



Feather River Tribal Health, Inc.

Sponsoring Tribes: Berry Creek Rancheria, Mooretown Rancheria & Enterprise Rancheria

OROVILLE CLINIC • (530) 534-5394
2145 5th Avenue • Oroville CA 95965

YUBA CITY CLINIC • (530) 751-8454
555 West Onstott Road • Yuba City CA 95993

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.

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REGISTRATION FORM

Scanned Date: _____ Initials: _____

REGISTRATION NUMBER:

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CLIENT COMPLETES QUESTIONS

	Last	First	Middle	Maiden
Name				
Sex M F	Birthday	Soc. Sec. #	City of Birth	State of Birth

When did you move to your current community? _____ Married Single
 Religious preference: _____ Household income: _____ Yearly Monthly

Mailing Address:	Street	City	State	Zip
Street Address:	Street	City	State	Zip
Phone#:	Home () ()	Work () ()	<input type="checkbox"/> Cell () ()	<input type="checkbox"/> Message
Ethnic Origin:	<input type="checkbox"/> American Indian <input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Hispanic or Latin			
Internet Access:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from: <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Health Care Facility <input type="checkbox"/> Library <input type="checkbox"/> Tribal/Community Center			
Insurance Information:	<input type="checkbox"/> Medicare <input type="checkbox"/> Medi-cal <input type="checkbox"/> CMSP <input type="checkbox"/> Prescription Ins <input type="checkbox"/> Private Ins <input type="checkbox"/> Other			

Father's Last Name:	Last	First	MI	Birthplace (City/State)	Tribe
Mother's Maiden Name:	Last	First	MI	Birthplace (City/State)	Tribe

Patient's Employer:	Name	Address	Telephone
Spouses Employer:	Name	Address	Telephone
If child, Father's Employer:	Name	Address	Telephone
If child, Mother's Employer:	Name	Address	Telephone

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

Tribal Code <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				CHS <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligibility I D C	Other information _____
Name <input type="checkbox"/> MM	Office <input type="checkbox"/> Oro <input type="checkbox"/> YC	Department <input type="checkbox"/> Patient Services	Date			

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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:

Name	Relationship	Phone/Cell Number

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: _____

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Feather River Tribal Health, Inc.

AUTHORIZATION 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.

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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:
Day Phone: (____) _____

Text:
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

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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: _____