NORTHEASTERN RURAL HEALTH CLINICS

Northeastern Rural Health Clinics (NRHC) is a federally and state funded community health center. Due to funding sources we must report certain data on our patient population, including ethnicity (race), income information and resident status. No individual information or patient names are included in our data reporting. We thank you for your assistance in supplying this information. This information is kept strictly confidential and is used for data purposes only to help us continue to receive funding to serve you better.

HAVE YOU EVER BEEN SEEN AT ANY OF NORTHEASTERN'S CLINICAL SITES? ( ) YES ( ) NO

Patient Legal Name: _____
Last First Middle Nickname or Alias

Previous Names Used: _____

SSN# _____ **DOB** _____ Age _____ **Sex** ☐ Male ☐ Female

Twin? Yes or No If yes, Name of Twin: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address if different: _____ City: _____ State: _____ Zip: _____

Phone # _____ Alternate # _____ Daytime# _____

Preferred Language (circle one) English Spanish Other:

Contact Preference: ( ) E-mail ( ) Patient Portal ( ) Phone Cell ( ) Phone Home ( ) Text ☐

Special Instructions; See Comments: _____

Are you a Veteran? Yes No Marital Status: _____ Student: Yes No Part-time

Are you a Tobacco User? Yes ☐ No ☐ If Yes please circle one: Smoke Chew

Primary Physician: _____ Primary Dentist: _____

E-mail Address: _____

Place of Employment: _____ Part-time/Full-time/Seasonal

Emergency Contact: _____ Relationship _____ Phone# _____

If under 18 Birth Mother's Full Name _____
Last First Middle Maiden Name

Support person/Care Giver: _____ Relationship _____ Phone _____

Role: ( ) Caregiver ( ) Emergency Contact ( ) Next of Kin

Continued on back☞

Resident Status: This information is for data purposes only, please circle one:

Doubling Up | Not Homeless | Shelter | Street

Transitional | Unknown/Unreported

Migrant Worker ( ) None ( ) Migrant ( ) Not a Farm Worker ( ) Seasonal

Public Housing: ( ) No ( ) Other ( ) Public Housing ( ) Tenant Based Voucher

Ethnicity/Race (circle one**):** Asian | Pacific Islander | Alaskan Native | American Indian

Black or African American | Native Hawaiian or Other Pacific Islander | White | Declined

Do you consider yourself Hispanic or Latino? Yes | No | Declined

Payment Information: Circle one and present documentation to Front Desk:

Self-pay | Medi-Cal | Insurance | Medicare | Sliding Fee | Other

Name of Insurance: _____

Responsible Party Information: (If Different from Patient it Must be Filled out)

Legal Name: _____
Last First Middle

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ SS#: _____ Marital Status: _____

Home Phone #: _____ Work # _____

Occupation: _____ Part-time/Full-time/Seasonal

Place of Employment: _____

Other Family Members related to Responsible Party (name and relationship)

_____

Please indicate your family income below (this information is to be used for data purposes only).

For a Family of (circle one):	**Circle Lower or Higher**	
1	Is your income Lower or Higher than →	$23,342/year
2	Is your income Lower or Higher than →	$31,461/year
3	Is your income Lower or Higher than →	$39,581/year
4	Is your income Lower or Higher than →	$47,701/year
5	Is your income Lower or Higher than →	$55,820/year
6	Is your income Lower or Higher than →	$63,940/year
7	Is your income Lower or Higher than →	$72,059/year
8	Is your income Lower or Higher than →	$80,180/year

****For more information, or if you have special circumstances, please ask to see our Patients Account Advisor****

NORTHEASTERN RURAL HEALTH CLINIC

The below person(s) have my permission to speak to NRHC regarding my appointments and treatment.

Name:	Relationship:	Phone #:

_____ If a referral is required from my visit today or in the future; it is ok to leave a message on my Phone or with the above person(s) regarding appointment information.

Comment: _____

_____ It is okay to call and confirm appointments and leave a message on the machine or with the person who answers the phone.

Comment: _____

_____ It is okay to call and leave a message for me to call provider regarding my labs or test results.

Comment: _____

Patient or Legal Guardian Signature: _____

Date: _____

PAYMENT & TREATMENT AGREEMENT

By signing below I agree to and authorize the following:

- All the information I have provided on this "Patient Information Sheet" is true.
- I authorize the staff of Northeastern Rural Health Clinics (NRHC) to treat, test, and examine myself and any children/family member listed in the information I have provided.
- I authorize assignment of benefits (payments from a third party) for medical service to be paid to NRHC.
- I agree that I will receive a bill and pay the cost for services not covered by my health insurance or reimbursed by other funding programs.
- I understand use of any medical insurance or state funding means that NRHC may release information to the insurance company or the State of California about my medical diagnosis and care.
- I understand that NRHC uses outside laboratories for some of their tests.
- I understand that I may receive a bill from an outside laboratory if my insurance does not cover the cost of the test.

Patient or Legal Guardian's Signature: _____ Date: _____

Witness Signature and Title: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT OF RECEIPT

Acknowledgement of Receipt:

By signing this form, you acknowledge either receipt of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics, or that you have read a copy of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice from one or our Customer Service Representatives.
If you have any questions about our "Notice of Privacy Practices", please contact the Privacy Officer at (530) 251-5000.

___ I acknowledge receipt of a copy of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics.

___ I acknowledge that I have read a copy of "Notice of Privacy Practices" of Northeastern Rural Health Clinics.

Date: _____ Time: _____ AM / PM

Signature: _____
(Patient or Legal Representative)

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____
(Patient or Legal Representative)

Northeastern Rural Health Clinics

Northeastern Health Center
1850 Spring Ridge Drive
Susanville, CA 96130
530-251-5000

Westwood Family Practice
209 Birch Street
Westwood, CA 96137
530-256-3152

☐ Administration
530-251-5000
Fax 257-6015

☐ Billing Services
1-800-371-3445

☐ Urgent Care, Suite A
Noreen Frieling, FNP
530-251-5000
Fax 257-4088

☐ WIC Program Services
Barbara Byers, RD
530-257-7094
Fax 251-1256

☐ Family Health, Suite B
Pamela Orr-FNP
530-251-5000
Fax 257-8232

☐ Family Health, Suite C
Rich Carlton, M.D.
Dean Brown, PA-C
530-251-5000
Fax 257-8232

☐ Family Health, Suite D
John Dozier, MD
Christine Birch, PA-C
Lindsey Steglich, PA-C
530-251-5000
Fax 257-3943

☐ Occupational Medicine, Suite E
Eileen Searcy, PA-C
530-251-5000
Fax 252-1653

☐ Family & Women's Health, Suite F
Steven Braatz, MD
530-251-5000
Fax 257-3944

☐ Family & Women's Health, Suite G
Naomi Rea, FNP, CNM, Medical Director
530-251-5000
Fax 257-3944

☐ Dental Services
Charles Giddings, DDS, Dental Director
Tiffany Gorr, DDS
530-251-5000
Fax 257-4537

☐ Westwood Family Practice
Vincent Natali, MD
Nan Cayler, PA-C
530-256-3152
Fax 256-2061

To Our Patients:

This notice is to advise all patients of our existing "No Show" policy and payment policy.

NO SHOW POLICY:

Our goal at Northeastern is to provide the best services to our community. When an appointment is missed it keeps another patient from being seen in a timely manner. With the number of "No Show" patient appointments on the rise, *we require* a 24-hour notice if you are unable to make your scheduled appointment. We will allow voicemail cancellations as long as they are received before the office opens at 7:00 a.m. After repeated no show appointments, future scheduled appointments will be at the discretion of your provider. You may be receiving a letter outlining your future appointments signed by your Provider or the Medical Director. As an alternative you can elect to be seen as a walk in patient in Urgent Care (with the exception of those seeking refills on prescriptions).

PAYMENT POLICY:

All payments, including co-pay are due at the time of service. If you are unable to make a payment at the time of visit, your appointment may be rescheduled.

We appreciate your understanding concerning this matter and with your cooperation we will be able to continue providing our community with the many services we offer.

Patient: _____

Signature: _____

Date: _____

Staff Initials: _____