NATIVE HEALTH

4041 North Central Avenue, Building C - Phoenix, AZ 85012
(602) 279-5262

NHW COMMUNITY HEALTH CENTER
a division of NATIVE HEALTH

2423 West Dunlap, Suite 140 - Phoenix, Arizona 85021
(602) 279-5351

NEW PATIENT REGISTRATION FORM

REVISED: 08/2016

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:_____

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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

FAMILY HISTORY: Put "x" were appropriate

Please identify family members with any of the following:

	living	deceased	if deceased, please list reason	age	Family health status: excellent	good	poor	Alcoholism	High Blood Pressure	Cancer	high Cholesterol	Diabetes	Obesity	Depression	Stroke	Heart Disease	Tuberculosis (TB)
mother																	
father																	
grandmothers																	
grandfathers																	
sibling(s)																	
child(ren)																	

SOCIAL HISTORY:

Do you smoke cigarettes? ☐Yes ☐No If yes, number of packs a day _____ number of years _____

Other types of tobacco: ☐Pipe ☐Snuff ☐Cigar ☐Chew ☐E-Cigarette (E-Cig)

number of times a day_____ number of years_____

May we refer you to a tobacco program liaison regarding the issue above? ☐Yes ☐ No

Do you use drugs? ☐Yes ☐No If yes, type:_____ Number of use per week: ____

Do you drink alcohol? ☐Yes ☐No

If yes, how much and how often do you drink? _____

May we refer you to a substance abuse counselor regarding the issue(s) above? ☐Yes ☐No
all referrals are strictly confidential

Are you sexually active? ☐Yes ☐No If yes, sexual partner? ☐male ☐female ☐both

Method of birth control (if sexually active): _____

Would you like to be given a HIV test? ☐Yes ☐No ***results are strictly confidential***

Has anyone, including you partner ever forced you to have sexual activity against you will? ☐Yes ☐No

Has anyone, including your partner ever threatened or abused
you or your children physically, emotionally, or sexually? ☐Yes ☐No

May we refer you to a victim service advocate regarding the issue above? ☐Yes ☐No
all referrals are strictly confidential

Patient Signature: _____ Date: _____

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TREATMENT/PAYMENT AGREEMENT

I request NATIVE HEALTH/NHW Community Health Center to provide me and/or my family with medical/dental 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 services to be paid to NATIVE HEALTH/NHW Community Health Center. 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 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:_____

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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

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Notice of Health Information Practices

You are receiving this notice because your health care provider participates in an electronic information service offered by The Network, a nonprofit 501(c)(3) non-governmental organization operated by Arizona Health-e Connection (AzHeC). This service does not cost you anything and can help your doctor and health care providers better coordinate your care by *securely sharing your health information.* This notice explains how electronic information sharing works and will help you understand your rights regarding this service under Arizona law.

If you would like your doctor and other health care providers to electronically and securely share your health information to better coordinate your care, YOU DO NOT NEED TO DO ANYTHING.

Your information will automatically be shared with your health care providers, unless you decide to "Opt-Out." (**See *Your Rights Regarding Electronic Information Sharing***)

What does it mean to securely share information and how can it help you get better care?
In a paper-based medical system, your medical tests or lab results are either mailed or faxed to your primary care doctor. But sometimes paper or faxed records are lost or don't arrive in time for your doctor visit.With electronic information sharing, your doctors and other health providers are able to securely share your health information with each other in a safe and timely manner.

What medical information is available to be securely shared?
Authorized medical practices will be able to share several types of health information about you, including but not limited to:
- Hospital: Admission and discharge information from hospitals that use the service
- Medical history
- Medicines you take
- Allergies – including allergies to medicines
- Lab test results and radiology reports
- Doctor visit information
- Health plan enrollment and eligibility

Who can view your medical information electronically?
Only people involved in your care have access to your information. This may include doctors, nurses, and other care providers who are providing and coordinating your care. Your health insurer may also view your information to help coordinate or manage your care.

How is your medical information protected?
The Network is required to follow federal law – the Health Insurance Portability and Accountability Act or "HIPAA" – to protect your private health information. People with access have a unique username and password and get training before they can see your information, so that they know how to protect it. In addition, the system records every time someone looks at your medical information, and you can ask for a list of who has viewed your information and when.

Are there additional security measures?
Information is shared using secure, encrypted transmission.

Your Rights Regarding Secure Electronic Information Sharing

If you do nothing, your information may be securely shared with your health care providers.

You have the right to:
1. Ask for a copy of your medical information that is available to be shared. Just ask your health care provider and you can get a copy within 30 days or sooner.

2. Request to have any information corrected. If any information in the system is incorrect, you can ask that provider to correct the information.

3. Ask for a list of providers who have viewed your information. Contact The Network for a list of people who have viewed your information in the system. Please let The Network 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 to keep your medical information from being shared electronically through The Network. Specifically, you may:
1. "Opt-Out" of having your information available for sharing. To Opt-Out, you must ask your provider for the Options Change Form. After you submit the form, your information will not be available for sharing. Caution: There are risks in preventing your health care providers from sharing your health care information, especially in an emergency.

2. Choose to exclude some information from being shared. For example, if you see a clinician and you do not want that information shared, you can prevent it. On the Options Change Form, fill in the information and name of the provider for the information that you do not want shared. Caution: If that 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. Change your mind at any time. If you say no today, you can change your mind at any time. If you do nothing today and allow your health records to be shared, you may "Opt-Out" in the future.

For questions or further information:

Call (602) 688-7200 | Email: thenetwork@azhec.org | Visit www.azhec.org

3877 N. 7th Street, Suite 130 | Phoenix, Arizona 85014

Signature:_____ Date:_____

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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 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/NHW Community Health Center 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 NATIVE HEALTH/NHW Community Health Center Patient Rights and Responsibilities Policy is available at the front desk.

Patient/Guardian Signature:_____ Date:_____