Tule River Indian Health Center, Inc.
P.O. Box 768
Porterville, CA 93258

Telephone Number: (559) 784-2316
Fax Number: (559) 784-4308
Patient Number: _____

PATIENT REGISTRATION

Date of Registration _____

LAST NAME	FIRST/MIDDLE NAME	PREVIOUS NAMES	SEX	BIRTH DATE: MM/DD/YYYY

MAILING ADDRESS (ST., P.O. BOX)	CITY/STATE/ZIP	COUNTY
HOME ADDRESS	**CITY/STATE/ZIP**	**COUNTY**
TELEPHONE NUMBER: **HOME:** **MESSAGE:**	**PREVIOUS ADDRESS (CITY/STATE/ZIP)**	**BIRTHPLACE:** **CITY:** **STATE:**

SOCIAL SECURITY NUMBER	MARITAL STATUS:	VETERAN
	____SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED	YES ____ NO_____

PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ TELEPHONE: _____
CITY: _____ STATE: _____ ZIP: _____

==========

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ TELEPHONE: _____
CITY: _____ STATE: _____ ZIP: _____

FATHER'S NAME: First: Middle: Last:	DATE OF BIRTH: TRIBE:	PLACE OF BIRTH City: State: County:

MOTHER'S MAIDEN NAME: First: Middle: Last:	DATE OF BIRTH: TRIBE:	PLACE OF BIRTH City: State: County:

IF AMERICAN INDIAN : TRIBE	MEMBER OF INDIAN HOUSEHOLD: YES NO PLEASE CIRCLE	IF NON-INDIAN
RESERVATION RESIDING ON :		ETHNIC BACKGROUND/RACE

CHILDREN'S FULL NAME	TRIBE	SEX	SS#	DATE OF BIRTH

RELIGIOUS PREFERENCE: _____

TULE RIVER INDIAN HEALTH CENTER, INC.
PATIENT'S RIGHTS and RESPONSIBILITIES

AS A PATIENTS OF TULE RIVER INDIAN HEALTH CENTER, INC. YOU HAVE THE RIGHT TO:

1. Be given information about your rights and responsibilities for receiving ambulatory health care services.
2. Receive a timely appointment with your provider.
3. Be given information regarding policies, procedures, and charges for services.
4. Be given information regarding available services, including after-hours and emergency services,
5. Choose your health care providers.
6. Be given appropriate and professional care without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.
7. Be treated with courtesy, respect, consideration, and dignity.
8. Be free from physical and mental abuse and/or neglect.
9. Be identified properly by name and title.
10. Be given complete and current information concerning your diagnosis, treatment, alternatives, risk, and prognosis as required by your physician's legal duty to disclose, in terms and language you can reasonably be expected to understand.
11. A unique healthcare plan to meet your needs.
12. Participate in the development of your plan.
13. Be given an assessment and update of your health care plan as necessary.
14. Be given privacy and confidentiality.
15. Review your clinical record at your request as outlined by Tule River Indian Health Center, Inc.'s policies and procedures.
16. Be given information regarding anticipated transfer of care to another health care facility and or/or termination of services to you.
17. Voice grievance regarding your care and the staff without being threatened, restrained, and discriminated against.
18. Refuse treatment within confines of the law.
19. Refuse to participate in experimental research.
20. Be given information concerning the consequences of refusing treatment or not complying with treatment plans.

AS A PATIENT OF TULE RIVER INDIAN HEALTH CENTER, INC. YOU HAVE THE RESPOSIBILITY TO:

1. Give accurate and complete information concerning past illnesses, hospitalization, medications, allergies, and other pertinent information.
2. Assist in maintaining a safe environment,
3. Inform the health center when you will not be able to keep a scheduled appointment.
4. Request further information concerning anything you do not understand.
5. Voice any and all concerns with health care provider.
6. Provide a responsible adult to transport you home and remain with you for 24 hours, if required by the provider.
7. Accept personal financial responsibility for any charges not covered by insurance.
8. Behave respectfully toward all health care professionals and staff, as well as other patients.

I HAVE REVIEWED AND UNDERSTAND MY BILL OF RIGHTS/RESPONSBILITIES AS DESCRIBED ABOVE.

PATIENT SIGNATURE: _____

STAFF SIGNATURE: _____

DATE: _____

(Approved 02/2016)

Tule River Indian Health Center, Inc.
PO Box 768
Porterville, CA 93258
PH (559) 784-2316 FX (559) 791-2599

Acknowledgement of Receipt of Advanced Directive and Notice of Privacy Practices Information

Advanced Directive

Initial after each statement

1. I have been offered written materials about my right to accept or refuse medical treatment ____
2. I understand that I am not required to have an **ADVANCED DIRECTIVE** in order to receive medical treatment(s) at the Tule River Indian Health Center, Inc. _____

Please check one of the following:

_____ I have executed an **ADVANCED DIRECTIVE** for health care.

_____ I have **NOT** executed an **ADVANCED DIRECTIVE** for health care.

By signing below, I agree that my typed initials on this form, as well as the indicator "x", are legally binding and of my own accord, I will not, at any time in the future, repudiate the meaning of my typed initials or indicator "x", or, claim that my typed initials or indicator "x" are not of my own accord, or that they are not legally binding.

Notice of Privacy Practices

The Notice of Privacy Practices is a complete description of my rights as a patient of the Tule River Indian Health Center, Inc. (TRIHCI). By signing below, I am stating I have received the Tule River Indian Health Center, Inc. ***Notice of Privacy Practices.***

PATIENT NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

RELATIONSHIP (if not the patient): _____

(Approved 02/2016)

Purchased/Referred Care (PRC) Contract

Tule River Indian Health Center, Inc. will not authorize payment and will deny Purchase/Referred Care (PRC) to individuals if the steps below are not followed:

1. Must have complete Patient Registration, Indian Documentation, Birth Certificate, Social Security, Residency Verification, ID & Alternate Resource on file to be eligible for PRC.
2. PRC can only authorize Level I Emergency/Acutely Urgent care, Level II Preventative Care and Level III Primary and Secondary Care. Only the Tule River Indian Health Board (TRIHB) can change these items, they are based on availability of funds.
3. You must have an annual medical exam to continue PRC eligibility. If this is not done annually you will be considered Direct Care.
4. Must be screened for an alternate resource. **Required to apply** for the alternate resource if there is a reasonable indication that one exists, **if you refuse or fail to comply** in providing the required paperwork you **will be denied PRC.** Contact our Benefits Coordinator for assistance.
5. Must utilize all alternate resources (i.e. Medicare, Medi-cal, Insurance, Veterans, County and State Programs).
6. Must been seen within the Tule River Indian Health Clinic for Referrals to Specialty Care, outside labs and radiology. These specialty referrals must be updated on a yearly basis.
7. Patient must have a Purchase Order from the PRC Department for any and all outside provider visits.
8. Must notify PRC Department within 72 hours of emergency care. Elders have 30 days to notify the PRC Department. Eligibility will then be verified by the PRC Department.
9. Must live within the CHSDA (Tulare County).
10. **TRICHI is not an entitlement or a private Insurance Company. Do not assume TRIHCI will automatically pay any or all of your bills. It will be your responsibility to follow up with the PRC staff when you turn your bills in. Each individual is responsible to bring in their itemized bills and EOB's (explanation of benefits) form the insurance company for payment processing. Without both documents your bills will be on hold until we receive all the related paperwork or your bills will be sent back to you.**
    Pursuant to the eligibility criteria you acknowledge you will submit pertinent paperwork/information within thirty (30) days in order to be qualified for PRC when notified.
    I have read, received, and understand all Purchased/Referred Care Policies. I agree to follow all guidelines that are required of me.

    Patient Name: _____

    Patient or Guardian Signature: _____

    Witness: _____

    Date: _____

(Approved 02/2016)

Tule River Indian Health Center, Inc.
PO Box 768
Porterville, CA 93258
PH (559) 784-2316 FX (559) 791-2599

CONSENT OF PATIENT

The undersigned patient/guardian consent to authorize the Medical Provider(s) including Mid-Level Provider(s) employed by the Tule River Indian Health Center, Inc. to administer/perform examinations, treatments, diagnostic procedures and immunizations against disease which now or during the course of the patient's care deemed advised.

I the undersigned consent to have a photo taken that will be placed in the electronic health record. I the undersigned accept financial responsibility for any and all charges incurred for services rendered. I the undersigned consent to assignment of benefits whereas payments will be payable directly to the Tule River Indian Health Center, Inc.

Print Name: _____

Signature of Patient/Guardian: _____

Date: _____

Tule River Indian Health Center, Inc.
PO Box 768
Porterville, CA 93258
PH (559) 784-2316 FX (559) 791-2599

AUTHORIZATION FOR CONSENT FOR MEDICAL TREATMENT OF MINOR CHILD

I hereby give authorization for my child _____ to receive treatment by medical, dental, and outreach staff as well as any other ancillary Health Services provided by the Tule River Indian Health Center.

I also give my permission for _____ to request any medical treatment to be given to my child and to act on my behalf to consent to said treatment for my child in my absence.

This authorization is effective immediately and is subject to revocation at any time except to the extent that action has already been taken. Otherwise this authorization expires one year from the date of signing.

Witness: _____

Parent or Legal Guardian: _____

Date: _____