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.

COMPLETE THE FOLLOWING

To update your information as an 18 year old you will need:

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:**
   Please contact Patient Services for updates to your insurance or address.
   Please contact PRC Billing to report a 72 hour notice or PRC bills at ext 318 or 226.
6. **FRTH does not accept Medical discount cards.**

Mikki Registration Clerk *3/2024*
530-534-5394 x228 Fax 533-1113

REGISTRATION FORM

Scanned Date:_____ Initials:_____ **REGISTRATION NUMBER:** | | | | | | |

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** Email _____

Religious preference:_____ Household income:_____☐ Yearly ☐ Monthly

Mailing Address:	**Street**	**City**	**State**	**Zip**
Street Address:	Street	City	State	Zip

Phone#: **Home** ( ) **Work** ( ) ☐ **Cell** ( ) ☐ **Message**

Ethnic Origin: ☐ 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

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 | | |

CHS ☐ Yes ☐ No

Eligibility I D C

Other information _____

hd/New Pt/Reg frm Rev 9/16

Name ☐ MM	Office ☐ Oro ☐ YC	Department ☐ 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:_____

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: _____ Work/Day Phone: _____

Mailing Address: _____ Cell Phone: _____

City/State/Zip: _____ Email: _____

- 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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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:**_____

Print Name:_____