Nevada Urban Indians, Inc.

PATIENT & CLIENT REGISTRATION FORM

Full Legal Name: ___________________________________ Date of Birth: ________________________ Sex: _________

City & State of Birth: ________________________________ Social Security Number: _____________________________

Physical Address: ___________________________________ Mailing Address: ___________________________________

City: ___________________ State: _____ Zip: __________ City: ____________________ State: _____ Zip: _________

Marital Status: ___________________ Spouse's Name: _____________________________ Total # in Household: _________

Total Household Income: ________________ Migrant Worker? YES NO Homeless? YES NO

Ethnicity: Hispanic Not Hispanic Race: American Indian Asian Black Pacific Islander White

Sexual Orientation: _________________________________ Gender Identity: ______________________________________

Do you have an Advance Directive? YES NO Would you like written information on Advance Directives? YES NO

Employer: ______________________________________ Spouse's Employer: ______________________________

Address: ____ Address: ____

City: ___________________State: ____ Zip: _________ City: __________________ State: ____ Zip: _________

Phone Number: ___________________ Status: FT PT Phone Number: ___________________ Status: FT PT

Complete the following if patient is a minor:

Father's Employer: _____________________________ Mother's Employer: ______________________________

Address: ____ Address: ____

City: ___________________State: ____ Zip: _________ City: __________________ State: ____ Zip: _________

Phone Number: ___________________ Status: FT PT Phone Number: ___________________ Status: FT PT

Are you an Enrolled Member or Descendant of a Federally Recognized Tribe? Please present Tribal Card or Document.

Tribe of Membership: ____ Enrollment #: ___________________________

Tribal Blood Quantum: ________ Indian Blood Quantum: ________ Do you live on a Reservation? YES NO

Name and location of Reservation ____

Father's Name: __________________ Father's Birthplace City: _________________ State: ___ Phone: ___________________

Federally recognized tribe enrolled with: ____

Mother's Name: __________________ Mother's Birthplace City: _________________ State: ___ Phone: _________________

Federally recognized tribe enrolled with: ____

Nevada Urban Indians, Inc.

HOW CAN WE CONTACT YOU?

Personal Phone: ______________________________ Ok to call? YES NO Ok to leave a message? YES NO

Other Phone: ______________________________ Ok to call? YES NO Ok to leave a message? YES NO

Do you have access to the Internet? YES NO Where? School Work Home

Email Address: ______________________________ Ok to send generic health information to your email? YES NO

In Case of an Emergency:

Emergency Contact Name: ____________________ Contact Phone: ________________ Relationship: __________

Address: ____

Next of Kin Name: ______________________ Contact Phone: __________________ Relationship: _________

Address: ____

Are you a Veteran? YES NO Valid VA Card? YES NO Vietnam Service Indicated? YES NO

Service Branch: ____________________ Service Entry Date: __________ Service Separation Date: __________

Are you still Service Connected? YES NO Do you have a CLAIM NUMBER? ________________________

PRIVATE INSURANCE INFORMATION – Please present all Cards

Name of Policy Holder: ______________________ Date of Birth: __________ Phone Number: ______________

Employer: ___________________________ Policy #: __________________ Date Eligibility Began: _________

MEDICARE/MEDICAID INFORMATION – Please present all Cards

Name of Policy Holder: ______________________ Date of Birth: _________ Phone Number: _______________

Group Name: ______________ Medicare/Medicaid #: __________________ Date Eligibility Began: ___________

By signing below, I certify the above information to be accurate and true.

In the event of an emergency, I give full permission to the employees of Nevada Urban Indians, Inc., to disclose my Medical & Personal Health information, on a need to know basis, to my emergency/next of kin contacts.

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Parent/Guardian's Signature (If Patient is a Minor) Date

Nevada Urban Indians, Inc.

HIPPA PATIENT/CLIENT RIGHTS

As a client/patient at Nevada Urban Indians, Inc., you have the right to:

1. Receive quality healthcare, which uses current technologies and treatment practices.
2. Expect accessible, clean and safe offices that offer adequate seating and privacy.
3. Expect your healthcare provider and his/her staff to demonstrate respect and common courtesy when you are treated.
4. Expect your provider to tell you about what is happening during your care and to clearly describe diagnosis and treatment options available.
5. Get clear answers to your questions.
6. Be included in the decisions that affect your health, and be informed of the options and associated risks.
7. Be informed about available preventative health services and programs designed to improve and maintain your health status and quality of life.
8. Expect your Medical Records to be accurate, organized and confidential.
9. Voice complaints about a provider, the healthcare setting, or your quality of care to a staff member. You may file complaints with the Medical Business Manager.
10. Voice complaints regarding privacy issues with the HIPAA Compliance Officer and/or Secretary of Health and Human Services at the U.S. Department of Health and Human Services.
11. Receive information that is readable and easily understood.
12. Expect to be given an appointment within a reasonable amount of time.
13. NUI’s written Notice of Privacy Practices.
14. Have access to your medical record with a designated NUI staff member present.
15. Request a restriction, amendment, correction, confidential communication, or accounting of disclosures of your protected health information.

______________________________ ______________

Patient/Client Signature Date

______________________________ ______________

Parent/Guardian Signature Date

Nevada Urban Indians, Inc.

AUTHORIZATION FOR TESTING AND DISCLOSURE

Should any exposure to communicable disease by any means (needlestick/sharps injury, exposure to bodily fluids, etc.) occur to an employee or contractor of Nevada Urban Indians, Inc., I, ______________________________________, hereby, voluntarily consent to any testing needed to determine the presence of communicable diseases, including but not limited to, Human Immunodeficiency Virus (HIV), Hepatitis-B (HBV), Hepatitis-C (HCV) and Syphilis (VDRL).

I authorize Nevada Urban Indians, Inc. to furnish the results of my tests to the injured employee or contractor of Nevada Urban Indians, Inc. and I understand that the testing will be free of charge.

I understand that under Nevada law, Nevada Urban Indians, Inc. is obligated to report a positive HIV test result to the State Health Officer or his/her representative and that such a report must disclose, among other things, the name, address, telephone number and date of birth of the person tested.

I understand that Nevada Urban Indians, Inc. can refuse to offer any services to me if I do not consent to the testing listed above.

I further understand that I have a right to receive a copy of this authorization upon my request and I may revoke this consent in writing at any time.

____
Patient's Printed Name

___________________________________ ______________________
Signature Date

___________________________________ ______________________
Parent/Guardian's Signature (If Patient is a Minor) Date

Consent for Services, Treatment and/or Healthcare Operations

I hereby give consent to Nevada Urban Indians Inc. (NUI) for services/treatment. I am fully aware that diagnosis and/or treatment may be conditioned upon my consent as evidenced by my signature on this document. I was offered a copy of NUI's Consent for Services, Treatment and Healthcare Operations and I understand that if I choose to not receive a copy today, that a copy is available to me at any time.

➡ Signature: ______________________________ Date: ____________________

Acknowledgement of Late/Cancellation/No Show Policy

Late Arrivals: If you arrive late for your scheduled appointment, we will try to work you into our schedule, but only if it does not delay the appointments of other clients/patients. If it would delay other appointments, you will be asked to reschedule your appointment.

No Show: In order to treat our clients/patients effectively, if you need to cancel an appointment, we ask that you give a minimum of two-hour notice. If you do not show up for your appointment without calling or giving advance notice for two appointments within a 90-day time period, you will not be seen at the clinic for the following 90 days. In addition, refills of your medications will only be available for the first 30 days.

• Your signature shows that you understand the importance of arriving on time to appointments and calling in advance to cancel an appointment, as outlined above.

➡ Signature: ______________________________ Date: ____________________

If you have insurance…

If NUI has a contract with your insurance company we will file today's charges with that insurance company. You will be resonsible for your co-payment and/or deductible, and the cost of any services not covered by insurance. You may receive a bill from NUI for any unpaid balance.

➡ I understand that I am financially responsibly for all charges not covered by my insurance. **Initials _______**

If you do not have insurance…

If you do not have insurance or NUI does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. This will be collected at checkin. NUI has a competitive Sliding Fee Scale program to assist underinsured or uninsured patients. Sliding Fee Scale payments cover the office visit only. You may also be required to meet with NUI's Clinical Applications Counselor to assist you in getting signed up for insurance.

• If your treatment requires more complex evaluations, procedures, vaccines or supplies, you will be charged for those in addition to the appropriate office visit fee. Your medical provider will let you know if your treatment will incur any additional charges. They will then escort you to the front desk area to pay those additional fees prior to service and treatment being provided.

➡ I DO NOT have insurance and I acknowledge that I am resonsible for all costs. **Initials _______**

Release of Information & Assignment of Benefits

NUI may disclose all or part of my medical record to an Insurance Company, Corporation, or Indian Health Service which is, or may be liable for, all or part of NUI's service charges. This may include, but is not limited to a hospital, insurance company, specialty physician, dentist, laboratory or welfare department. I understand I may be referred to a physician specialist and my health information may be disclosed with the physician I was referred to coordinate my treatment.

I assign my insurance benefits (if any) to NUI pertaining to payment for any services (Medical, Laboratory, Supplies, Mental Health and Substance Abuse) furnished to me by NUI. I authorize the direct payment of such benefits to be paid directly to NUI.

➡ Signature: ______________________________ Date: ____________________

Acknowledgement of Receipt of Privacy Practices

Your name and Signature below indicate that you have been made aware of NUI's Notice of Privacy Practices on the date indicated. You were offered a copy of this document and understand that if you choose to not receive a copy today, that a copy is available to you at any time, upon request.

Name: (Please Print) ____

➡ Signature: ______________________________ Date: ____________________

If a minor signs this consent form, please complete the following:

______________________________ ______________________________

Name (Please Print) & Relationship to Patient Date

______________________________ ______________________________

Parent/Guardian Signature Date