

**FRESNO AMERICAN INDIAN HEALTH PROJECT
DOCUMENT CHECKLIST FOR HEALTH RECORDS**

Client Name: _____ Chart Number: _____

CHILD 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**

___ **Client Intake Registration Form**

___ **Client's Bill of Rights**

___ **Health Assessment Form**

___ **Notice of Privacy Practices Notification**

___ **Medical Record Access Form**

___ **Birth Certificate (children)**

___ **Parent's 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**

___ **Immunization Record (children 0-17)**

___ List of Prescription Medications (If client is taking any)

___ List of over the counter Medications (Tylenol, Vitamins, Tums, Herbs, Teas)

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 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 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 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: _____



FAIHP

Fresno American Indian Health Project

HRN: _____
Received By: _____
Date Entered: _____

Child Registration Form

PLEASE PRINT CLEARLY

Date: ____/____/____

Client's Legal Name: _____

AKA (also known as): _____ PCP (Primary Care Provider): _____

Date of Birth: ____/____/____ SSN: ____-____-____

Gender: Male Female Other

Are you currently homeless: Yes No

Are you currently residing in a temporary living facility: Yes No

Home Address: _____

Mailing Address (If different than home): _____

City/State/Zip Code: _____

Preferred Phone#: _____ Secondary Phone#: _____

Internet Access: Yes No If YES, Where? Home Work E-mail Address: _____

Preferred Method of Communication: Phone E-Mail Mail Text

Race: (Select all that apply)		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Native Hawaiian/ Pacific Islander	<input type="checkbox"/> Asian
<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic

If American Indian/ Alaskan Native:
Tribe: _____ Enrollment #: _____
If you are not American Indian/ Alaskan Native, are you a member of an Indian Household? <input type="checkbox"/> Yes <input type="checkbox"/> No

In Case of Emergency

Primary Contact Name: _____ Relationship: _____

Preferred Phone#: _____ Secondary Phone#: _____

Home Address: _____ City/State/Zip Code: _____

Person outside of residence

Secondary Contact Name: _____ Relationship: _____

Preferred Phone#: _____ Secondary Phone#: _____

Home Address: _____ City/State/Zip Code: _____

Number of People in Household (Immediate family **only**): _____ Household Income (Monthly): _____

Primary Language: _____ Interpreter Required: Yes No

Other Language: _____

Parent/Legal Guardian Signature

Date

Review by: FAIHP Staff

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 within a reasonable timeframe.
- ❖ 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.

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- ❖ The client has the right to be accorded safe 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.
- ❖ The client has the right to information about knowledge, skills, and credential of provider.

CLIENTS HAVE THE RESPONSIBILITY 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 we suspect 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.
- ❖ Photos/videos may be taken as part of an event for promotion material or social media. Please notify the front desk if you have concerns or would like to decline your participation.

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

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Client's Bill of Rights ACKNOWLEDGEMENT RECEIPT

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.

Client/Parent/Guardian Signature _____ **Date** _____

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

Fresno American Indian Health Project Child Initial Health Assessment

Name:	
What services were you needing today?	
Primary Care Provider:	Last visit date:
Birth Date:	Birth Place:
Weight:	Height:
Sex:	Sexual Identity:
Allergies:	

PROVIDE THE FRONT DESK WITH IMMUNIZATION RECORDS

Birth History

Birth weight: _____ Was the delivery: () Vaginal () Cesarean

Did you breast feed: () Yes () No How long did you exclusively breast feed? _____

If early, how many weeks gestation? _____

If Cesarean, why? _____

Did your baby have any problems right after birth? () Yes () No Explain: _____

Was the baby born: () At Term () Early () Late

Did your baby go home with mother from the hospital? () Yes () No Explain: _____

During pregnancy, did mother: Smoke () Yes () No / Drink alcohol () Yes () No

Use Drugs or medications () Yes () No What: _____ When: _____

Did mother have any illness or problem with her pregnancy? () Yes () No Explain: _____

Past History

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

() Constipation requiring doctor visits	() Frequent abdominal pain
() Asthma, bronchitis, bronchiolitis, or pneumonia	() Bladder or Kidney infection
() Any heart problem or heart murmur	() Bed-wetting (after 5 years old)
() Anemia or bleeding problem	() (For girls) Started menstrual periods?
() Convulsions or other neurologic problem	() (For girls) Problems with periods?
() Chronic skin problems (acne, eczema, etc)	() Diabetes
() Thyroid or other endocrine problem	() Other:

If you checked any of the above diagnoses please provide additional information _____

Family History

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

() Heart Disease	() Stroke	() Mental Illness	() Suicide
() High Blood Pressure	() Cancer	() Liver and kidney Problems	() Asthma
() Bleeding Disorders	() Drug Abuse	() Seizures Disorder	() Alcoholism
() Mental Retardation	() There's anyone that smokes in the home that the child resides in?		
() Diabetes Who:	() Other:		

If you checked any of the above diagnoses please provide additional information _____

Development

Are you concerned about your child's physical development?
() Yes () No Explain: _____

Are you concerned about your child's mental or emotional development?
() Yes () No Explain: _____

Does your child often seem sad or depressed? Yes/No

Are you concerned about your child's attention span?
() Yes () No Explain: _____

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____



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 a program, FAIHP also keeps a record. 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.
- Means used by Medicare, Medicaid, private insurance or FAIHP to verify the services billed.
- Tool for education of health care professionals.
- Source of data for 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 agrees to your request, we will comply with your request unless the information 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.faihp.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 may provide you services.**
- **Notification/Communication with Family if they are responsible for your treatment.**
- **Uses and Disclosures about the Deceased.**
- **To notify you of Treatment Alternatives and Other Health Benefits and Services.**
- **To contact you for Appointment Reminders.**
- **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.
 - (3) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic or if FAIHP may disclose your health information if you may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- **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.
- **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:
 - (1) **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.
 - (2) **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 Chief Executive Officer at Fresno American Indian Health Project.

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.

Fresno American Indian Health Project

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

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

Print Name of Client Client Signature Date

Or

Print Name of Client Representative Representative's Signature Date

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

Fresno American Indian Health Project

Service Access Permission Form

PROTECTED HEALTH INFORMATION

Please indicate below any persons and/or organizations that are permitted to coordinate care on your behalf.

I do not wish to list any individuals or organizations.

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____ Date of Birth: _____

EXCEPTIONS: _____

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____ Date of Birth: _____

EXCEPTIONS: _____

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____ Date of Birth: _____

EXCEPTIONS: _____

ORGANIZATION:

CVIH Behavioral Health

Medicine Shoppe

CVIH Medical

North Fork TANF

OVCDC

Sierra Tribal Consortium

Other: _____

Patient Name (PRINT)

Patient Date of Birth

Signature: Patient/Personal Representative

Date

Name of Patient Guardian/Conservator

Relation to Patient or Authority to Act