



NEW PATIENT REGISTRATION FORM

REVISED: 07/2018

Patient Name: (last, first, middle initial) _____

Other Names Used/Preferred Name: _____ Sex: _____ Date of Birth: _____

Social Security #: _____ Place of Birth (City, State): _____ Date when you began residing in Phoenix: _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Address: (street #, Apt #) _____ City _____, AZ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Additional Phone: _____

In case of emergency, contact: _____ Relationship: _____ Emergency Phone: _____

Tribe of Membership: _____ Tribe of Quantum: _____ Indian Blood Quantum: _____

Tribal Enrollment Number: _____ Other Tribe: _____

Some of the following questions may be uncomfortable for you to answer; however, your honest responses will assist NATIVE HEALTH in providing the best services for you as an individual. By answering the following questions you will help us to qualify for resources that support the services we provide for you.

Ethnicity: _____ Race: _____ Primary Language: _____ (Other) _____

Sexual Orientation:

- Lesbian/Gay/Homosexual
- Straight/Heterosexual
- Bisexual
- Something Else/Other
- Don't Know/Questioning
- Choose Not To Disclose

Gender Identity:

- Male
- Female
- Other/Gender Variant/Inter-sex
- Transgender Male/Female-to-Male
- Transgender Female/Male-to-Female
- Choose Not To Disclose

Sex Assigned At Birth

- Male
- Female
- Choose Not To Disclose

What pronoun do you prefer to be addressed by: She/Her He/Him They Zie/Hir Other: _____

Military Veteran: Yes No If yes, which branch: _____ Migrant Worker: Yes No Homeless: Yes No

Do you have Internet access: (home, work, library) Yes No Email address: _____

Preferred Language: _____ Number in household that you are financially responsible for: _____ Total Household Income: _____

Name of employer: _____ Address: _____

Income Period: Yearly Monthly Weekly Daily

THE PRECEDING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. TREATMENT/PAYMENT AGREEMENT FOR NATIVE HEALTH /NHW COMM. HEALTH CENTER I request NATIVE HEALTH/NHW Community Health Center to provide me and/or my family with medical care. I acknowledge my responsibilities to pay for the care according to the fees established. Furthermore, I authorize assignment of benefits for medical services to be paid to NATIVE HEALTH/NHW Community Health Center. By signing below I also acknowledge I have received a copy and an explanation of the Health Insurance Portability and Accountability Act Privacy Rule.

Signature: _____ Date: _____

Customer Care Representative: _____ Date: _____



Patient Intake Form

Please print and fill out as completely as possible

Today's Date: _____

Patient Name: _____
Last First MI

Date of Birth: _____ Place of Birth: _____

Marital Status: Married Single Divorced Widowed

Number of Children: _____ Ages of children: _____

Occupation: _____

Employer: _____

MEDICAL HISTORY:

Are your influenza/pneumovax immunizations current? Yes No

Have you been diagnosed as diabetic? Yes No Date of diagnosis: _____

Have you ever been given a colorectal cancer screening? Yes No If yes, when: _____

FEMALE MEDICAL HISTORY:

Pregnancy history: never been pregnant abortion(s) miscarriages tubal pregnancies live births

Have you ever been given a mammography screening? Yes No

If yes, when: _____ where: _____

Have you ever been given a pap screening? Yes No

If yes, when: _____ where: _____

continue on back



TREATMENT/PAYMENT AGREEMENT

I request NATIVE HEALTH/NHW Community Health Center/NATIVE HEALTH Maryvale to provide me and/or my family with medical, dental or behavioral health care. I acknowledge my responsibilities to pay for the care according to the fees established. Furthermore, I authorize assignment of insurance/benefits for medical, dental or behavioral health services to be paid to NATIVE HEALTH/NHW Community Health Center/NATIVE HEALTH Maryvale. By signing below I also acknowledge I have received a copy and explanation of the Health Insurance Portability and Accountability Act Privacy Rule.

Further, I understand that I am responsible for payment of any services I request for myself/family that are not covered by my insurance/benefits package.

NATIVE HEALTH/NHW Community Health Center/NATIVE HEALTH Maryvale reserves the right to collect any unpaid amounts.

BY SIGNING THIS AGREEMENT, I ATTEST THAT ALL INFORMATION PROVIDED DURING REGISTRATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

patient signature _____ date: _____

CCR signature _____ date: _____



STUDENT, INTERN AND VOLUNTEER PATIENT/CLIENT CONSENT FORM

REV: 04/2015

NATIVE HEALTH, through the Medical, Dental, Behavioral Health (BH) and/or WIC Clinics, provides educational opportunities for Students, Interns and Volunteers (S/I/V) from various educational institutions. As appropriate, we may include a Student/Intern or Volunteer to join our licensed providers in the provision of the intake, examination and/or service/treatment process. If you agree to include S/I/V in your treatment process, we must have your consent.

Please read the following and feel free to ask any questions. If you give your consent, please sign at the bottom. Our intent is to give you the highest quality care possible.

I understand that Students, Interns and Volunteers are an important part of professional education and I consent to the following:

- a. Patient/Client Intake
- b. Supervised service/treatment process
- c. _____ consultation

- By signing the consent form it does not obligate the patient to any treatment.
- You have the option to revoke, **IN WRITING**, this consent at any time during the service/treatment process.
- The original form will be filed in the patient chart and a copy provided to the patient or parent/guardian of the pediatric patient, if requested.

Parent / Patient / Guardian Signature

Date

Provider & Clinic Signature

Date

PATIENT RIGHTS AND RESPONSIBILITIES

As the accredited Medical and Dental Home of our patients, NATIVE HEALTH is committed to the following Patient Rights and Responsibilities. Patients have a fundamental right to medical care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. NATIVE HEALTH/NHW Community Health Center/NATIVE HEALTH Maryvale strives to provide understanding and respect of these values in meeting patients' needs as long as these values are within the health center's capacity, its stated mission and philosophy, and relevant laws and regulations. We honor and attest to your rights as a patient to:

ACCESSIBLE CARE

- Receive appropriate medical, dental, and behavioral health care without discrimination
- Communicate and receive a timely response to your concerns by contacting a NATIVE HEALTH employee
- Access protective services
- Receive referrals to other health care professionals to optimize health status
- Communication assistance if you do not speak or read English, or are hearing or visually impaired
- Patients have the right to change providers if other qualified providers are available

RESPECT AND DIGNITY

- Be assured of the confidentiality of your health information
- Make informed choices about your care and treatment, including the decision to refuse treatment
- Complete an Advance Directive/Living Will and have your stated wishes honored
- Be assured of considerate and respectful treatment regardless of race, color, creed, ethnic or national origin, cultural background, religion or belief, age, sex, gender identity, gender expression, sexual orientation, economic status, education, disability or illness
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, restraint or seclusion, retaliation for submitting a complaint or misappropriation of personal and private property by NATIVE HEALTH's personnel.

INVOLVEMENT OF FAMILY AND FRIENDS

- Involve family members and friends in your care, when it is safe and possible

COORDINATION OF CARE

- Participate in the development and implementation of care along with your chosen family and representatives
- Know the name of your primary medical, dental or behavioral health provider
- Know the names and professional titles of caregivers participating in your care
- Participate in the development and implementation of your care plan
- Appoint a representative of your choice to make informed decisions about your care

INFORMATION, EDUCATION AND COMMUNICATION

- Be given complete and current information about your diagnosis, condition, and treatment and outcomes of care, including unanticipated outcomes, in a manner that you can understand

- Participate in decisions about your diagnosis, treatment and care
- Know the potential risks and benefits of procedures and treatments
- Receive and examine an explanation of charges, regardless of source of payment in a manner that you can understand
- Receive health information and education to optimize your health and self-management

PHYSICAL COMFORT

- Be cared for in a healing environment which is clean, safe, and respectful of your personal privacy
- Receive appropriate pain assessment and management with the intention to maximize your comfort.

EMOTIONAL SUPPORT

- Express concerns, be heard, and receive an appropriate response

TRANSITION AND CONTINUITY OF CARE

- Expect reasonable continuity of care and be advised of continuing healthcare requirements

PATIENT RESPONSIBILITIES

As a partner on your healthcare team, we ask you to:

- Provide complete and accurate information about your current and past state of health, including allergies, past illnesses, hospitalizations, and the medications you are taking
- Report changes in your condition or symptoms, including pain, to a member of the healthcare team
- Talk to us about your pain and options for minimizing it
- Ask questions when you do not understand what we are saying or asking you to do
- Follow the treatment plan that you developed with your healthcare providers
- Accept responsibility for your health outcome, if you choose not to follow your treatment plan
- Follow the rules and regulations of our health center, which have been put in place for your safety and the safety of others
- Assist us in providing a safe environment by sharing your observations if you perceive unsafe conditions or practices
- Show respect and consideration for your healthcare professionals and other patients and families by controlling noise and disturbances, not smoking, and respecting others' property
- Assure your financial obligation for health care is fulfilled as promptly as possible.

If you would like to express a concern or complaint about your care, treatment or safety, please contact the Quality Assurance Manager. A copy of the Patient Rights and Responsibilities Policy is available at the front desk.

Patient/Guardian Signature: _____ Date: _____

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally-assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may “opt out” of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.
2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.
3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.
4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

Signature: _____ Date: _____