



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: _____

Previous Names Used: _____ Nickname or Alias: _____

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

Sexual Orientation (check one): Homosexual (Lesbian, gay) Heterosexual (Straight) Bisexual

Don't Know Choose not to disclose

Something else (please describe): _____

Gender Identity (check one): Male Female Transgender (Female to Male) (Male to Female) Non-Conforming (neither exclusively male or female)

Assignment at Birth (check one): Male Female Unknown Choose not to disclose

Preferred Pronoun (check one): He/Him She/Her They/Them

Mailing Address: _____

City:

State:

Zip:

Physical Address (if different): _____

City:

State:

Zip:

Home Phone: _____ **Mobile Phone:** _____ **Work Phone:** _____

Email Address: _____ Would you like to sign up for Patient Portal? Yes No

Do you give NRHC consent to send automated text alerts on your mobile phone regarding appointments? Yes No

Do you give NRHC consent to disclose childhood immunization to CAIR? Yes No

Primary Physician: _____

Primary Dentist: _____

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Preferred Language (check one): English Spanish Other: _____

Ethnicity (check one): Hispanic/Latino Not Hispanic/Latino

Race (check one): White Asian Pacific Islander Alaskan Native American Indian
 Native Hawaiian or Other Pacific Islander Black or African Black or African

Marital Status (check one): Single Married Divorced Separated Widowed Partner

Would you like to receive a Patient Care Summary after visits? Paper Print Out Patient Portal No Thanks

Number of persons in the household:

Would you like to apply for our Sliding Fee Discount Program? Yes No

Income level: (please circle your approximate annual gross household income)

\$12,000	\$16,000	\$20,000	\$24,000	\$28,000
\$32,000	\$36,000	\$40,000	\$44,000	\$48,000
\$52,000	\$56,000	\$60,000	\$64,000	\$68,000
\$72,000	\$76,000	\$80,000	\$84,000	\$88,000
\$92,000	\$96,000	\$100,000	\$104,000	\$108,000
\$112,000	\$116,000	\$120,000	\$124,000	\$128,000
\$132,000	\$136,000	\$140,000	\$114,000	\$148,000
\$152,000	\$156,000	\$160,000	\$164,000	\$168,000

****For more information, or if you have special circumstances, please ask receptionist/front desk****

Migrant Worker: None Migrant Not a Farm Worker Seasonal

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

Not Homeless Doubling Up Homeless Shelter

Transitional Street Other: _____

Are you a Veteran? Yes No	Public Housing: <input type="checkbox"/> No <input type="checkbox"/> Other <input type="checkbox"/> Public Housing <input type="checkbox"/> Tenant Based Voucher
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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: _____
First: MI: Last:

Mailing Address: _____
City: State: Zip:

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

Date of Birth: _____ **SS#:** _____ **Phone #:** _____

Employment: _____ **Gender:** _____ **Email:** _____

Relationship to Patient: (Check one):

- Self – Patient is the insured Spouse – Patient is the spouse of the insured
 Natural Child – Insured has financial responsibility Natural Child – Insured does not have financial responsibility
 Parent Grandparent Step Child Foster Child Grandchild Niece/Nephew
 Other: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Support person/Caregiver: _____ **Relationship:** _____ **Phone #:** _____

Role: Caregiver Emergency Contact Next of Kin Guardian Other: _____

Place of Employment: _____ **Occupation:** _____ **Phone #:** _____

Preferred Pharmacy: _____ **Preferred Lab/Draw Station:** _____

I Decline to participate in the sure scripts import of my medication History.

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

Name:	Relationship:	Phone #:

Initial Below:

_____ 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: _____

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)

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.

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)

Witness Signature: _____ **Title:** _____



NORTHEASTERN RURAL HEALTH CLINICS

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 of our Patient Support Coordinators.

If you have any questions about our “Notice of Privacy Practices”, please contact the Privacy Officer at (530) 251-1454.

Initial Below:

_____ 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

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 Name: _____

Signature: _____

Date: _____

Staff Initials: _____