health (FRTH) Notice of Privacy Practices upon registration. An additional copy is available upon request.

Print Name of Responsible Party: X

Patient Signature: X ____________________________ Date: __________

(Parent or Guardian if Patient is a Minor)

FAMILY INFORMATION: Family size: ______  Annual Income: $ _________________

EMERGENCY CONTACT – Must be completed

Name: ____________________________  Relationship: ____________________________

Address: ____________________________  Phone: ____________________________

City/State/Zip: ____________________________  Cell: ____________________________

MINOR CONSENTS ONLY

Print Name of Parent/Guardian: ____________________________

Relationship to minor (check one):  □ Parent  □ Guardian  □ Other ____________________________

NOTE: If signed by other than parent, a copy of guardianship papers or legal consent to obtain treatment must be attached.
INTENTIONALLY LEFT BLANK
APPOINTMENT REMINDERS/CLINICAL CALLS & TEXTS

APPOINTMENT REMINDERS: Please indicate whether you would like to receive an appointment reminder call or text from FRTH.

☐ YES.
  ➢ If you are unavailable, the following information will be left on your voicemail or text:
    • date, time, department and/or provider

  ➢ FRTH STAFF WILL IDENTIFY THEMSELVES ON YOUR VOICEMAIL

* Please indicate WHAT number we may use for the above permission

☐ Voice Mail: ☐ Text:
  Day Phone: (___)_____________  Cell Phone: (___)_____________

☐ NO, I do not want to receive appointment reminder calls/texts from FRTH

PLEASE NOTE: YOU WILL NOT RECEIVE AN APPOINTMENT REMINDER/OR ANY OTHER CALL FROM FRTH

➢ EXCEPTION:
  IN THE CASE OF AN URGENT SITUATION, FRTH WILL ATTEMPT TO CONTACT YOU

IF YOU REQUIRE TRANSPORTATION FROM FRTH, YOU WILL BE CONTACTED PRIOR TO YOUR VISIT

__________________________________________  __________________________
Patient Signature                        Date

NAME_____________________________  DOB_________  MR#_____________
ACKNOWLEDGMENT OF RECEIPT OF FRTH NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Feather River Tribal Health (FRTH) Notice of Privacy Practices

Print Patient Name: ___________________________ Date: __________

Signature Patient Or Representative: ___________________________ Date: __________

Print Name: __________________________________________

State Relationship to Patient or Witness, If Signature is by thumb or mark: __________________________________________

Signature of FRTH Employee: ___________________________ Date: __________

Print Name: __________________________________________

FOR PATIENTS UNABLE TO ACKNOWLEDGE RECEIPT

I hereby certify that the patient was unable to acknowledge receipt of the FRTH Notice of Practices because: __________________________________________ Initial: ______

PATIENT HANDBOOK ACKNOWLEDGEMENT OF RECEIPT

Attached is a copy of the Patient Handbook for Feather River Tribal Health, Inc. This handbook outlines the guidelines for services provided by our healthcare facilities as well as provides information about the organization.

It is the responsibility of the Feather River Tribal Health to provide this information to the patient. It is the responsibility of the patient to acknowledge receipt of the handbook and agree to comply with the guidelines as they are outlined.

By signing this acknowledgment, the patient acknowledges receipt of this patient handbook and the information that it contains.

Patient Signature: ___________________________ Date: __________

Printed Name: __________________________________________