Central Valley Indian Health, Inc.

NON-INDIAN PATIENT REGISTRATION REQUIREMENTS

1. NON-INDIAN REGISTRATION FORM
2. PATIENT RIGHTS AND RESPONSIBILITIES
3. PHOTO IDENTIFICATION
4. SOCIAL SECURITY NUMBER
5. INSURANCE CARDS

The completed Non-Indian registration packets and insurance cards are to be submitted to the CHS/Eligibility office for patient registration.

The patient rights and responsibilities, photo identification and insurance card copies are to be kept in the patient's medical and or dental chart. Eligibility files are not maintained for Non-Indian patient's in the CHS/Eligibility office.

2740 Herndon Avenue • Clovis, CA 93611
Phone: 559/299-3262
Fax: 559.862.2744

(09.20.13)

__CLOVIS ____MED __DEN
__PRATHER ____MED __DEN
__NORTH FORK____MED __DEN
__TACHI____MED __DEN

DO YOU HAVE ANY SPEICAL NEEDS?
____SIGHT ___ HEARING
___AMBULATORY
___ SPEECH

CENTRAL VALLEY INDIAN HEALTH
NON-NATIVE REGISTRATION

PATIENT INFORMATION	**CHART NO:_____**
LEGAL LAST NAME:	**FIRST:** **MIDDLE:**
DATE OF BIRTH:	**CITY OF BIRTH:** **STATE OF BIRTH:**
SEX:	**SOCIAL SECURITY NUMBER:**
MARITAL STATUS: SINGLE___ MARRIED__ DIVORCED___ WIDOWED___ SEPARATED___ SIGNIFICANT OTHER ____	
MAILING ADDRESS:STREET NAME AND NUMBER OR PO BOX: _____	
CITY: _____	**STATE: _____** **ZIP CODE: _____**
STREET ADDRESS(IF DIFFERENT FROM MAILING ADDRESS): _____	
CITY: _____	**STATE: _____** **ZIP CODE: _____**
HOME PHONE#	**CELL PHONE#:**
DATE MOVED TO PRESENT COMMUNITY:	
INTERNET ACCESS: YES____ NO _____ WHERE _____ E-MAIL ADDRESS:_____	
NUMBER IN HOUSEHOLD	
FATHER'S NAME (FIRST & LAST):	
FATHER'S CITY & STATE OF BIRTH:	
MOTHER'S MAIDEN NAME (FIRST AND LAST):	
MOTHER'S CITY AND STATE OF BIRTH:	
EMPLOYMENT INFORMATION FOR YOURSELF *(OR PARENT'S INFORMATION FOR CHILD UNDER 18 YEARS OF AGE)*	
YOUR EMPLOYERS NAME: *(OR FATHER'S FOR CHILD)*	
EMPLOYER STREET/MAILING ADDRESS:	
CITY: **STATE:** **ZIP CODE:** **PHONE NUMBER:**	
SPOUSES EMPLOYER NAME: *(MOTHER'S FOR CHILD)*	
EMPLOYER STREET/MAILING ADDRESS:	
CITY: **STATE:** **ZIP CODE:** **PHONE NUMBER:**	
ETHNICITY(GROUP ASSOCIATION): **___ DECLINED TO ANSWER** **___HISPANIC OR LATINO** **___NOT HISPANIC OR LATINO** **___UNKNOWN BY PATIENT**	
RACE (BIOLOGICAL): **___INDIAN/ALASKAN NATIVE** **___HISPANIC OR LATINO** **___ BLACK OR AFRICAN AMERICAN** **___ NATIVE HAWIIAN OR OTHER PACIFIC ISLANDER** **___WHITE** **___ASIAN** **___FILIPINO** **___DECLINED TO ANSWER** **___UNKOWN BY PATIENT**	
PRIMARY LANGUAGE:_____ PROFICENCY: ___VERY WELL ___WELL ___NOT WELL ___NOT AT ALL	
OTHER LANGUAGES SPOKEN: _____ PREFERRED LANGUAGE:_____	

__CLOVIS ____MED __DEN
__PRATHER ____MED __DEN
__NORTH FORK____MED __DEN
__TACHI____MED __DEN

DO YOU HAVE ANY SPEICAL NEEDS?
____SIGHT ___ HEARING
___AMBULATORY
___ SPEECH

CENTRAL VALLEY INDIAN HEALTH
NON-NATIVE REGISTRATION

MIGRANT WORKER: ___ YES ___ NO	**IF YES, SEASONAL OR MIGRANT AGRICULTURAL WORKER**	
HOMELESS: ___ YES ___ NO	**SHELTER: ___ YES ___NO**	
RELIGIOUS PREFERENCE (OPTIONAL):		
EMERGENCY CONTACT (IF FOR A CHILD, PLEASE FILL- IN PARENT/GUARDIAN NAME)		
EMERGENCY CONTACT NAME:		
EC PHONE:	**EC RELATIONSHIP:**	
EC ADDRESS-STREET:		
EC ADDRESS-CITY:	**STATE:**	**ZIP CODE:**
NEXT OF KIN (CLOSEST LIVING RELATIVE)		
NOK NAME:	**NOK RELATIONSHIP:**	
NOK PHONE:		
NOK ADDRESS-STREET:		
NOK ADDRESS-CITY:	**STATE:**	**ZIP CODE:**
INSURANCE INFORMATION **ATTACH COPY OF MEDI-CAL, MEDI-CARE OR INSURANCE CARDS**		
DO YOU HAVE MEDICARE? YES___ NO___	**DO YOU HAVE MEDI-CAL? YES___ NO___**	
DO YOU HAVE PRIVATE INSURANCE? YES___ NO___		
INSURANCE NAME:	**POLICY#**	**SUBSCRIBER:**
SUBSCRIBER'S DOB:	**SOC. SEC. NUMBER:**	
VETERAN INFORMATION		
VETERAN : ___YES ___NO	**SERVCE BRANCH (LAST):**	
SERVICE ENTRY DATE (LAST):	**SERVICE SEPARATION DATE (LAST):**	
SERVICE CONNECTED: ___YES ___NO	**DESCRIPTION OF VA DISABILITY:**	
VALID VA CARD: ___YES ___NO	**ASSIGNMENT AND RELEASE:**	

AUTHORIZATIONS FOR RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING DIAGNOSIS OF A MEDICAL CONDITION FOR THE SOLE PURPOSE OF SUBMISSION OF CLAIMS TO THIRD PARTY BILLING INSURANCE CARRIERS. I FURTHER AUTHORIZE CENTRAL VALLEY INDIAN HEALTH TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESS OF THIS CLAIM. I HERBY ASSIGN ANY INSURANCE BENEFITS TO CENTRAL VALLEY INDIAN HEALTH AND AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CENTRAL VALLEY INDIAN HEALTH. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE DEDUCTIBLE, CO-PAYMENT AND CHARGES NOT COVERED BY SAID INSURANCE OR GOVERNMENT AGENCY.
I HEREBY DECLARE THAT I HAVE READ THE PATIENT REGISTRATION FORM, AND KNOW AND UNDERSTAND THE CONTENTS THEREOF AND THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN: ***DATE:***

OFFICE USE ONLY:

RECEIVED INSURANCE CARD: YES NO	
ENTERED INTO SYSTEM ON:	ENTERED BY:
NON-NATIVE/ INELIGIBLE FOR DIRECT OR CONTRACT CARE SERVICES	REGISTRATION COMPLETE: YES NO
MISSING DOCUMENTS:	

(REV. 09.20.13)

__CLOVIS ____MED __DEN
__PRATHER ____MED __DEN
__NORTH FORK____MED __DEN
__TACHI____MED __DEN

DO YOU HAVE ANY SPEICAL NEEDS?
____SIGHT ___ HEARING
____AMBULATORY
____ SPEECH

CENTRAL VALLEY INDIAN HEALTH
NON-NATIVE REGISTRATION

ATTACHMENT A

CENTRAL VALLEY INDIAN HEALTH, INC.
2740 HERNDON AVE, CLOVIS CA 93611
(559) 299.3262 XT 1811

PATIENT REQUIREMENT FOR
ALTERNATE RESOURCE DETERMINATION

DATE: _____ DATE OF BIRTH:_____

PATIENT NAME: _____

ADDRESS:_____CITY/STATE/ZIP:_____

HM. PHONE:_____ CELL: _____

This information is necessary pursuant to Indian Health Service Regulations, 42 CFR, Subpart G, Paragraph C. You must provide this facility with a copy of the alternate resource's eligibility determination.

PLEASE CHECK THE LINE THAT PERTAINS TO YOU THE PATIENT:

YES_____ NO____ Do you have Covered California

YES _____ NO____ Do you have Medi-Cal?

YES _____ NO____ Do you have Medicare?

YES _____ NO____ Do you have private health insurance, including Kaiser Insurance?

YES _____ NO____ Do you have CMSP from Fresno, Madera or Kings County?

- If you answered **YES** to any of the above questions, please give your card to the Medical Receptionist to copy for your file.
- If you answered **NO** to all of the above questions, you will need to be screened by the Patient Services Representative at 299.3262 XT 1811. You can also apply at the Social Services Office in the county you reside.
- If you are employed, we need a statement from your employer stating that you do not have medical insurance.
- If you need assistance, please contact the CVIH Patient Services Representative. You will have 60 days to complete the necessary information and return it to the CHS/Eligibility Office. If no information is returned, and there is no request for assistance, a CHS denial letter will be issued.

Sincerely,

CENTRAL VALLEY INDIAN HEALTH

(09.20.13)

FOR OFFICE USE ONLY

_____

PATIENT SERVICES REP. DATE

CENTRAL VALLEY INDIAN HEALTH, INC

PATIENT RIGHTS & RESPONSIBILITIES

Thank you for choosing Central Valley Indian Health, Inc. as your primary health care provider. We look forward to serving you in the most thorough and professional manner possible. As we enter into this healing partnership, we would like to emphasize the fact that you have certain rights and responsibilities as our patient. These rights and responsibilities help ensure an environment where true healing can take place. By being informed yourself and by keeping your provider informed on matters pertaining to your health, both you and the provider can work toward a common goal – preservation of health. With this *partnership in healing* concept in mind:

You have the right to:

1. Be treated with respect, consideration and dignity.
2. Be provided appropriate privacy.
3. Have your disclosures and records treated confidentially, and except when required by law, given the opportunity to approve or refuse their release.
4. Be provided, to the degree known, complete information concerning your 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.
5. Be given the opportunity to participate in decisions involving your health care, except when such participation is contraindicated for medical reasons.
6. Change your provider if another qualified CVIH provider is available.
7. File suggestions, complaints or grievances when you feel your rights have not been met. All suggestions, complaints and grievances should be reported to the Director of the Department you wish to discuss.
8. Request information regarding your health care professionals' credentials.

You have a responsibility to:

1. Provide complete and accurate information to the best of your ability about your health, any medications, including over-the-counter products, dietary supplements and any allergies or sensitivities.
2. Follow the treatment plan prescribed by your provider.
3. Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.
4. Inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
5. Accept personal financial responsibility for any charges not covered by your insurance or CVIH.
6. Be respectful of all the health care providers and staff, as well as other patients.
7. Be sure you understand all oral and written instructions given by a CVIH provider.
8. Report any changes in your health.
9. Keep appointments or cancel at least 24 hours in advance.
10. Provide CVIH with current Medi-Cal, private insurance or other third party payer information at the time services are rendered.
11. Make payment for services provided on the day of your visit unless prior arrangements have been made.

As a partner in the healing process, I have read and understand The CVIH Patient Rights & Responsibilities.

_____ _____

Patient Signature Date

(09.20.13)