San Diego American Indian Health Center

HRN _____

Received By: _____

Date Entered:

Patient Registration Form

PLEASE PRINT CLEARLY

Patient's Legal Name: _____ AKA (Also Known As): _____

SSN: _____ **Birthdate**: _____ **Primary Care Provider:** _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female Male-to-Female ☐ Other ☐ Choose not to disclose

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

Ethnicity (select one): ☐ Hispanic or Latin Origin ☐ NOT Hispanic or Latin Origin

Race (Select one):

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

If American Indian/Alaskan Native:
Tribe: _____ Enrollment #: _____ Indian Blood Quantum: _____

If you are not American Indian/Alaskan Native, are you a member of an Indian household? ☐ Yes ☐ No

Primary Language: _____ Preferred Language: _____ Interpreter Required: ☐ Yes ☐ No

English Proficiency: ☐ Not at all ☐ Not Well ☐ Well ☐ Very Well

Home Address: _____ **Apt #**_____

City: _____ **State**: _____ **Zip Code:** _____

Mailing Address (if different from home): _____

Home Phone#: _____ **Work Phone #:** _____ Ext: _____ **Cell Phone #:** _____

Can we leave a message on the above phone numbers? ☐ Yes ☐ No **Preferred Method of Contact:** ☐ Phone ☐ Email ☐ Mail

Internet Access: ☐ Yes ☐ No **If YES**, where? ☐ Home ☐ Work **Email Address:** _____

Would you like to sign up for the Personal Health Record (PHR) where you can view your health information? ☐ Yes ☐ No

---

Emergency Contact

Primary Contact Name: _____ Relationship: _____

Home/Cell Phone #: _____ Work Phone #: _____

Secondary Contact Name: _____ Relationship: _____

Home/Cell Phone #: _____ Work Phone #: _____

Please complete reverse side

San Diego American Indian Health Center

Patient Registration Form

Person Responsible for Patient's Financial Obligation, If Self, Please Indicate:

Name: _____ Relationship: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Home Phone#: _____ Daytime/Cell Phone#: _____

Work Phone#: _____ Ext#: _____

Home Address (If Different from Patient's address):

_____ City _____ State _____ Zip_____

Employer Name: _____City/State/Zip Code: _____

As a Federally Qualified Health Center, SDAIHC is required to report the following information for the population we serve:

Number of People in Household (Immediate family ***only***) _____ **Household Income** (Monthly) _____

Migrant Worker (or dependent of)**:** ☐ Yes ☐ No **Homeless:** ☐ Yes ☐ No

U.S. Veteran: ☐ Yes ☐ No **If yes, Branch:** _____ **Vietnam Vet:** ☐ Yes ☐ No

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

---

To the best of my knowledge, all of the information above is true and correct.

I hereby authorize Medical/Dental/Psychological treatment for the above patient.

Patient/Guardian Signature: _____ **Date:** _____

If Guardian, Print Name: _____

Relationship to Patient: _____

San Diego American Indian Health Center

HRN _____

Received By: _____

Date Entered: _____

Insurance Information

PLEASE PRINT CLEARLY

Patient's Legal Name: _____ DOB: _____/_____/_____

Primary Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Policy #: _____

Group #: _____

Effective/Issue Date: _____

Secondary Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Policy #: _____

Group #: _____

Effective/Issue Date: _____

Dental Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Policy #: _____

Group #: _____

Effective Date: _____

PLEASE COMPLETE REVERSE SIDE

San Diego American Indian Health Center

HRN _____

Received By: _____

Date Entered: _____

Assignment of Benefits

By signing below:

- I, the undersigned, hereby authorize assignments of and direct billing to Medi-Cal, Medicare and/or any other insurance benefits to San Diego American Indian Health Center for services provided to the patient.
- I further agree and acknowledge that my signature on this document authorizes San Diego American Indian Health Center to obtain and release any medical/dental/behavioral and billing information to Medi-Cal, Medicare and/or any other insurance necessary to process my claim(s), including determining eligibility and seeking reimbursement for services provided.
- If my insurance company reimburses me directly instead of San Diego American Indian Health Center, I will submit payment in the same amount to San Diego American Indian Health Center within thirty (30) days on my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center within thirty (30) days of my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center if there is any change in my insurance, including the addition and/or loss of any insurance coverage. If I fail to notify the clinic of any such changes in insurance, I may be responsible for any charges as a result.
- Lab Work – I have the option of billing my services or paying for the cost of the labs at the time of the visit.
- I understand that I am responsible for the deductible non covered services and any balance due after insurance.
- I understand and waive my right to confidentiality if a collection service or court action becomes necessary to collect my delinquent account.

_____

Name of Responsible Party (Please Print)

_____

Signature of Responsible Party Date

San Diego American Indian
HEALTH CENTER

HRN _____

Received By: _____

Date Entered: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received from the San Diego American Indian Health Center a Clinic Services Information brochure. This brochure contains general clinic services information which includes the following:

- Eligibility For Services
- Payment Policy
- Billing Inquiries
- Appointments Policy
- Appointment Cancellation Policy
- Late Arrival Policy
- Missed Dental Appointment Policy
- Medical/Dental/Behavioral Health Services Information
- Patient Rights and Responsibilities
- Other Services
- Notice of Privacy Practices
- Additional Uses of Information
- Dental Material Fact Sheet

_____

Patient Name (Please Print)

_____

Signature Date

Please complete reverse side

San Diego American Indian
HEALTH CENTER

Promoting Excellence in Health Care with Respect for Custom and Tradition

GENERAL CONSENT FOR TREATMENT & ASSIGNMENT OF BENEFITS

Patient's Name: _____ Chart Number: _____

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:
   The undersigned consents to the patient entering the Center identified above and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include examination, radiological services, emergency services, laboratory procedures, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:
   The Center will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that the Center may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient. Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

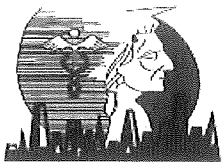
3. Payment for services:
   I, the undersigned, certify that the information given to the Center in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me, and authorize the Center to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Patient/Legal Representative



San Diego American Indian
HEALTH CENTER

MENTAL HEALTH HISTORY

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

SOCIAL SECURITY: _____ DATE OF BIRTH: _____

Referred By (Please circle): SELF_____FRIEND _____PROVIDER _____

1. Concern(s)/Problem(s) for which you are seeking care:

_____

2. Previous treatment for this or other mental health:

What	When	Where	Medication (Name)

_____

3. Current and past medical problems (include hospitalizations and or head injuries)

What	When	Where	Medication (Name)

_____

4. Current or recent medication usage (not listed above):_____

5. Allergies (medication and other): _____

6. Please answer the following (Please Circle):

Regular Alcohol Use: Daily Weekly Monthly Occasional Never

Tobacco Smoker: Never Not Now stopped Yes (If yes ____ packs per day)

Street Drug Use: Daily Weekly Monthly Occasional Never

PLEASE TURN OVER

7. History of Treatment for (please circle):

Alcohol: Yes No When: Now Other Date: _____

Drug Problem: Yes No When: Now Other Date: _____

Regularly involved in recovery program: Yes No

8. Family History (Please Circle):
Behavioral Health Issues Medical Problems Alcoholism/Drug Abuse

Please Explain:

_____

_____

9. Current Living Situation (Please Circle): Alone With Family

With Friends Residence Program

10. Current Employment (Please Circle): Employed Full-Time Employed Part-Time

Unemployed Last Time Employed: _____

11. Education (Please Circle): Eighth Grade Completed High School GED

College Post-Graduate

Degree: _____

12. Feelings (Please Circle ALL That Apply):

Happy Depressed Thinking of Suicide Fearful Anxious Panic

Angry Irritable Confused Suspicious Hallucination (hearing/seeing)

13. Is there anything else you want your provider to know:

_____

_____

Over the last two weeks, how often have you been bothered by any of the following problems? (Please circle to indicate your answer.)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thinking that you would be better off dead or that you want to hurt yourself in some way	0	1	2	3

Total:

10. If you checked off ANY problems, how DIFFICULT have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please Circle)

Not Difficult At All Somewhat Difficult Very Difficult Extremely Difficult

SUBSTANCE USE ASSESSMENT

	Age At First Use	Frequency of Use: Daily, Once A Week, Once A Year	How Do You Use? (Oral, Smoke, Snort; IV)	Date of Last Use	Current Use
Caffeine					
Nicotine					
Alcohol					
Marijuana					
Meth/Amphetamines					
Cocaine/Crack					
Heroin					
Methadone					
Hallucinogens					
Barbituates					
Inhalants					
Steroids					
Spice					
Prescription/Over The Counter Drugs					
Other					

Drug of choice: _____

Used to relax or to help sleep: _____

Used to relieve pain or to feel better/numb: _____

Ever have withdrawal symptoms? What kind? _____

Any work, school, relationship, legal, or money problems because of your use?

_____

Longest period of clean time: _____

Family history of substance use (Who?): _____

Has anyone told you they were worried about your drinking/drug use or asked you to stop? Who?

_____

Have you attended AA/NA/Wellbriety? When? _____

Do you attend support groups now? Which ones? _____

Do you have a sponsor? _____

Any other current or past addictive behaviors? (Gambling, eating, sex, working, shopping, hording, caffeine, nicotine)

_____

Do you think your drinking/drug use is a problem? _____

Do you want it to stop? _____

_____

Patient Signature Date

_____

Staff Signature Date

San Diego American Indian
HEALTH CENTER

BEHAVIORAL HEALTH ADMISSION AGREEMENT & CONSENT FOR TREATMENT

I, _____ request Behavioral Health and/or Substance Abuse services from the San Diego American Indian Health Center.

By signing this document, I am acknowledging that I have read this Admission in its entirely, have asked any questions necessary to guarantee that I have understood what my rights and limits to confidentiality are, what the fees for service guidelines are, what my client rights are, and what San Diego American Indian Health Center rules and regulations are regarding: client expectations, terminations & discharges, and filing a grievance, in the event that I am unable to satisfactorily resolve a dispute I have with the counselor/therapist assigned to me.

A. Fee for service: San Diego American Indian Health Center employs a sliding fee scale for uninsured patients. The sliding fee discount is based on Federal Poverty Guidelines and is updated annually. The patient discount is based on financial documentation received and reviewed as a part of the registration process; it is updated annually or any time there is a change in income. The sliding fee scale will be applied to all uninsured patients that do not qualify for special programs or do not have third party insurance. The SDAIHC is not an Indian Health Service facility. No patient will be denied care denied care due to inability to pay; however, it will be the policy of the SDAIHC to pursuer balances owed to the agency for services.

B. I understand the issues/problems I talk about with my therapist or counselor are confidential and will be kept private unless:

- I am determined to be a threat to my own safety and well being
- I am determined to be a threat to the safety and well-being to others
- There is the possibility of child abuse, dependent adult or elder abuse

C. I understand if any of these violations occur, my therapist or counselor is required by law to make this information available to one or more of the following: Child Protective Services, Adult Protective Service, law enforcement, or medical/psychiatric authorities.

D. I give my informed consent and release of information for coordination of my treatment and services within the SAN DIEGO AMERICAN INDIAN HEALTH CENTER. This includes scheduling appointments, billing, medical and dental staff, substance abuse staff, and behavioral health staff. I further understand my client records may be audited by a funding agency, insurance company or used for billing procedures.

E. Client Rights and Responsibilities: Clients have been provided with a copy of the SDAIHC Patient Rights and Responsibility. In addition to reading and understanding the SDAIHC. Patient Rights and Responsibilities Client further acknowledges that they are expected to attend scheduled counseling appointments, participate in the development of their treatment plan the course of their treatment as well as comply with the twenty-four (24) hour cancellation policy.

F. San Diego American Indian Health Center Behavioral Health Department Rules and Regulations: (1) No alcohol or drug use 24hrs. prior to counseling appointment; (2) No threat(s) of violence against SAN DIEGO AMERICAN INDIAN HEALTH CENTER staff or property; (3) No possession of any weapon on SAN DIEGO AMERICAN INDIAN HEALTH CENTER property; (4) Client will be discharged when treatment has been completed, treatment is no longer warranted per clinical review, or client no longer requests services.

G. Production of records by a healthcare professional is governed by Health and Safety Code § 123111.

This Section provides, in pertinent part: "~123110. Inspection of records; Copying of records; violations; Construction of section.

PLEASE TURN OVER

BEHAVIORAL HEALTH ADMISSION AGREEMENT & CONSENT FOR TREATMENT

(a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available. However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient's representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

(b) Additionally, any patient or patient's representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied. A fee of $5.00 plus 25 cents per page and any additional reasonable clerical costs incurred in making records available will be charged when a patient requests a copy of his or her records. In addition to a written request, he or she must come in person to collect the records and sign the HIPPA receipt that they have received them.

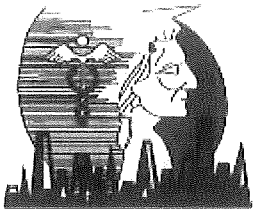
All staff members sign confidentiality statements

H. Reasons for Termination:

1. Two (2) consecutive no show/no cancellations
2. Non-compliance with treatment plan
3. Threat/act of harm against San Diego American Indian Health Center staff and/or property
4. Client's primary service need is determined to be outside the scope of the program
5. Client left before completing treatment (i.e., "drops out" or moves out of area)
6. Incarceration
7. Not responding to treatment goals, including new goals established by re-assessing needs
8. Client refuses services.

I give my informed consent and release of information of the coordination of my treatment and services within San Diego American Indian Health Center. This includes scheduling appointments, billing, medical and dental staff, and behavioral health staff. I further understand my client records may be audited by a funding agency, insurance company, or be used for billing purposes.

Client Name (please print)	Date:
Client Signature	Date:
Signature of Parent/Guardian (if minor)	Date:
Therapist/Counselor Signature	Date:
Witness	Date



San Diego American Indian
HEALTH CENTER

PATIENTS' RIGHTS

Each client shall the rights that include, but are not limited to, the following:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2. All patients have the right to expect that all services provided are held in the strictest confidence. No information will be released to other sources without the written approval of the patient or their legal guardian.
2. To be accorded dignity, consideration and respectful services in contact with staff, volunteers, board members, and other persons.
3. To be accorded safe, healthful and comfortable accommodations to meet his or her needs.
4. To be free from verbal, emotional, physical abuse, and/or inappropriate sexual behavior.
5. To be informed by the program of the procedures to file a grievance or appeal discharge.
6. To be free of discrimination based on ethnic group identification, race, religion, age, sex, color, economic status, level of education, or disability.
7. To be accorded access to his or her file.
8. All patients have the right to be provided appropriate privacy.
9. All patients have the right to know who is responsible for providing services and their professional qualifications.
10. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
11. All patients have the right to have all of their questions regarding their illness and treatment answered fully and to their personal satisfaction. When possible a second opinion may be obtained.
12. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
13. All patients have the right to refuse treatment regardless of the advice of the attending provider.
14. All patients have the right to know the cost of services including contractual service costs prior to receiving care. A copy of the fee schedule is available upon request for review.
15. All patients have the right to appeal to the Center's Executive Director any questions concerning services obtained at the San Diego American Indian Health Center.
16. All patients have the right to refuse to participate in experimental studies.

San Diego American Indian Health Center is NOT an emergency center or hospital. If you feel you need emergency services you should call 911 or go to the nearest emergency center. Emergency services are not covered benefits of the San Diego American Indian Health Center.

CONSENT TO FOLLOW-UP

Patients consent to have behavioral health follow-up: If a patient misses a therapy appointment, or upon discharge, if appropriate, staff will follow-up with a client a month after discharge to check on a patient's continued progress.

As a patient of the San Diego American Indian Health Center, I understand my Patients' Rights and agree to consent to follow-up with any treatment I receive.

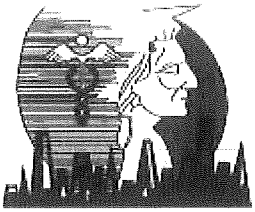
_____

Patient's Signature Date

_____

Behavioral Health Staff Date

Patients' rights; original signed for in patient's chart; patient is given a copy for his/her records. Updated 4.2017



San Diego American Indian
HEALTH CENTER

MEDICAL/DENTAL/BEHAVIORAL HEALTH CENTER
Form 200
Consent For Treatment
45 CFR 164.506

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our using and disclosing protected health information about you for limited purposes of receiving treatment from us, obtaining payment for the health care services provided to you and our own health care operations.

You have the right to revoke this consent, but such revocation must be made in writing. Your revocation will be honored on the day that it is signed, except where we have already made disclosures in reliance on your prior request.

I agree to the contained within this Consent:

Patient's Signature: _____ Date: _____

Patient Name (Please Print): _____

Patient's Representative Signature (Legal guardian and/or Parent): _____