Consolidated Tribal Health Project, Inc.

6991 North State Street • Redwood Valley, CA 95470
Mail: P.O. Box 387 • Calpella, CA 95418
707-485-5115 • 800-642-CTHP

www.cthp.org

CTHP Consortium Tribes

Cahto Tribe of the Laytonville Rancheria

Coyote Valley Band of Pomo Indians

Guidiville Rancheria of California

Hopland Band of Pomo Indians

Pinoleville Pomo Nation

Potter Valley Tribe

Redwood Valley Little River Band of Pomo Indians

Sherwood Valley Rancheria of Pomo Indians of California

Yokayo Provisional Council Tribe of Indians *(ex officio)*

Healthy Individuals

Healthy Families

Healthy Communities

Quality Healthcare Since 1984

Dear Applicant,

RE: Patient Registration

Thank you for choosing Consolidated Tribal Health Project for your health and wellness needs. Before you can schedule an appointment, you must complete the Patient Registration process.

This Registration Packet is the first step of this process. Review the documents and provide all of the required information so that we can help secure coverage for you, if needed, and determine your eligibility for special services.

Once you complete the required forms and you have all of your required documentation ready, contact CTHP's Registration Clerk to schedule an appointment. The Registration Clerk will review your documentation and answer any questions you may have.

Patients who are less than 18 years of age require a parent or their legal guardian to complete and sign their paperwork.

Documents to complete and return:

- ☐ CTHP Patient Registration Form
- ☐ CTHP Conditions of Treatment
- ☐ Information Regarding Your Health Care Coverage
- ☐ Notice of Privacy Practices

Upon successful completion of the registration process, you may schedule appointments.

IMPORTANT: Patients shall provide originals of all required documentation.

Adult Patients *(18 years of age and older)*

- ☐ Photo ID *(driver's license, passport)*
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Tribal documentation of enrollment
- ☐ Proof of Coverage *(Private Insurance, Medi-Cal, Medi-Cal/Partnership HealthPlan of California or Medicare cards)*

Pediatric Patients *(0 to 17 years of age)*

California State Law mandates that all minors shall be accompanied by a parent or guardian on initial visit. If minor is accompanied by guardian, all required legal documents shall be provided.

- ☐ Photo ID of parent or guardian
- ☐ Legal documents of guardianship
- ☐ Social Security Card
- ☐ Birth Certificate for child
- ☐ Tribal documentation of enrollment for child or parent
- ☐ Proof of Coverage *(Private Insurance, Medi-Cal, Medi-Cal/Partnership HealthPlan of California or Medicare cards)*

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HRN

Patient Registration Form

Patient Name: _____
Last First Middle Initial

Physical Address: _____
Street Address Apt. City State & Zip Code

Mailing Address *(if different from above)*: _____

Telephone: (H) _____ (C) _____ (W) _____

Email address: _____

Do you have internet access? ☐No ☐Yes ☐At home ☐On phone ☐Other: _____

Social Security Number: _____ **Date of Birth:** _____
MM/DD/YEAR

Employment Information: ☐ Self Employed ☐ Employed

Name of Company/Employer: _____

Address of Company/Employer: _____

Phone: _____

Place of birth: _____

When did you move to Mendocino County? _____
DD/MM/YEAR

Father's Full Name: _____

Mother's Full Maiden Name: _____

Patient Demographics

Gender Assigned at Birth: ☐ Female ☐ Male ☐ Intersex

Pronoun Preference: ☐she/her ☐he/his ☐they/them

I identify as: ☐ female ☐male ☐ trans male to female ☐ trans female to male

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Race: ☐ American Indian/Alaska Native Tribe & Enrolment #: _____

☐ White ☐Hispanic ☐Asian ☐African American/Black ☐Filipino/Pacific Islander

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Migrant Worker? ☐No ☐Yes

Homeless? ☐ No ☐Yes If yes, specify: ☐Shelter ☐Transitional ☐Street ☐Doubling up ☐Other: _____

Preferred Language of Communication ☐ English ☐ Spanish ☐ Other: _____

Do you require an interpreter? ☐No ☐Yes If yes, specify: spoken language: _____

☐Sign Language Other *(specify)*: _____

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Emergency Contact Information

Name: _____

Relationship to Patient: _____

Telephone: _____

Address: _____

Next of Kin Information

Name: _____

Relationship to Patient: _____

Telephone: _____

Address: _____

Financial Responsibility

Do you have insurance? ☐No ☐Yes If yes, name of insurance company:_____

ID and Group Number: _____ Contact Number: _____

Do you have dental insurance? ☐No ☐Yes If yes, name of insurance company:_____

ID and Group Number: _____ Contact Number: _____

Medicare ☐No ☐Yes ID #: _____

Medi-Cal/Partnership HealthPlan of CA ☐No ☐Yes ID #: _____

Are you a U. S. Veteran? ☐No ☐Yes Branch of Service: _____

Number in Household: _____ Monthly Income: $_____ Annual Income: $_____

Advanced Directives/Living Will. I have an Advanced Directive/Living Will. ☐Yes ☐No

I want to complete an Advanced Directives document. ☐ Yes ☐No ☐ I need more information.

For Patients Under 18 Years of Age

Name of Legal Guardian: _____
Last First Middle Initial

Physical Address: _____
Street Address Apt. City State & Zip Code

Mailing Address *(if different from above)*: _____

Telephone: (H) _____ (C) _____ (W) _____

Email address: _____

Release of Information / Assignment of Benefits

☐ I grant Consolidated Tribal Health Project, Inc. (CTHP) permission to release information as needed for insurance processing.

☐ I grant permission for my insurance provider to release payment to CTHP.

Treatment Authorization

I hereby authorize treatment.

Screener's Initials

_____
Print Name of Patient or Guardian

_____ _____
Signature Date

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Conditions of Treatment

Behavioral Health, Dental and Medical Treatment and Services Consent

I hereby:

☐ Grant permission for Behavioral Health / Dental and/or Medical Treatment and Services to be rendered as needed.

☐ Grant consent for Consolidated Tribal Health Project (CTHP) to share: diagnostics procedures, including x-ray examinations, laboratory procedures, injections, anesthetics, operations, removal of tissue and disposal of tissue, administration of medications, and other services provided to the patient by a licensed Behavioral Health Provider, Dentist, Registered Dental Hygienist, Registered Dental Assistant, Dental Assistant, Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, Licensed Vocational Nurse, Certified Medical Assistant, Registered Dietitian, Licensed Acupuncturist, Doctor of Chiropractic, and/or Certified Massage Therapist.

☐ Understand that I am under the care of my attending licensed Behavioral Health Provider, Dentist or Physician, and that CTHP is not liable for any act or omission when following the instructions of said licensed Behavioral Health Provider, Dentist or Physician.

Responsibility for Payment

☐ I understand that I am responsible for payment for all Behavioral Health, Dental and Medical Treatment Services provided to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier.

Eligible American Indian patients may receive some services at no charge.

Release of Information

☐ CTHP may release all of part of my records to any person or corporation which is, or may, be liable for payment for services rendered, including, but not limited to insurance companies, Medi-Cal/Partnership HealthPlan of California, Workers Compensation carriers and my employer.

☐ CTHP may release immunization information to schools, school districts and public health departments that need immunization information for compliance with regulations regarding public health and public health emergency declarations.

Assignment of Benefits

☐ I hereby assign and authorize all insurance and other benefits payable to me by reason of my care at CTHP be paid to Consolidated Tribal Health Project, Inc.

☐ If payment by my insurance company is assigned to me, I will turn the benefits over to CTHP.

☐ I certify that I have read this document, and I understand and will fully comply with its terms.

☐ I certify that I am the patient or the parent/legal guardian/duly authorized agent (attorney-in-fact) for health care decisions for the patient.

_____

Print Name of Patient

_____ _____

Signature Date

Relationship to Patient: ☐Self ☐Custodial Parent/Legal Guardian ☐Health Care Agent (Attorney-in-Fact) *Must provide copy of Durable Power of Attorney for Health Care.*

This agreement shall remain in effect for one year from the date of signature.

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Information Regarding Your Health Care Coverage

MediCal/Partnership HealthPlan of California
MediCal allows services like clinic visits. Referrals to specialists may require additional authorization or payment directly from the patient.

Coverage can vary, so contact the Billing Department for the most current information before your appointment. You are responsible for payment at the time of visit.

California State Law requires Providers to use the Medi-Cal/Partnership HealthPlan of California identification number printed on your Benefits Identification Card when submitting a claim.

Please present your Medi-Cal/ Partnership HealthPlan of California Benefits Identification Card to the Receptionist at the time of check-in.

Medicare does not pay for chiropractic, acupuncture or dental services.

Insurance
Insurance companies allows a limited number of visits per year each for acupuncture and chiropractic clinics unless otherwise stated by the insurance carrier.

If you are interested in the types of services your plan covers, it is your responsibility to call your plan and ask for a copy of the services allowed.

Should you desire more than the limited number of allowed under this program, you will be responsible for payment for each appointment to the acupuncture and chiropractic classes.

Dental Benefits under your insurance plan does not always cover all services provided by the dental department. Some insurance policies will only pay for certain procedures and it is then the responsibility of the individual insured to pay for those services not covered under the existing plan.

CTHP will prior authorize with your dental insurance for any individual services over $250.00 before providing treatment. At this time, we will be able to determine your financial responsibility for the treatment and a payment plan will be initiated.

If you are interested in the types of services your plan covers it is your responsibility to contact your plan and request a copy of services available.

_____ I understand the above information.
_____ I accept responsibility for charges not covered by my insurance.

_____
Print Name of Patient

_____ _____
Signature Date

If you have questions about coverage, contact:
Andrea Ramirez, Billing Clerk III, at 707-467-5631 or
Michelle Edwards, Billing and Front Desk Manager, at 707-467-5637

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Patient Acknowledgement of Financial Responsibility

The following is Consolidated Tribal Health Project, Inc.'s (CTHP) financial policy. Please read it and sign your acknowledgment of your financial responsibility.

Updated Contact Information

It is your responsibility to provide updated contact information to CTHP. Inform CTHP of changes to your address, telephone number and/or other contact information.

Insurance and All Other Alternate Healthcare Benefits

- Present your current insurance card at each visit.
- CTHP will bill your insurance or alternate healthcare organization directly for and services rendered.
- Copayments are collected at the time of check-in, before your appointment.
- Payment for services not covered by your insurance, if known, will be collected by CTHP at the time of check-in for your appointment.
- You are ultimately responsible for payment of any services rendered by CTHP.
- If you are uncertain about your health insurance policy benefits, contact your health insurance carrier or your employer.

Self-Pay / No Insurance Coverage

- A minimum payment of $100 will be collected at check-in, before your appointment.
- A statement for any balance owed will be mailed to you.

Failure to Pay

- Failure to pay account balances will result in sending the patient's account to collections.
- Patients cannot schedule an appointment until the balance owed is paid in full, or the patient has established a payment plan with CTHP.

Acknowledgment

I have read and understand the terms of this Acknowledgment.

My signature below serves as my acknowledgment that I am financially responsible for any fees and/or charges incurred for serviced provided by CTHP.

Patient Name: _____

_____ _____

Signature of Patient or Patient's Legal Parent/Guardian **Date**

Consolidated Tribal Health Project, Inc.

Notice of Privacy Practices

Please Review This Document Carefully

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

If you would like assistance in reviewing this document, or if you have any questions about the contents, ask the Receptionist and they will find a staff member who can assist you.

CTHP's Obligations

CTHP is required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

How CTHP May Use and Disclose Your Health Information

The following describes the ways CTHP may use and disclose health information that identifies you *("Health Information").*

Except for the purposes described below, CTHP will use and disclose Health Information *only* with your written permission. You may revoke such permission at any time by writing to our Health Records Supervisor.

For Treatment. CTHP may use and disclose Health Information for your treatment, and to provide you with treatment-related health care services. *For example, CTHP may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.*

For Payment. CTHP may use and disclose Health Information so that CTHP or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. *For example, CTHP may give your health plan information about you so that they will pay for your treatment.*

For Health Care Operations. CTHP may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. *For example, CTHP may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality.*

CTHP also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

How CTHP May Use and Disclose Your Health Information

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. CTHP may use and disclose Health Information to contact you to remind you that you have an appointment with us. CTHP may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Notice of Privacy Practices

Individuals Involved in Your Care or Payment for Your Care. When appropriate, CTHP may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. CTHP may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, CTHP may use and disclose Health Information for research. *For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition.*

Before CTHP use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, CTHP may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations

As Required by Law. CTHP will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. CTHP may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. CTHP may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. *For example, we may use another company to perform billing services on our behalf.*

All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, CTHP may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, CTHP may release Health Information as required by military command authorities. CTHP may also release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. CTHP may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. CTHP may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if CTHP believes a patient has been the victim of abuse,

neglect or domestic violence. CTHP will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. CTHP may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. CTHP may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, CTHP may disclose Health Information in response to a court or administrative order. CTHP also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. CTHP may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. CTHP may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. CTHP also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. CTHP may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. CTHP may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, CTHP may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures Requiring CTHP to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, CTHP may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your

health care. If you are unable to agree or object to such a disclosure, CTHP may disclose such information as necessary if CTHP determines that it is in your best interest based on our professional judgment.

Disaster Relief. CTHP may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. CTHP will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your Written Authorization Is Required For Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and CTHP will no longer disclose Protected Health Information under the authorization. Disclosure that CTHP made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Health Records Supervisor.

CTHP has up to 30 days to make your Protected Health Information available to you and CTHP may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. CTHP may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

CTHP may deny your request in certain limited circumstances. If CTHP denies your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and CTHP will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity.

CTHP will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a

readable hard copy form. CTHP may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information CTHP has is incorrect or incomplete, you may ask CTHP to amend the information. You have the right to request an amendment for as long as the information is kept by or for CTHP. To request an amendment, you must make your request, in writing, to the Health Records Supervisor.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures CTHP made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to the Health Records Supervisor.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information CTHP uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information CTHP discloses to someone involved in your care or the payment for your care, like a family member or friend. *For example, you could ask that CTHP not share information about a particular diagnosis or treatment with your spouse.*

To request a restriction, you must make your request, in writing, to the Health Records Supervisor. CTHP is not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If CTHP agrees, CTHP will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and CTHP will honor that request.

Right to Request Confidential Communications. You have the right to request that CTHP communicate with you about medical matters in a certain way or at a certain location. *For example, you can ask that we only contact you by mail or at work.* To request confidential communications, you must make your request in writing to the Health Records Supervisor. Your request must specify how or where you wish to be contacted. CTHP will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask CTHP to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at CTHP's web site, www.cthp.org. To obtain a paper copy of this notice, ask reception or PRC staff. Any CTHP staff member can assist you if the document is unavailable.

Notice of Privacy Practices

Changes to This Notice

CTHP reserves the right to change this notice and make the new notice apply to Health Information CTHP already have as well as any information CTHP receives in the future. CTHP will post a copy of our current notice in the main clinic lobby. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with CTHP, or with the Secretary of the Department of Health and Human Services.

To file a complaint with CTHP, contact the Executive Director. All complaints *must* be made in writing. You will not be penalized for filing a complaint.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

Written requests may be sent to:
Health Records Department
Consolidated Tribal Health Project, Inc.
P. O. Box 387
Calpella, CA 95418
Attention: Health Records Request; Confidential

Written complaints may be sent to:
Executive Director
Consolidated Tribal Health Project, Inc.
P. O. Box 387
Calpella, CA 95418
Attention: Patient Feedback; Confidential

Phone Contacts:
Executive Director
707-467-5616

Notice of Privacy Practices

Patient Acknowledgement of Receipt

Please initial below:

☐ I received a copy of Consolidated Tribal Health Project's Notice of Privacy Practices.

☐ I acknowledge that it is my responsibility to review this document to understand CTHP's Notice of Privacy Practices.

☐ I understand that if I have any questions about CTHP's Notice of Privacy Practices, I can ask for assistance. Assistance is available from CTHP staff as listed in CTHP's Notice of Privacy Practices.

Patient Name *(please print)*: _____

_____ _____

Signature of Patient Date

Patient Representative:

Name *(please print)*: _____

Relationship to patient *(check one)*:

☐ relative ☐ friend ☐ legal guardian ☐ other: _____

_____ _____

Signature of Patient Representative Date
Or Witness *(if signature is by X mark)*

FOR CTHP USE ONLY

_____ _____

Name & Title of CTHP Employee *(please print)* Date

_____ _____

Signature of CTHP Employee Date

Consolidated Tribal Health Project, Inc.

HRN

Authorization for Use or Disclosure of Protected Health Information

Complete All Sections, Date and Sign

I. Patient Name: _____

Date of Birth: _____

Address: _____

I hereby voluntarily authorize the disclosure of information from my dental record/medical record.

II. This information is to be disclosed by: **And is to be provided to:**

Name of Facility:	Name of Person/Organization/Facility: HIM Department / CTHP
Address:	Address: P. O. Box 387
City, State	City, State Calpella, CA 95418

III. The purpose or need for this disclosure is *(check all that apply)***:**

☐ Further Medical Care ☐ Attorney ☐ Insurance ☐ Disability

☐ School ☐ Research ☐ Personal Use

☐ Other:_____

☐ Health Information Exchange (IHS/Other_____)

IV. The information to be disclosed from my dental record/medical record *(check all that apply)***:**

☐ Entire Record *(three years of chart notes, lab results, images/x-rays, etc.)*

☐ Only information related to *(e.g. procedures, surgeries, etc.)*: _____

☐ Only the period of events from _____ to _____

☐ Other *(e.g. PRC, Billing, etc.)*_____

☐ Problem Summary List ☐ Last mammogram

☐ Medication List ☐ Last colonoscopy

☐ Immunizations ☐ Last Dexa scan

☐ Last pap smear

If you want any of the following sensitive information disclosed, check applicable boxes:

☐ Alcohol/Drug Abuse ☐ HIV/AIDS-related Treatment ☐ Treatment/referral

☐ Mental Health *(Other than psychotherapy notes)*

☐ Psychotherapy Notes ONLY. By checking this box, I am waiving any psychotherapist-patient privilege.

Consolidated Tribal Health Project, Inc.

HRN

Authorization for Use or Disclosure of Protected Health Information

V. I understand that I may revoke this authorization in writing, submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization.

If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy.

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration* event is stated.

For Health Information Exchange authorizations, it is recommended to expire in at least five years. Specify new date: _____

I understand that CTHP will not condition treatment or eligibility for care on my providing this authorization, except if such care is: (1) research-related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined if 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient or Personal Representative *(state relationship to patient)*	Date
Signature of Witness *(if signature of patient is a thumbprint or mark)*	Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor [5 USC 552a(i)(3)].

If no records are available, please reply and indicate the reason:

☐ not a patient ☐ no records within the timeframe requested

☐ other: _____

Health Information Management Department
Consolidated Tribal Health Project, Inc.
P. O. Box 387
Calpella, CA 95418
P: 707-485-5115 / F: 707-485-8271

Consolidated Tribal Health Project, Inc.
6991 N. State St. / Redwood Valley, CA 95470
P. O. Box 387 / Calpella, CA 95418
707-485-5115

Authorization for Another Adult to Consent to Treatment of a Minor

Each minor child less than 18 years of age must be accompanied by an adult who is 18 years of age or older and authorized by the parent or legal guardian of the child to consent to medical, dental, behavioral health treatment for that child.

CTHP staff cannot assume responsibility for accompanying minor children during medical, dental or behavioral health visits as a function of their job duties.

Name of (minor) patient: _____ DOB: _____

Parent/Guardian Statement

☐ I certify that I am the custodial parent or legal guardian of the above-mentioned minor patient.

☐ I hereby authorize the following individual(s) to consent to treatment for the above-mentioned minor patient.

_____ _____
Name of Authorized Adult Relationship to Child

_____ _____
Name of Authorized Adult Relationship to Child

_____ _____
Name of Authorized Adult Relationship to Child

_____ _____
Name of Authorized Adult Relationship to Child

This agreement shall remain in effect for one year from the date of signature or until revoked or replaced by a subsequent authorization.

Name of Custodial Parent or Guardian: _____

_____ _____
Signature of Custodial Parent or Guardian Date

_____ _____
Address Contact number(s)

Consolidated Tribal Health Project, Inc.
6991 N. State St. / Redwood Valley, CA 95470
P. O. Box 387 / Calpella, CA 95418
707-485-5115
www.cthp.org

Appointment Confirmation Authorization

Consolidated Tribal Health Project offers appointment reminders for our patients.

Behavioral Health and Dental reception staff will call patients to remind them of their appointments.

The Medical Department uses an automated system.

It is very important for patients to make sure we have updated telephone contact information. If patients realize they are not receiving appointment reminders, they should contact the Receptionist to make their contact information is updated.

Patient Name: _____

☐ I authorize Consolidated Tribal Health Project, Inc. (CTHP) to contact my phone number and leave a message for the purpose of confirming my CTHP appointments as follows *(check all that apply)*:

- ☐ in the voicemail system of the primary phone number that I provided on my Patient Registration Form.
- ☐ with an authorized person when someone answers my phone. Name(s) of authorized individuals: _____

☐ I do not wish to receive appointment reminders by telephone. I understand that I can change this status any time. *(To do so, inform the receptionist when you check in for your next appointment, or call 707-485-5115 to update your information.)*

☐ I understand that the only information to be provided during an appointment reminder will be the date and time of my appointment.

☐ I understand that no information regarding my health status or the nature of the appointment will be provided in the voicemail message, or to any persons answering my phone.

☐ I understand that I can rescind my authorization and ask not to receive appointment reminders at any time.

This authorization shall remain in effect for as long as the patient is an active CTHP patient or until they withdraw this authorization.

_____ _____

Patient Signature Date

Consolidated Tribal Health Project, Inc.
6991 N. State St. / Redwood Valley, CA 95470
P. O. Box 387 / Calpella, CA 95418
707-485-5115
www.cthp.org

Portal Adoption

CTHP's offers a Patient Portal through Athena, our electronic health records system. The portal allows you to access your medical health record, request an appointment and view lab results.

Indicate your preference with respect to the Patient Portal by checking one of the following:

☐ Block Portal Access

☐ Yes, I am interested in portal access.

☐ Do not send portal adoption emails

Communicator Automated Messaging Preferences

Check all that apply:

I do not want any reminders. ☐

I know that I can change my preferences at any time. I consent to the following reminders:

Health Notifications	☐ Email	☐ Phone	☐ Text
Appointments	☐ Email	☐ Phone	☐ Text
Announcements	☐ Email	☐ Phone	☐ Text
Billing	☐ Email	☐ Phone	☐ Text

For more information about the Patient Portal, call Michelle Edwards, Billing and Front Desk Manager, at 707-467-5637.

CTHP Health and Wellness
MEDICAL HISTORY FORM

Today's Date: _____ Your Full Name:_____ Birth Date:_____

State the reason for your visit:_____
Medications: Please list any prescribed medications and over-the-counter vitamins/supplements/herbs you take:

_____

_____

Have you taken any antibiotics in the past month? ☐ Yes ☐ No
Allergies: Please check allergies that you have experienced in the past.
Medications ☐ Yes ☐ No If yes, please list drug AND reaction _____
X-ray dye or contrast ☐ Yes ☐ No Latex allergy ☐ Yes ☐ No Food allergy ☐ Yes ☐ No

Family History: Please check illnesses that have occurred in any of your **blood** relatives.
☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Thyroid Problems
☐ Mental Illness ☐ Cancer ☐ Breast / Ovarian Cancer in Female Members
Father: Living ☐ Yes ☐ No Cause of death or significant health problems _____
Mother: Living ☐ Yes ☐ No Cause of death or significant health problems _____
Did your mother use DES while pregnant with you? ☐ Yes ☐ No

Personal Medical History: Please check illnesses or conditions which you have had.

☐ Heart Disease	☐ High Blood Pressure	☐ Diabetes	☐ Thyroid Problems
☐ Liver Disease	☐ High cholesterol	☐ Stroke	☐ Cancer _____
☐ Gallbladder Disease	☐ Anemia or Blood Disorder	☐ STDs_____	☐ Blood clot in arm/legs/lung
☐ Abnormal Mammogram	☐ Breast disease/problems	☐ Abnormal pap smear	☐ Ovary/Uterus problems
☐ Migraine headaches	☐ Intestinal/stomach problems	☐ HIV or AIDS	☐ Asthma
☐ Kidney/bladder problems	☐ Seizures	☐ Major depression	☐ Psychiatric problems

☐ Other medical problems including genetic:_____

Previous Surgeries: Please list surgery and year _____

_____

_____

Imaging/Tests: Have you had a mammogram? ☐ Yes ☐ No If yes, when_____
Have you had a colonoscopy? ☐ Yes ☐ No If yes, when_____
Have you had a bone density scan? ☐ Yes ☐ No If yes, when_____
Have you had a pap smear? ☐ Yes ☐ No If yes, when_____

Screening:
Little interest/ pleasure in doing things? ☐ Yes ☐ No
Feeling down, depressed or hopeless? ☐ Yes ☐ No
Social History:

Tobacco: ☐ None ☐ Now: Packs per day_____ ☐ Ex-smoker: Quit date_____
Alcohol: ☐ None ☐ Social ☐ Weekly ☐ Daily
Feel like you should cut down on your drinking? ☐ Yes NO☐ Have you felt bad or guilty about your drinking? ☐ Yes NO☐
Do people annoy you by critisizing your drinking? ☐ Yes NO☐ Have you had a drink first thing in the morning? ☐ Yes NO☐
Illegal drug use: ☐ Yes ☐ No

Do you feel safe in your current relationship? ☐ Yes ☐ No ☐ NA
Do you feel safe in your current living situation? ☐ Yes ☐ No