FRESNO AMERICAN INDIAN HEALTH PROJECT
DOCUMENT CHECKLIST FOR HEALTH RECORDS

Client Name:_____

ADULT REGISTRATION
Check each item that is in the client's records.
Blank spaces indicate that the document is not present or needs to be updated.
Bold items are required in order to complete client registration.

DATE: _____

____ **Informed Consent and Disclosure: (needs to be signed)**

____ **Client Intake Registration Form: (needs to be signed)**

____ **Client's Bill of Rights: (needs to be signed)**

____ **Health History Form: (needs to be signed)**

____ **Notice of Privacy Practices Notification: (needs to be signed)**

____ **Drivers' License or California Identification Card**

____ **Social Security Card**

____ **Tribal Enrollment Letter or Card**

____ **Income Verification** (Last 6 months—i.e. pay stubs, notice of action, food stamp cards)

____ Medi-Cal / Medi-Care Card / Private Insurance Card

____ List of Medications (if client is taking any)

____ Birth Certificate (children)

____ Immunization Record (children 0-17)

____ DV/IPV Exam Code #34 (results entered into RPMS)

____ Selective Service (males 18-26)

____ **OTHER**_____

INTERNET ACCESS AT HOME? _____ **Registration Complete Staff Initials:**_____

FRESNO AMERICAN INDIAN HEALTH PROJECT

1551 E. Shaw Ave., Suite 139 Fresno, CA 93710 • Phone (559) 320-0490 Fax (559) 320-0494

INFORMED CONSENT AND DISCLOSURE OF SERVICES

I understand that the services provided by Fresno American Indian Health Project include direct services as well as referral and linkage services.

FAIHP PROVIDES THE FOLLOWING SERVICES AS APPROPRIATE TO EACH CLIENT:

- ◊ Substance Use/Abuse Services
- ◊ Case Management Services
- ◊ Employment Services
- ◊ Social Services (Housing, Nutrition, Transportation)
- ◊ Senior Activities
- ◊ Cultural/Spiritual Activities
- ◊ Mental Health Services
- ◊ Referral to Medical Services
- ◊ Referral to Dental Services
- ◊ Referral to Residential Treatment/Detox
- ◊ Referral to Sober Living
- ◊ Referral to Traditional Practitioners

The direct services listed above are provided free of charge to all qualified FAIHP Clients. FAIHP staff will work with the clients to secure services and funding available from various resources outside of FAIHP. FAIHP does not guarantee payment for services that are referred to an appropriate health or substance abuse treatment provider.

Initials _____ I understand that this consent acknowledges my participation in the services provided by FAIHP & requires the discussion of my health conditions and health needs with a FAIHP staff member.

Initials _____ I authorize FAIHP Staff to provide the necessary or advisable health screening, assessments and evaluations for the purpose of providing direct services and linkage/referral services for:

[ ] Myself _____ (Print Name)

[ ] My Child _____ (Print Child's Name)

Initials _____ I understand that some or all of my/my child's personal health information may be shared among FAIHP Professional Staff and outside Service Providers in order to link me/my child to the appropriate services and to provide active case management services.

Initials _____ I understand that I will not be charged for Direct Services provided by the FAIHP.

Initials _____ I understand that FAIHP is not responsible for fees to outside service providers unless I obtain a written referral/authorization for payment from my Case Manager prior to service.

Patient Release of Information

I, _____ hereby authorize Fresno American Indian Health Project to request and receive copies of my medical information for any services that I receive from outside service providers. I understand that this information will be used to update my records at the FAIHP and to provide appropriate Case Management follow-up and referral services. I further understand and agree that requests for specific information regarding HIV/AIDS status and/or treatment, treatment for drug, alcohol or substance abuse and information related to the treatment of mental health, developmental or psychiatric conditions require a separate consent.

Signed: _____ Date: _____

Witness/Case Manager: _____ Date: _____

FRESNO AMERICAN INDIAN HEALTH PROJECT
FRESNO, CALIFORNIA

All information provided is Confidential

Client Registration Form **Chart ID#**

_____ Initial _____ Update Today's Date _____

Client Name _____ Other Name(s) used _____

Date of Birth _____ Age _____ Soc Sec # _____

Sex Male ___ Female ___ T/G ___ Place of Birth (City and State) _____

Present Address _____
Street City State Zip Code How long at this address?

Home Phone # _____ Office / Mobile Phone # _____

Tribal Affiliation _____ _____
(Reservation, Rancheria, Native Corp., Public Law Land)

Blood Quantum _____ American Indian Verification
(i.e.. Full, 3/4 1/2 1/4 1/8 etc)

- ☐ CDIB Obtained
- ☐ CDIB Pending
- ☐ No CDIB Available
- ☐ Letter of Descendent

Race/Ethnicity (if other than Am. Indian) _____

Emergency Contact _____ Relationship to Client _____

Address _____ Phone # _____
_____ Phone # _____

	Name	Relationship to Client	Sex	AI/AN	DOB	Occupation / Source of Income	Monthly Income
1	Client	Self					
2							
3							
4							
5							
6							
Continue on back if additional space is needed							
Total # in Household ____						**Total Monthly Income**	

Health Care Information (UAll Staff will need to get a copy or your health care card)
___ Medicare ___ Medi-Cal ___ CMS ___ CHAM ___ Veteran ___ Railroad Retirement ____ Private
Is the client claimed as a dependant or married, or do parents of spouse have health care coverage? ___ Yes ___ No
If yes, please specify: _____

My signature is a statement that the information provided is truthful and accurate

_____ _____
Client Signature (or Parent/Legal Guardian if applicable) **Date** **Reviewed by: FAIHP Staff**

For Official Use Only: Initial Registration conducted through which department of FAIHP
___ FAIHP ____ OTHER (Please specify):_____

Revised 08/13/2007 11:12AM

Fresno American Indian Health Project

Client's Bill of Rights

The client has the right to receive services and to exercise the following rights without regard to gender, culture, ethnic group identification, economic status, education level, disability, age, creed, religion or sexual orientation. This statement shall not preclude FAIHP from emphasizing services for the American Indian/Alaska Native community:

- The client has the right to receive considerate and respectful care and to be accorded dignity in contact with staff, volunteers, board members, and other persons.
- The client has the right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- The client has the right to expect that all communications and records pertaining to his/her care be treated as **confidential** except in cases of threat to self or others, child abuse, elder or dependent adult abuse or court order. The client's written permission shall be obtained before their records can be made available to anyone not directly concerned with their care. FAIHP shall assure confidentiality in accordance with Title 42, Code of Federal Regulation, Part 2.
- The client has the right to know the name of the provider who has primary responsibility for coordinating their care and the names and professional relationships of other providers who will see them.
- The client has the right to obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms that the client can be reasonably expected to understand.
- The client has the right to participate in decisions regarding their care unless the health or safety of self or others is being compromised or the client is in an altered state.
- The client has the right to refuse treatment to the extent permitted by law, and to be informed of the health care consequences of the action.
- The client has the right to be accorded access to his or her file.
- The client has the right to leave the premises even against the advice of their providers.
- The client has the right to expect that Fresno American Indian Health Project will make reasonable response to all requests for services and provide clear explanations for any services that cannot be provided.
- The client has the right to expect reasonable continuity of care and to know in advance the time and location of appointments.
- The client has the right to know what the program rules and regulations are that apply to his/her participation in the program.
- The client has the right to be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care. The Client has the Right to Refuse participation in Experimental Research.

Revised July, 2007

CLIENT COPY

Fresno American Indian Health Project

- The client has the right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- The client's rights will be extended to and apply to any person who is identified to have legal responsibility to make decisions regarding the care of the client.
- The client has the right to appeal a discharge or file a complaint with the Program Director according to the grievance procedure. This information is available at the front desk.

CLIENTS HAVE THE RESPONSIBILTY TO:

- Provide accurate and complete information concerning your health history, financial status and/or any other information that is required by FAIHP in order to provide services.
- Inform Fresno American Indian Health Project and/or referring facilities if you are not able to keep any appointments 24 hours prior to the scheduled appointment.
- Request further information concerning anything you do not understand.
- Speak with the Program Director if you are having difficulty with any staff member.
- Treat the staff and other clients in a respectful and courteous manner.
- Follow all rules and guidelines for program participation and use of the FAIHP facilities.

FAIHP HAS THE RIGHT TO:

- Refuse service to any client who is verbally or physically abusive or threatening to any staff member or other client (on the phone or in person).
- Refuse service to any client who is under the influence of alcohol, drugs or other substance.
- Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined for use of FAIHP programs or facilities.

I have reviewed the Client's Bill of Rights and understand what my rights and responsibilities are as described above. Furthermore, I understand that I may file a grievance using FAIHP procedures* if I feel these rights have been violated.

Signature of Client _____ **Date** _____

Signature of FAIHP Staff _____ **Date** _____

*The Grievance Policy and Comment Forms are available at the front desk upon request.

Revised July, 2007

MAKE A COPY FOR CLIENT

Fresno American Indian Health Project Inital / Annual Health Assessment

Name **Sex M / F** **Age:**

Health History - Have you ever had or ever been diagnosed with any of the following:

Yes / No Any health problems or illness that may be contagious to others around you
If yes, give details:

Yes / No Heart Disease (429.2)
Yes / No Taking any medications for a heart condition
Yes / No Heart Attack (412.0) Date:
Yes / No Chest Pain or Angina (413.9)
If yes, give details:
Yes / No Shortness of Breath (786.05)

Yes / No Stroke (436.0) Date:
Yes / No Head injury that resulted in a loss of consciousness
If yes, give details:

Yes / No Respiratory Illness, Asthma, Emphysema or chronic bronchitis(493.9)
Yes / No Tuberculosis (011.9)
Yes / No Positive PPD Test for TB Date: -795.5

Yes / No High Blood Pressure (401.9)
Yes / No Diabetes: Type 1 (250.01) Type 2 (250.00) During Pregnancy (648.80)
Yes / No Taking any mediations for diabetes, insulin or oral
Yes / No Non-intentional weight changes of more than 10 lbs. Gain (783.1) Loss (783.21)

Yes / No Rectal Bleeding (569.3)
Yes / No Vaginal Bleeding (623.8)
Yes / No Blood clots in your legs or elsewhere that required medical attention
If yes, give details:

Yes / No Arthritis or Joint Problems (715.98)
If yes, give details:
Yes / No Any Physical Disabilities: Describe:

Yes / No History of Cancer
If yes, give details:

Yes / No History of any other illness that my require regular medical attention
If yes, give details:

Yes / No Diagnosed with any type of hepatitis or other liver disease
If yes, give details:

Yes / No Been told you have a thyroid or other glandular disease
If yes, give details:

Yes / No Hospitalized due surgery, illness or injury
If yes, give details:

Yes / No Kidney stones, kidney infections or bladder infections

Allergies : Please list any allergies to foods, bites, medications:

Family History

Check all items that apply to blood relatives (parents, grandparents, siblings)

( ) Heart Disease (V17.3)
( ) High Blood Pressure (V17.4)
( ) Diabetes (V18.0)
( ) Cancer, Breast (V16.3)
( ) Cancer, Prostate (V16.42)
( ) Cancer, Lung (V16.1)
( ) Stroke (V17.1)
( ) Bleeding Disorders (V18.3)
( ) Father died of Heart Attack before 60
( ) Mother died of Heart Attack before 60
( ) Mother or Sister died of Breast Cancer
( ) Other:
( ) Alcoholism (V61.41)
( ) Suicide (300.9)
( ) Asthma (V17.5)
( ) Allergies (V19.6)
( ) Mental Illness (V17.0)

When was the last time you were seen by a health care provider for any health problem?

Date: For what purpose:

Are you currently taking any medications?

Medication Amount When taken (i.e.. 1 x day, 2 x day, morning, evening)

Are you currently taking any over-the-counter medications? (Tylenol, Ibuprofen, Tums or Maalox)

Medication Amount When taken (i.e.. 1 x day, 2 x day, morning, evening)

Eyes & Ears

Do you wear or need to wear glasses, contact lenses or hearing aids? Yes / No

If yes, please explain

Dental

Do you currently have any dental or tooth pain? Yes / No

If yes, please explain

When was the last time you had a dental exam? Date: _____

Do you wear dentures or other dental appliances that require a dentist's care? Yes / No

If yes, please explain

Women

Currently Pregnant	Yes / No	Due Date	
Have you received pre-natal care	Yes / No		
Number of Pregnancies	# _____		
Number of Live Children	# _____		
Abortions (SA) (TA) or Miscarriage	Yes / No	Dates:	
Do you practice Breast Self Exam	Yes / No		
Clinical Breast Exam	Yes / No	Date: _____	
Last Mammogram	Pos / Neg	Date: _____	
Last Pap / Pelvic Exam	Pos / Neg	Date: _____	

Men

Last Prostate Exam Pos / Neg Date:

Last Testicular Exar Pos / Neg Date:

Health and Behavior Patterns

Tobacco Use	Smoking	None	Previous	Current	Packs per day:
	Smokeless	None	Previous	Current	Amount per day:
	Ceremonial Use Only				

Health and Behavior Patterns (Continued)

Alcohol Use	Sober	None	Previous	Current	Drinks per week
Drug Use	Clean	None	Previous	Current	Amount per week:

In the past **7 days**, what types of drugs or alcohol have you used?

Type of Drug/Alcohol	Route of Administration

In the past **year**, what types of drugs or alcohol have you used?

Type of Drug/Alcohol	Route of Administration

Sexually Active	Yes / No
Use a latex condom during sex (Prevent STI & HIV)	Yes / No
Do you use a condom every time you have sex?	Yes / No

Comments:

Using Family Planning	Yes / No	Specify Method:
Have you ever used needles to inject medications or drugs?		Yes / No
Have you ever had an HIV test?		Yes / No
Have you ever been forced or intimidated into sexual activity in which you did not want to participate?		Yes / No
Tattoo(s) Yes / No	Body Piercing	Yes / No
Were any tattoos or piercing done at home or non-professionally?		Yes / No

Exercise and Activity Patterns

Types of Activity:
Number of days per week:
Amount of time per week:

Sleep patterns	Poor	Fair	Good	Hours per night:
Energy level	Low	Fair	Good	

Nutrition and Eating Patterns

Number of meals per day:
Servings of Fruit per day:
Servings of Vegetables per day:
Servings of Bread, Grain, Potato per day:
Servings of Dairy per day:
Servings of Meat / Protein per day:
Number of times you eat out per week:

Do you add oil, fat or lard to your cooking	Yes / No
Do you add or use salt	Yes / No
Do you take vitamins or supplements	Yes / No
Do you have a refrigerator at home	Yes / No
Do you have a stove at home	Yes / No

Stress and Coping Patterns

Please circle any of the following symptoms or difficulties that apply to you:

Headaches	Dizziness	No Appetite
Stomach Troubles	Fatigue	Increase Alcohol Use
Nightmares	Taking Sedatives	Tremors
Feel Tense	Feel Panicky	Take Drugs
Suicidal Thoughts	Shy with People	Unable to Relax
Over Ambitious	Can't Make Decisions	Irritability
Don't Like Weekends	Don't Like Vacations	Inferiority Feelings
Can't Make Friends	Difficulty Concentrating	Financial Problems
Bad Home Conditions	Thoughts About Hurting Self	Thoughts of Hurting Someone Else
Palpitations	Depression	Unable to Have a Good Time
Anger	Sexual Problems	Insomnia (Problems Sleeping)
Bowel Disturbances	Memory Problems	

Have you ever hurt yourself or attempted suicide? Yes / No

Have you ever hurt someone else? Yes / No

Family Safety

Has a family member/intimate partner called you names, threatened your safety, insulted, put-down or degraded you? Yes / No How recent? _____

Has a family member/intimate partner ever hit, slapped, punched, kicked, shoved, grabbed, or pulled your hair? Yes / No How recent? _____

Has a family member/intimate partner ever forced you to engage in any type of sexual activity against your will? Yes / No How recent? _____

Do you currently feel afraid for your safety? Yes / No

Spiritual Practice

Do you believe in a Great Spirit, God or Higher Power? Yes / No

Have you ever participated in American Indian ceremonial activities? Yes / No

Do you think that cultural or spiritual activities will benefit your health & wellness? Yes / No

Do you attend church, Native American church or ceremony regularly? Yes / No

Are you interested in participating in cultural or traditional American Indian ceremonies such as sweat lodge, purification ceremony or Pow Wow? Yes / No

Would you be interested in other holistic practices (chiropractic or acupuncture)? Yes / No

Home Safety Information

Do you have smoke detectors in your home or apartment Yes / No

Do you have car seats or booster seats for your kids Yes / No / Not Applicable

Are medicine and cleaning supplies locked in cabinets Yes / No

Are emergency phone numbers posted Yes / No

Is there a gun in your house Yes / No

Health Insurance Information - (Case Manager to Complete)

Private Insurance Y / N

Specify Provider:

Medi-Cal	Eligible	Y / N	Enrolled:	Yes	New
Healthy Families	Eligible	Y / N	Enrolled:	Yes	New
Medi-Care	Eligible	Y / N	Enrolled:	Yes	New

Employment Information

Currently Working	Y / N	Part-time	Full-time
Cal Works Recipient	Y / N		
TANF Recipient	Y / N		

Fresno American Indian Health Project Inital / Annual Health Assessment

Veteran Status

Military Service	Y / N	
Veteran Status	Y / N	_____ Wartime/Campaign _____ Other
Service Related Disability	Y / N	Explain:

Any other information regarding your health that will help us to provide services?

Client Authorization:

I acknowledge that the information provided is correct regarding my health and behaviors. I understand that my care will be coordinated with a Case Manager and provided by a Public Health Nurse prior to any access to primary or specialty care. . I further give authorization and consent that my health assessment and treatment plan may be discussed confidentially among health professional within United American Indian Involvement, Inc. in order to determine the best/most appropriate treatment plan for me.

Client Name	Signature	Date

Reviewed by Case Manager:

Name	Signature	Date

Reviewed by Health Care Provider:

Name	Signature	Date

For Office Use Only

DV / IPV Exam Screening (Circle One)

Negative Present Past Refused Unable to Screen

Comment: _____

_____

_____

FRESNO AMERICAN INDIAN HEALTH PROJECT.
Notice of Privacy Practices

This notice summarizes how medical information about you may be used and disclosed and how you can get access to this information.

Your provider will discuss this information with you and you will be given a copy of the complete Privacy Notice. Please ask your provider any questions you have or if you do not understand your privacy rights.

PLEASE REVIEW IT CAREFULLY.

Fresno American Indian Health Project
1551 E. Shaw Ave., Suite 139
Fresno, CA 93710

SUMMARY OF YOUR PRIVACY RIGHTS

I. Understanding Your Health Record Information

Each time you visit a Fresno American Indian Health Project facility for services, a record of your visit is made. If you are referred by FAIHP through the Contract Health Service (CHS) program, FAIHP also keeps a record of your CHS visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment
- Communication source between health care professionals
- Tool with which we can check results and continually work to improve the care we provide
- Means used by Medicare, Medicaid, private insurance or FAIHP can verify the services billed.
- Tool for education of health care professionals
- Source of data for medical research, facility and program planning
- Legal document that describes the care you receive

Understanding your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

II. Your Health Information Rights

Although your health record is the physical property of the Fresno American Indian Health Project the information belongs to you.

You have the right to:

- **Inspect and receive a copy of your health record**
- **Request a restriction** on certain uses and disclosures of your health information. If FAIHP is agrees to your request, we will comply with your request unless the information is needed to provide you with emergency services.
- **Request a correction/amendment to your health record**
- **Request confidential communications about your health information.** You may ask that we communicate with you at a location other than your home.
- **Receive a listing of certain disclosures FAIHP has made** of your health information upon request.
- **Revoke your written authorization to use or disclose health information**. This does not apply to health information already disclosed or used or in circumstances where we have taken action on your prior authorization.

III. FAIHP Responsibilities

Fresno American Indian Health Project is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Honor the terms of this notice or any subsequent revisions of this notice.

FAIHP reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. If FAIHP makes any significant changes to this Notice, we will make the notice of change public. FAIHP also will post any revised Notice of Privacy Practices at public places in its health care facilities and on its web site at www.uaii.org or you may also request a copy of the notice be sent to you. FAIHP understands that health information about you is personal and is committed to protecting your health information. **FAIHP will not use or disclose your health information without your permission, except as described in this notice and as permitted by the Privacy Act.**

IV. How FAIHP may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

- **In order to provide your treatment.**
- **For the payment of services you receive.**
- **For normal health care operations and conducting routine business**
- **To Business Associates /MOU Providers so they my provide you services**
- **Notification/Communication with Family** if they are responsible for your treatment
- **Research** that has been approved and there are established protocols to ensure the privacy of your health information.
- **Uses and Disclosures about the Deceased**
- **To notify you of Treatment Alternatives and Other Health Benefits and Services**
- **To contact you for Appointment Reminders**
- **Food and Drug Administration (FDA)** in connection with an FDA-regulated product.
- **Workers Compensation** if required by law
- **Public Health:** FAIHP may use or disclose your health information to public health or other appropriate government authorities as follows:
  (1) FAIHP may use or disclose your health information to government authorities that are authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions;
  (2) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of child abuse or neglect, and
  (3) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic violence as required by law, or as authorized by law if FAIHP believes it is necessary to prevent serious harm. Where authorized by law, FAIHP may disclose your health information if you who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- **Correctional Institution** health information necessary for your health
- **Law Enforcement** as authorized by law or in response to a court order
- **Health Oversight Authorities:** These oversight activities include: investigations, audits, inspections and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance.
- **Compelling Circumstances** affecting the health or safety of an individual.

- where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person;

Non-Violation of this Notice: **FAIHP is not in violation of this Notice** or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses protected health information under the following circumstances:

- **Disclosures by Whistleblowers:** If a FAIHP employee or contractor (business associate) in good faith believes that FAIHP has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by FAIHP has the potential of endangering one or more patients or members of the workplace or the public and discloses such information.
- **Disclosures by Workforce Member Crime Victims:** Under certain circumstances, a FAIHP workforce member (either an employee or contractor) who is a victim of a crime on or off the facility premises may disclose information about the suspect to law enforcement official provided that:
  a. The information disclosed is about the suspect who committed the criminal act.
  b. The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time.

To Exercise Your Rights
To exercise your rights under this Notice, to ask for more information, or to report a problem regarding your Privacy Rights, contact the Services Program Director or Executive Director at Fresno American Indian Health Project.

You may request copies of the full Privacy Notice and the procedures and forms to exercise your rights under the HIPAA Privacy Act at the front desk of any FAIHP Department.

If you believe your privacy rights have been violated,
You may file a written complaint with:

The California Area Office of Indian Health Service
650 Capitol Mall
Sacramento, CA 95814

or

The Secretary of Health and Human Services
U.S. Department of Health and Human Services
Washington, D.C. 20201.

There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of FAIHP Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Fresno American Indian Health Project. (FAIHP) Notice of Privacy Practices at the following department:

- ❑ The Fresno American Indian Health Project.

_____	_____	_____
Print Name of Client	Client Signature	Date

Or

_____	_____	_____
Print Name of Client Representative	Representative's Signature	Date

_____	_____	_____
Print Name of FAIHP Staff	Staff Signature	Date

_____

Staff Member's Position/Title

If Client is Unable to Acknowledge Receipt of Privacy Notice

I hereby certify that the client was unable to acknowledge receipt of the FAIHP Notice of Privacy Practices because:

_____

_____

_____	_____	_____
Print Name of FAIHP Staff	Staff Signature	Date

FAIHP

Fresno American Indian Health Project

Office Location:
1551 E. Shaw Ave. Ste. 139
Fresno, CA 93710

Office Hours:
Monday - Friday
8:00am - 5:00pm

Phone:
(559) 320-0490
Fax: (559)320-0494

Should you need medical attention during the hours that we are closed please go to your nearest emergency room.