DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W. HOLDEN PLACE, DENVER, CO 80204 PHONE: (303) 953-6600 FAX: (303) 781-433 WWW.DIHFS.ORG

PATIENT INFORMATION

First Name:	Last Name	Middle Initial:
DOB:	SSN:	Preferred/Legal Name:
Gender: ❑ Male ❑ Female	Transgender: ❑ Yes ❑ No	Sexual Orientation:

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed/Widower ❑ Legally Separated ❑ Unknown

Home Phone:	Work:	Cell:

Internet Access: ❑ Yes ❑ No Email Address:

Home Address: City: State: Zip Code:

Mailing Address *[if Different]* : City: State: Zip Code:

If patient is a child/minor-how are you related? : ❑ Mother ❑ Father ❑ Legal Guardian **Your Full Name :**

Are you Enrolled in a Federally Recognized Tribe? ❑ Yes ❑ No	**Name of Tribe Affiliated with?**	**What State is your Tribe in?**	**What Is your Blood Quantum?**

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Declined to specify ❑ Unknown by Patient ❑ Other_____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ White ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Decline to Answer ❑ Unknown by Patient ❑ Other_____

What language do you speak? Do you have limited English proficiency? ❑ Yes ❑ No

Are you a Veteran: ❑ Yes ❑ No	Are you a Migrant worker: ❑ Yes ❑ No	Do you Live in Public Housing: ❑ Yes ❑ No	Are you Homeless: ❑ Yes ❑ No

If Homeless: *Where do you stay* ❑ Streets ❑ Shelter ❑ Doubling up ❑ Other : _____

PHARMACY INFORMATION

Pharmacy Name: Address: Phone: Fax:

EMPLOYMENT INFORMATION

Are you Employed? ❑ Yes ❑ No **If Yes:** ❑ Full Time ❑ Part Time / ❑ Self Employed / ❑ Active Military duty / ❑ Active National

Employer Name: Employer Address:

Are you a Student? ❑ Yes ❑ No *If Yes*: ❑ Full Time ❑ Part Time / **Are you Retired?** ❑ Yes ❑ No / **Are you Disabled?** ❑ Yes ❑ No

HOUSEHOLD INCOME

Number of People in your Household? **Total Household Income? Yearly:** **Monthly:**

INSURANCE INFORMATION

Do you have Insurance: ❑ Yes ❑ No **What Type of Insurance**: ❑ **Medicaid** ❑ **Medicare** ❑ **Other**

Name of Insurance:	Policy Number:	Group #:
[Subscribers Name]:	[Subscribers D.O.B]:	[Subscribers SSN #]
Responsible Party:	Relationship to Patient:	

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EMERGENCY CONTACT

Name of friend or relative:	Relationship to patient:	Home	Cell phone	Work phone
Address:	City:	State:		Zip:

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATON

I grant Denver Indian Health and Family Services permission to release information using the following method of communication.

Please Check Box where you would like us to contact you and if it is okay to leave a message at the following numbers:

❑ Home Phone_____ ❑ Cell Phone _____ ❑ Work Phone_____

May we leave text message on cell phone for appointment information: ❑ Yes ❑ No

The type of information can be disclosed:

❑ ANY information about patient treatment ❑ Laboratory Results ❑Referral Information (outside services)

❑ Prescription Drug Information ❑ Appointment Information ❑ Other: Please Specify_____

Patient/Parent/Guardian Signature: _____

Printed name: _____ **Date:** _____

You must complete and sign this release form giving us permission to use this method of communication

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I grant Denver Indian Health and Family Services permission to release my protected health information (lab results, medications and other health related information, etc.) to the following person

Name of friend or relative:	Relationship to patient:	Home	Cell phone	Work phone
Address:	City:	State:		Zip:

This consent will expire when revoked by patient/representative or 1 year from the date of signing, or in the case of a minor, on the date the minor becomes and adult under state law, whichever occurs first.

Patient/Parent/Guardian Signature: _____**Date:** _____

Printed name: _____

DIHFS Staff Signature: _____**Date:** _____

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FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RECORDS RELEASE CONSENT FOR TREATMENT

1) I authorize Denver Indian Health and Family Services, Inc. (DIHFS) to release and/or obtain information regarding treatment to third party payers such as Medicaid, Medicare, Private Insurance or other for billing purposes and/ or submitting billing claims to insurance carrier(s) and for any reason in accordance with acceptable medical and other treatment practices, pursuant to the law.

2) I authorize agency contact with me by phone, mail, email, etc. by identifying DIHFS by name, address, phone number, and/or logo.

3) I understand that by receiving services from treatment providers for myself or my family, I am accepting responsibility for payment charges. Payment is due when treatment is rendered regardless of insurance coverage.

4) By signing below, I authorize Denver Indian Health and family services to perform medical treatment and/or provide other integrated health care treatment deemed necessary by the medical provider(s) and clinical staff, other agency staff or clinical consultants with whom DIHFS has contractual relationships to provide treatment services, whenever necessary and appropriate for my child and/or my healthcare.

Patient/Parent/Guardian Signature: _____**Date:** _____

Printed name: _____

NOTICE OF PRIVACEY PRACTICE (HIPPA)

This notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review this carefully.

Denver Indian Health and Family Services have always considered physician-patient confidentiality and integral part of patient care. As part of the Balanced Budget Act of 1997, new legislation regarding the privacy of your protected health information (PHI) will become effective April 14, 2003.

The law, known as HIPAA (Health Insurance Portability and Accountability Act), requires that all healthcare providers maintain privacy and protected health information and provide individuals with notice of its legal duties and privacy practices with respect to protected health information. This office is required to follow the terms of the notice currently in effect.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other healthcare providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods.

In addition, we may disclose identifiable person health information without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public purposes such as reporting of communicable diseases, birth, death, injury and child abuse or neglect; for auditing purposes; for research studies; and for emergencies. We may provide information when otherwise required by law, such as for law enforcement or by court order in specific circumstances. Contact with you may also take place in the form of appointment reminders, prescription refills, referrals, test results, etc.

I have received, read, and had the chance to ask questions about the rules and regulations related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

Patient/Parent/Guardian Signature: _____**Date:** _____

Printed name: _____

DIHFS Staff Signature: _____**Date:** _____

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CLIENT RIGHTS

As a recipient of the Denver Indian Health & Family Services, Inc. (DIHFS) services, you have the following rights:

1. To be treated with dignity and respect; as an individual who has personal needs, feelings, preferences, and requirements.
2. To privacy in your DIHFS program, in your care, and in the fulfillment of your personal needs.
3. To actively participate in the development of your treatment plan and objectives.
4. To refuse treatment to the extent permitted by law and to be informed of the consequences of this right.
5. To continuity of care. You will not be transferred or discharged, except for medical and/or therapeutic reasons, non-compliance to program's guidelines, for your personal care and treatment, or for the welfare of others. Should your transfer or termination become necessary, you will be given reasonable advance notice, unless an emergency or urgent situation exists.
6. To voice grievances in relation to policies, procedures, and services offered by this agency without fear or restraint, interference, or retaliation.
7. To confidential treatment of your personal and clinical records. Information from these sources will not be released without prior written consent from you, except as required by law, you have the right to be informed at your intake, of the conditions and situations that would result in the release of any information without your consent.
8. To be provided with a statement of treatment options and a treatment plan.

CLIENT RESPONSIBILITIES

As a recipient of Denver Indian Health and Family Services, Inc. (DIHFS) services, you are expected to participate in the following ways:

1. Responsible for providing input and assistance in developing his/her individual treatment plan.
2. Responsible for participating and/or determining personal investment in treatment goal achievement.
3. Responsible for attending all treatment sessions in a timely manner and giving timely notice of cancellations.
4. Responsible for attending all treatment activities in a sober condition.
5. Responsible for providing written approval for any release of confidential information to a third party (except when release is required by law).
6. A client may be requested to supply information and documents to allow for third party billing.
7. Responsible for conducting yourself in a non-threatening, non-destructive manner while at DIHFS and all DIHFS sponsored functions.
8. Responsible and agree to update as it changes (i.e.: phone number, address, and name changes)
9. Responsible and agree to update any required registration and/or other forms necessary to stay in compliance with DIHFS. **Refusing to do so, may cause delay in your service/treatment with the possibility of not being seen.**

By signing this document, I verify that all information is correct and that I agree to notify Denver Indian Health & Family Services of any changes in status, including change in Guardianship, Address, Phone Numbers, and Health Insurance.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Printed name: _____

DIHFS Staff Signature: _____ **Date:** _____

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NO SHOW POLICY

Denver Indian Health and Family Services is proud to be able to provide basic Medical, Dental, and Mental Health services to our community. There is a great need for these services. Clinic services are valuable to our community and can be costly.
We know that there are times when you may have made an appointment and we're unable to keep that appointment. However, when patients do not notify our office prior to missing the appointment it has an effect on both the community and the clinic. Perhaps another patient could have been seen in your space. Therefore, we are instituting the following rules to insure that we get the best use of medical, dental, and mental health professional's time:

CLINIC POLICY:

- Cancellation of appointments must be **at least 4 hours** prior to the appointment or it will be considered a **NO SHOW**.

- Only two "No Shows " per year will be allowed for appointments. After the second "No Show" a code is entered into our data base with the indicator "refused care" will be noted. The patient will not be allowed to schedule another appointment for a period of 6 months. This decision will be determined by the staff of the services to be provided to the patient.

- Dentist appointments: patients will not be allowed to miss any appointments or you will lose your privileges for 1 year.

- If you are more than 15 minutes late you will be rescheduled without notice. The DIHFS staff has the sole discretion in determining if they will be able to see you that day.

- We are now requesting the need for two verifiable phone numbers to contact you at for the following reasons; **One:** if we DIHFS needs to reschedule you due to the fact that the person or clinic is unexpectedly out, **Two:** to call and remind you one day prior of your scheduled appointment here at DIHFS.

Patient/Parent/Guardian Signature: _____**Date:** _____

Printed name: _____

DIHFS Staff Signature: _____**Date:** _____