DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W. HOLDEN PLACE, DENVER, CO 80204 PHONE: (303) 953-6600 FAX: (303) 643-5885 WWW.DIHFS.ORG

PATIENT INFORMATION

First Name: | Last Name: | Middle Initial:

DOB: | SSN: | Preferred/Legal Name:

Gender: ❑ Male ❑ Female | Transgender: ❑ Yes ❑ No | Sexual Preference: Straight Bisexual Gay/Lesbian Other

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: County:

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

IF PATIENT IS 18 YEARS AND UNDER (Child/Minor) PLEASE FILL OUT:

Parent/Guardian Name: _____ Parent/Guardian DOB: _____

How are you related: ❑ Parent ❑ Grandparent ❑ Legal Guardian ❑ Other _____

EMPLOYMENT INFORMATION

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

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

EMERGENCY CONTACT

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

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]**	

DEMOGRAPHIC INFORMATION (FOR FUNDING PURPOSES)

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 is your primary language? Are you fluent in English and **DO NOT** need a translator? ❑ Yes ❑ No

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

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	Seasonal Worker: ❑ Yes ❑ No

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

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HOUSEHOLD INCOME (FOR FUNDING PURPOSES)

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

PHARMACY INFORMATION

Pharmacy Name: **Address:** **Phone:** **Fax:**

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATON

Please Check Box where you would like us to contact you at the following numbers:

❑ Home Phone_____ ❑ Cell Phone _____ ❑ Work Phone_____

May we leave message on the phone number listed above: ❑ Yes ❑ No
May we send a text message to the cell phone number above: ❑ 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_____

I give permission to Denver Indian Health and Family Service to contact me using the above method of communication.

_____ _____
Patient Name Date

_____ _____
Patient Signature or Parent/Guardian if minor Relationship to Patient

_____ _____
Staff Signature Date

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I give permission to Denver Indian Health and Family Service to release my protected health information (lab results, medication 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 Name Date

_____ _____
Patient Signature or Parent/Guardian if minor Relationship to Patient

_____ _____
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 Name	Date
Patient Signature or Parent/Guardian if minor	Relationship to Patient
Staff Signature	Date

NOTICE OF PRIVACY PRACTICE (HIPAA)

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 Name	Date
Patient Signature or Parent/Guardian if minor	Relationship to Patient
Staff Signature	Date

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CLIENT RIGHTS

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

- To receive considerate and respectful health care.
- To privacy in your DIHFS program, in your care, and in the fulfillment of your personal needs.
- To be provided with a description of treatment options and a treatment plan.
- To actively participate in the development of your treatment plan objectives.
- To refuse treatment to the extent permitted by law and to be informed of the consequences of this right.
- To knowledge and information related to
    - Treatments and procedures
    - Providers' identities and credentials
    - Clinical records content and access
    - Alternative treatment options
    - Advance directives
- To continuity of care. You will not be transferred or discharged, except for medical and/or therapeutic reasons, noncompliance to program 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 notice, unless an emergency or urgent situation exists.
- To provide feedback, including complaints or grievances, in relation to policies, procedures, and services offered by DIHFS without fear or restraint, interference, or retaliation.
- 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.

CLIENT RESPONSIBILITIES

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

- To provide accurate and complete information and assistance in developing your individual treatment plan.
- To participate and/or determine your personal investment in treatment goal achievement.
- To attend all treatment sessions in a timely manner.
- To give 24 hours' notice in the event an appointment needs to be cancelled/rescheduled.
- To treat all other DIHFS patients or staff with consideration and respect.
- To conduct yourself in a non-threatening, non-destructive manner.
- To provide information and documents to allow for third party billing, when requested.
- To provide approval of any release of confidential information to a third party (except when release is not required by law).
- To update all personal information as it changes (i.e.: phone number, address, and name changes)
- 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.

I have read and understand my client rights and responsibilities. I verify all information is correct and I agree to notify DIHFS of any changes in status, including change in Guardianship, Address, Phone Numbers and Health Insurance.

_____	_____
Patient Name	Date
_____	_____
Patient Signature or Parent/Guardian if minor	Relationship to Patient
_____	_____
Staff Signature	Date

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NO SHOW, LATE & CANCELLATION POLICY

Denver Indian Health and Family Services (DIHFS) is proud to be able to provide comprehensive healthcare services to our community. There is a large demand for these services and every appointment can be meaningful to an individual's long-term health.

We at DIHFS understand that circumstances sometimes require you to cancel or reschedule your appointments. However, when patients do not notify our office in advance, it negatively impacts DIHFS's ability to provide care to our community. In an effort to provide timely care for as many patients as possible, DIHFS requires patients to cancel their appointments **with at least 24-hour notice**. If you miss an appointment without canceling with 24 hours' notice, you will be marked as a "No Show". If you accumulate 2 "No Shows" in a 6-month period, you will be subject to the No Show penalty (see below). If you are unable to keep your appointment, please call us at (303) 953-6600 as soon as possible to reschedule.

We recognize that providing the highest quality care means ensuring each patient gets the proper amount of time with their provider. Therefore, it is expected that each scheduled patient attends their visit on time. 10 minutes after your scheduled appointment, you will be counted as a no show. As a courtesy reminder, DIHFS will attempt to call you one business day prior to your appointment. If your phone number changes, it is your responsibility to call DIHFS and update the phone number on file.

No Show Penalty:

- After the second Dental No Show in 6 months, you will not be able to schedule an appointment for the next 6 months and can only be seen as "emergency basis only"
- After the second Primary Care (Medical Clinic) or Behavioral Health No Show in 6 months, you will be placed on a "same-day call status" for a period of 6 months. You will not be allowed to schedule appointments in advance and must call the day you want to be seen. If there is no appointment available, you may come into the clinic and wait to be worked into the schedule but there is no guarantee of being seen.

Thank you for your cooperation and understanding.

I have read and understand Denver Indian Health and Family Services No Show/Missed Appointment Policy. I understand my responsibility to plan appointments accordingly and notify Denver Indian Health and Family Services appropriately if I have difficulty keeping my scheduled appointments.

_____	_____
Patient Name	Date
_____	_____
Patient Signature or Parent/Guardian if minor	Relationship to Patient
_____	_____
Staff Signature	Date