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

NEW PATIENT PACKET

Birth to 12 years

PLEASE TAKE a copy of the Patient Hand Book and the Privacy Act (one per family of each)

DOCUMENTS NEEDED FOR REGISTRATION

For Native registration you will need:

1. **Picture ID**
2. **Indian Verification – CDIB (Certificate Degree of Indian Blood) card or letter from the BIA (Bureau of Indian Affairs), letter from Tribe or California Judgment Roll. Certified birth certificate (hospital birth announcements not accepted), if applicable. Marriage license, if applicable.**
3. **Insurance (both Medical & Dental), Medi-cal or Covered CA card and Prescription coverage (we need to make a copy).**
4. **Must include Immunization records.**

For Non-Native registration you will need:

1. **Picture ID**
2. **Insurance (both Medical & Dental), Medi-Cal or Covered CA card and Prescription coverage (we need to make a copy).**
3. **All Non-Native's have to go through a screening process. During this process if you have an emergency please go to the nearest Emergency Room. Call the number below to check status of your registration.**
4. **FRTH does not accept Medical discount cards.**
5. **Must include Immunization records.**

PLEASE NOTE: If you haven't been seen in 3 years after you have registered your file will be inactivated. BEFORE you can make an appointment you must be seen in Registration. Non-Native patient's applications will go through a screening process for approval.

We DO NOT ACCEPT incomplete registration packets!

Mikki M - Registration Clerk
Phone: 530-**534-5394 ext 228** Fax: 530-533-1113

6/2018 - 2019

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MEDI-CAL PATIENTS

The following information is for **all patients** that have Managed Care Medi-cal – either:
Partnership Health Plan or Kaiser

This information will affect you as a new patient and an established patient. The following process must be followed to become a patient or continue to be an established patient at Feather River Tribal Health.

PROCESS TO BE FOLLOWED

NEW PATIENTS:

1. Submit a completed New Patient packet. Incomplete packets will not be accepted.

2. All new Non-Native patients will go through a screening process for approval.

3. Once your application has been approved you will need to do the following before an appointment can be made.
   a. Check your insurance card to see who is listed as your PCP (Primary Care Provider – i.e. Clinic or Doctor). **Do not change this prior to being accepted as a patient here at FRTH**.
   b. If your PCP is Feather River Tribal Health, you won't need to change anything. If FRTH is not listed as your PCP you will be required to call and change the PCP to FRTH. You will then need to provide proof to FRTH by providing the reference number given to you at the time of your call. You will have 30 days to provide this proof to the clinic. **After 30 days the registration packet will no longer be valid and will be shredded.**

4. Newborns are covered under their mother for 30 days. The mother must have FRTH as their Primary Care Provider (PCP) prior to making an appointment for a newborn. After the 30 days the newborn must have their own insurance card and FRTH must be listed as their PCP.

ESTABLISHED PATIENTS:

1. Check your insurance card to see who is listed as your PCP (Primary Care Provider – i.e. Clinic or Doctor).

2. If your PCP is Feather River Tribal Health you won't need to change anything. If FRTH is not listed as your PCP you will be required to call your health plan and change the PCP to FRTH.
   Partnership Member Services: 800-863-4155
   Kaiser Member Services: 855-839-7613
   You will need to provide proof to FRTH by providing the reference number given to you at the time of your call. You will have 30 days to provide this proof to the clinic. **After 30 days the registration packet will no longer be valid and will be shredded.**

RELEASE OF INFORMATION

❑ New Pt

WHAT TO SHARE: This is where you can tell us what information you'd like shared.

WHAT INFORMATION WOULD YOU LIKE SHARED?		
❑ PROGRESS NOTES	FROM _____	TO _____ *(DATES)
❑ LAB RESULTS	FROM _____	TO _____ *(DATES)
❑ X-RAY/IMAGING/DIAGNOSTIC REPORTS:	FROM _____	TO _____ *(DATES)
❑ OTHER: _____		

SIGN HERE: By signing you are saying that you agree to the statement in the box.

I understand that certain information cannot be released without specific approval. This is needed by State and Federal law. Requests for disclosures for these types of records must be separate from other requests. I approve the release of the following protected or sensitive information:

Please **INITIAL** the records that can be shared.

_____ HIV/AIDS RELATED RECORDS _____ BEHAVIORAL/MENTAL HEALTH INFORMATION

_____ ALCOHOL/DRUG TREATMENT RECORDS

RIGHT TO REVOKE: I know I have the right to cancel this approval at any time. I know if I cancel this approval, I have to do it in writing and give my written statement to FRTH's Health Information Department. I know if I cancel, it will not apply to information that has already been shared because of this approval. I know if I cancel, it will not apply to my insurance company when the law lets them challenge a claim under my policy.

REDISCLOSURE: I know it's up to me if I want to share my health information. I know I don't need to sign this form in order to be treated at FRTH. I understand that redisclosure is not permitted unless in accordance with State and Federal law.

I know I can look at or get copies of the information that's being shared. This right is given by CFR 164.524. I know if I give approval the information shared with FRTH may be shared again with another medical center. This may not be protected by federal confidentiality rules. I know if I have questions about sharing my health information, I can call FRTH Health Information at (530) 534-5394.

I know unless I have canceled at an earlier time, this approval to share medical information will end on _____ (specific date or event). If no date or event is listed then this approval will end in one (1) year from the date signed.

SIGN: _____ **DATE:** _____

LEGAL REPRESENTATIVE (Relationship to patient/why you have authority to sign): _____

WITNESS (if needed _____ **DATE:** _____

Patient Name _____ DOB _____ MR# _____

REGISTRATION FORM

Scanned Date:_____ Initials:____ RPMS NUMBER:_____ NG# | | | | | |

CLIENT COMPLETES QUESTIONS

DEMOGRAPHICS

Prefix Last First Middle Suffix Previous Last Nickname

Name:

Social Security	Date of Birth	Age	SEX (Check one) ❑ Male ❑ Female ❑ None ❑ Undifferentiated ❑ Unknown

Mailing / Billing Address:_____
Street City State Zip

Address Type: ❑Home ❑Mailing ❑Temporary
Country: ❑USA ❑Other:_____ **County**: ❑Butte ❑Yuba ❑Sutter ❑ Other (list):_____

Secondary Address:_____
Street City State Zip

Address Type: ❑Home ❑Mailing ❑Temporary
Country: ❑USA ❑ Other:_____ County: ❑Butte ❑Yuba ❑Sutter ❑ Other (list):_____

Mother's Maiden Name:_____

INFORMATION NEEDED FOR MINORS AND INSURANCE

Father's Last First MI	**Mother's** Last First MI
Name:_____	Name:_____
Phone: ( ) DOB:	Phone: ( ) DOB:

Contact Preference: ❑None ❑Cell Phone ❑Confidential ❑Don't call home number ❑Don't call work number ❑Don't leave a message ❑Home Phone ❑Okay to leave message ❑Other ❑Work Phone
EXCEPTION: In the case of an urgent situation, Feather River Tribal Health will attempt to contact you.

Notifications: *Please mark only one.* ❑Phone Call ❑Voice reminders (automated call) ❑Text ❑Opt out

Home Phone: ( )_____ Day/Work Phone: ( )_____ Ext____

Cell Phone: ( )_____ Alternate/Message Phone: ( )_____

Marital Status: ❑Married ❑Single ❑Common Law ❑Divorced ❑Domestic/Life Partner ❑Legally Separated ❑ Widowed

Smoker: ❑Yes ❑No **Family Information:** Family Size:_____ Annual Income: $_____

Language Barrier: ❑Yes ❑No **Interpreter Needed?** ❑Yes ❑No ❑Sign Language

Signature:_____ Printed Name:_____ DOB:_____

Employer Name:_____ Phone: (___)_____

Address:_____City:_____State:_____Zip:_____

County:_____ Occupation:_____ ❑Unemployed ❑Retired

Student Status: ❑Not a Student ❑Full Time Student ❑Part Time Student
School Based Health Center: ❑Yes ❑No

Is Patient a Minor: ❑Yes ❑No **If yes, Relationship To Minor:** ❑Adopted Child ❑Brother ❑Father ❑Foster Child ❑Friend ❑Grandchild ❑Guardian ❑Mother ❑Natural Child ❑Nephew/Niece ❑None ❑Parent, child is the patient ❑Sibling ❑Significant Other ❑Sister ❑Step child ❑Other_____

Race:
❑American Indian/Alaska Native ❑White ❑Asian ❑Black/African American ❑Declined to specify
❑Native Hawaiian/Other Pacific Islander ❑ Other:_____

Preferred Language:
❑English ❑Spanish/Castilian ❑Other:_____

Religion:
❑None ❑Assembly of God ❑Christian ❑Catholic ❑Interdenominational ❑Jehovah's Witness ❑Latter Day Saint ❑Mormon ❑Nazarene ❑Pentecostal ❑Protestant ❑Seventh Day Adventist ❑Other_____

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Declined to Answer ❑Unknown/Not Reported

Homeless Status:
❑Homeless ❑Not Homeless ❑Doubling Up ❑Shelter ❑Street ❑Transitional ❑Unknown/Unreported

Migrant Worker Status: ❑Not a farm worker ❑Migrant ❑Seasonal

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

Tribe:_____Blood Quantum/Degree:_____Roll#:_____

Rancheria/Reservation:_____ Tribal Roll#:_____

NOTE: You must provide Indian Verification when you register as a patient. Examples of proof: CDIB card (Certified Degree of Indian Blood, Tribal card, be listed on the California Judgment Roll, Dawes Roll or be a Descendent (must use Certified Birth Certificates or Death Certificate to link to the Descendent).

Blood Quantum (for Native American only)
❑None ❑Full ❑Greater than or Equal to ½ but less than full half ❑Greater than or Equal to ¼ but less than full half ❑Indian but less than ¼ ❑Non Indian ❑Unspecified

Primary Medical Coverage: ❑Self Pay – Cash (No insurance) ☐ Native American (No Insurance)
Type of Insurance (please check all that apply):
❑Medicare (❑A ❑B ❑C ❑D) ❑Medi-Cal -- ❑Partnership Health Plan ❑Kaiser ❑CMSP
❑Private Ins ❑Dental Ins ❑Prescription ❑Other:_____

Public Housing Primary Care: ❑None ❑Other ❑Public Housing

Veteran Status: ❑Yes ❑No ❑Not collected yet ❑Other:_____

Signature:_____ Printed Name:_____ DOB:_____

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.

FEATHER RIVER TRIBAL HEALTH

Additional Patient Data

Patient Name:_____ Date of Birth:_____
(Please print)

1. Why do you want to be a patient of Feather River Tribal Health?_____
   _____
   _____
   _____

2. Who was your previous Provider (Doctor, FNP, PA, Clinic)?_____
   _____
   _____

3. Why are you changing providers?_____
   _____
   _____
   _____

4. Total number in Household:_____

5. Total Household Income: $_____ per year

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:_____

NAME _____DOB _____ MR# _____

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AUTHORIZATION TO CONSENT & DISCUSS TREATMENT OF A MINOR

I (We) The Undersigned Parent(s) of _____ a minor, do hereby authorize: (Grandparent/friend-someone you trust with your child)

☐**I decline** Consent for the Treatment of a Minor or to Discuss Treatment of a Minors health care issues.

Please print name(s):

1 - Name:_____ Relationship:_____

☐ I Consent To Treatment of a Minor ☐ I consent to Discuss minors health care issues.

☒ Medical, Dental, Pharmacy, Outreach, Patient Services, PRC & Referrals
BHS Initial:_____ (must initial to be valid)

2 - Name:_____ Relationship:_____

☐ I Consent To Treatment of a Minor ☐ I consent to Discuss minors health care issues.

☒ Medical, Dental, Pharmacy, Outreach, Patient Services, PRC & Referrals
BHS Initial:_____ (must initial to be valid)

3 - Name:_____ Relationship:_____

☐ I Consent To Treatment of a Minor ☐ I consent to Discuss minors health care issues.

☒ Medical, Dental, Pharmacy, Outreach, Patient Services, PRC & Referrals
BHS Initial:_____ (must initial to be valid)

As agent(s) for the undersigned to consent to any X-ray, medical diagnosis or treatment, and clinic care which is deemed advisable by, and is to be rendered under the general or special supervision of the clinic physician licensed under the provisions of the Medicine Practice Act and located at 2145 5th Avenue, Oroville, CA 95965-5870.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or clinic are being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or clinic are with the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain in effect until _____ unless soon revoked in writing to said agent(s).

Date:_____

Parent Signature:_____ Printed Name:_____

Legal Guardian Signature:_____ Printed Name:_____

Patient Name:_____ DOB:_____ MR#:_____

PEDIATRIC HEALTH QUESTIONNAIRE

Patient's Name:_____

MRN:_____ DOB:_____

Patient Name:_____ Today's Date:_____

Age:_____ DOB:_____

PARENT: Please fill out this form. Explain any "yes" answers in the space provided.

Mother's Name:_____ Age:_____ Occupation:_____ Health:_____

Father's Name:_____ Age_____ Occupation:_____ Health:_____

Sibling Name:_____ Age:_____ Health:_____

Sibling Name:_____ Age:_____ Health:_____

Sibling Name:_____ Age:_____ Health:_____

BIRTH HISTORY				CIRCLE		COMMENTS
PREGNANCY	Complications during pregnancy (infection, baby too small, poor movements)? Group B Strep screen positive? Hep B positive?			Yes	No	
	Medications during pregnancy?			Yes	No	
	Tobacco use?			Yes	No	
	Illicit drugs?			Yes	No	
DELIVERY	Was baby premature or how many weeks old when born?			Yes	No	
	Birth weight			Yes	No	
	Place of birth How many weeks when born?					
	Hearing test?			Yes	No	Result:
	Was Hep B vaccine for baby given at hospital?			Yes	No	Date:
	For boys only: Circumcision?			Yes	No	
	Any complications after birth (jaundice, breathing, feeding problem, infection)? Please comment if yes:			Yes	No	
	Medications during pregnancy:					
HOSPITALIZATIONS	Yes	No	Age:			
	Yes	No	Age:			
SERIOUS Illnesses or Medical Condition	Yes	No	Age:			
	Yes	No	Age:			
	Yes	No	Age:			
SURGERIES	Yes	No	Age:			
INJURIES	Yes	No	Age:			
FRACTURES	Yes	No	Age:			
CHICKENPOX	Yes	No	Age:			

CONCERNS SYMPTOMS

Are there any medical problems/concerns your child has? ☐Yes ☐No

Eye problems	Yes	No	Heart condition?	Yes	No	Caries	Yes	No
Ear problem/infection	Yes	No	Asthma	Yes	No	Diarrhea	Yes	No
Allergies, seasonal	Yes	No	Abdominal pain	Yes	No	Nose bleeds	Yes	No
Musculoskeletal	Yes	No	Constipation	Yes	No	Skin problems	Yes	No
Kidney Problems	Yes	No	Behavior problems	Yes	No	School failure	Yes	No

Other condition/social or medical condition:_____

ALLERGIES	Is your child allergic to any medications or foods, or environmental things?	Yes	No	Please list:
IMMUNIZATIONS	Do you have a record?	Yes	No	☐ Don't know
	Is your child up to date on Immunizations?	Yes	No	☐ Don't know
	Enrolled in the CA Immunization registry?	Yes	No	☐ Don't know
PREVIOUS PROVIDER		**Phone**		

Patient Name:_____ MRN:_____ DOB:_____

MEDICATIONS: Please list below any present medications your child is now taking or takes often. Include medications over the counter or herbs or fluoride.	
Name/Dosage	**Name/Dosage**

DENTAL HISTORY	Dentist name:_____ Any dental problems?_____ Is there fluoride in the water your child drinks? ☐ Yes ☐ No Water company?				
FAMILY HISTORY	Is there a family history of (circle yes or no): Asthma Yes No Heart Disease Yes No Tuberculosis Yes No Cancer Yes No Deafness Yes No Allergies Yes No Seizures Yes No Diabetes Yes No Thyroid Yes No Mental Retardation Yes No Slow Learner Yes No High Cholesterol Yes No Bipolar condition, ADHD, other Yes No Mental Illness (depression, etc) Yes No Unknown ☐ Foster Child ☐ Adopted Child Date since foster/adopted:_____				
DEVELOPMENTAL SOCIAL	Does your child have problems or any concerns with development?	Yes	No	☐ Don't know ☐ Newborn	
	Does your child have speech/language problems or concerns?	Yes	No		
	Motor Skills: Age when first sat _____ Crawled _____ Walked _____ Toilet trained _____				
	Does your child get along with other children?	Yes	No		
FOR SCHOOL AGE CHILDREN	Name of Child's School/City?			Grade:	
	Are there any school problems or concerns?	Yes	No		
SAFETY ENVIRONMENT	Living situation - Child lives with:_____ City: _____ ☐ House ☐ Mobile Home ☐ Apartment				
	Do you know the hottest temperature of the water in your home? (answer: 120°F or less)	Yes	No		
	Is there a working smoke alarm on each floor of your home?	Yes	No		
	Does child always use a car seat/booster/seat belt when riding in a car?	Yes	No		
	Are there any smokers in the household?	Yes	No	☐ Inside ☐ Outside	
	Does your child always wear a helmet when riding a bicycle or rollerblading?	Yes	No	N/A	
	Are there any problems with the condition of your home (peeling paint, insects, rats or mice?	Yes	No		
	Any weapons at home? ☐ Yes ☐ No Are they kept locked? ☐Yes ☐No				
TEEN CONCERNS	Smoking	Yes	No		
	Alcohol	Yes	No		
	Social/Recreational Drug Use	Yes	No		
	Sexual issues or sexually active	Yes	No		
	Are there any specific concerns?	Yes	No		
FOR YOUNG WOMEN	Age period began?_____ How many days it lasts?_____ Days between periods? Date of last period?				

Your previous medical records are important in providing us with a complete picture of your past medical history and current medical treatment. Did you bring them with you today? ☐ Yes ☐ No If not, please make arrangements to provide us with this information.

Filled out by:_____ Relationship:_____
(Please print)

Signature:_____ Date:_____ Phone #:_____

Reviewer Name/Clinician Signature:_____ Date:_____

RELEASE OF INFORMATION

❑ New Pt

FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)
555 W. ONSTOTT RD ♦ YUBA CITY CA 95993-5654 ♦ (530) 751-8454 ♦ FAX (530) 751-8456

PATIENT INFORMATION: Tell us about yourself or the person this form is for.

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

NICKNAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE NUMBER: _____

WHO IS SHARING:

WHO IS **GIVING** YOUR INFORMATION?	WHO IS **GETTING** YOUR INFORMATION?
❑ **FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)** 555 W. ONSTOTT RD YUBA CITY CA 95965-5654	❑ **FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)** 555 W. ONSTOTT RD YUBA CITY CA 95965-5654
❑ **CLINICIAN OR MEDICAL CENTER**	❑ **PATIENT OR LEGAL REPRESENTATIVE**
	❑ **CLINICIAN OR MEDICAL CENTER**
IF **NOT** FRTH:	NAME: _____
NAME: _____	RELATIONSHIP TO PATIENT: _____
FULL MAILING ADDRESS:	FULL MAILING ADDRESS:
_____	_____
_____	_____
_____	_____
FAX NUMBER: _____	FAX NUMBER: _____
PHONE NUMBER: _____	PHONE NUMBER: _____

HOW DO YOU WANT YOUR INFO SHARED: ❑ PAPER ❑ FAX TO: _____

WHY DO YOU WANT YOUR INFORMATION SHARED? WHAT IS IT GOING TO BE USED FOR?

❑**PATIENT REQUEST** ❑**CLINICIAN REQUEST** ❑**OTHER:** _____

This form complies with requirements of 45CFR164.508(c) & CA Civil Code §56.11

Patient Name_____ DOB_____ MR#_____