Northern Valley Indian Health, Inc.

Thank you for completely filling out this form as the information collected on this form is very important to our organization in regards to reporting statistical information that aids in receiving funding to help support our services. Please be assured that no private information is shared, only statistical information. Tribal Affiliation: Provide accepted documentation.

PATIENT REGISTRATION INFORMATION

This Form is Fillable

PATIENT INFORMATION:

Patient's legal last name:

Patient's legal first name:

Patient's Middle initial:

Patient's previous name:

Patient's preferred name:

Patient's phone/mobile # _____

PATIENT INFORMATION:

Mailing Home address: _____

(Physical address requested on 2nd page)

City:_____

State: _____ ZIP: _____ Country :_____

Home Phone:_____

Cell no:_____

Work Phone: _____ Ext:_____

Email: _____

Would you like to be Web Enabled for the patient Portal?

☐ **Yes or** ☐ **No**

If yes we will use your email above unless otherwise indicated.

How would you like us to notify you for appointment reminders? PLEASE SELECT ONLY ONE:

_____ Voice Number to call: _____

_____ Text Number to receive messages: _____

☐ **Do not send appointment reminders**

Patient's date of birth: / /

Sex/gender assigned at birth: ☐ MALE ☐ FEMALE

Are you Transgender: ☐ Yes ☐ No

Gender identity : ☐ Male ☐ Female ☐ non-binary/other

☐ Trans MTF ☐ Trans FTM

Current legal Gender: ☐ MALE ☐ FEMALE ☐ non-binary/other

Patient's Social Security Number: _____

PATIENT EMERGENCY CONTACT INFORMATION:

Relationship to patient: _____

First Name:_____

Last Name:_____ MI:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____

Work Phone:_____EXT:_____

Cell Phone:_____

PATIENT MARITAL STATUS:

☐ Divorced ☐ Married ☐ Partner ☐ Single

☐ Unknown ☐ Widowed ☐ Legally Separated

Primary Language: _____

Patient's Race:

☐ American Indian ☐ Black or African American ☐ Declined to Specify ☐ White or_____

(Please fill in blank)

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR:

Mother Name: _____

Phone:_____

Father Name: _____

Phone: _____

Guardian's Name:_____

Phone:_____

Guarantor (Person Responsible for bill)

Please check one below if not SELF complete information of person responsible

☐ **SELF** ☐ **Another patient or person** *if so complete this portion if not mark **SELF** and move on to next box.*

Name:_____ DOB_____

Address:_____ Phone:_____

Work:_____

Relationship to Patient:

ACCT/HRN# _____

PATIENT INFORMATION:

Patient's Ethnicity: ☐ Hispanic or Latino ☐ not Hispanic
☐ Declined to Specify or_____
(Please fill in blank)

Characteristic: Are you homeless? ☐ **Yes** ☐ **No**
If YES (enter where you live)
☐ **Doubling Up** ☐ **Migrant** ☐ **Other** ☐ **Seasonal**
☐ **Street** ☐ **Transitional** ☐ **Unknown**

Employment Status:
☐ Employed full-Time ☐ Employed Part-Time ☐ Not employed ☐ Self-Employed ☐ Retired ☐ On Military Duty ☐ Reserved or ☐ Unknown (Please select one)

Student Status:
☐ Full Time ☐ Not a Student ☐ Part Time Student
(Please select one)

Street Address if different then mailing address :
If same skip this section

Address:_____

City:_____**State:**_____**Zip:**_____

PATIENT EMPLOYER INFORMATION:

Employer Name:_____

Employer Address:_____

City:_____**State:**_____**Zip:**_____

PATIENT INFORMATION:

Are you Native American: ☐ **Yes or** ☐ **No**

Tribe of Membership:

Community of Residence:

Are you any of the following:
☐**Veteran** ☐**Migrant** ☐**Homeless**

INSURANCE INFORMATION:

Please fill in information below and provide a copy of: Medicare, Medi-Cal, or Private Insurance Card(s)

#1 Primary insurance:

Sub No:

Insured's name: ☐ **SELF**

Group No:

Medicaid ID No:

#2 Secondary insurance:

Insured's name:

Group No:

#3 (Tertiary)-Third Policy:

- *To the extent permitted under applicable law, I authorize the release of any information necessary to process claims for payment on my behalf. I also authorize any third-party payments to be sent payable to Northern Valley Indian Health, Inc. I understand I am responsible for any financial portions not covered by a third party or in-house service.*
- *I authorize Northern Valley Indian Health, Inc. to deposit checks received on account from my insurance company, when made out in my name.*
- ***If for an Adult Patient**: Northern Valley Indian Health, Inc. has my permission to provide routine and emergency Dental and/or medical care for myself. _____ (Patient Initials)*
- ***If for a Minor Patient:** Northern Valley Indian Health Inc. has my permission to provide routine and emergency Dental and/or medical care for my dependent child. _____ (Parent/Guardian Initials)*
- *Northern Valley Indian Health, Inc. has my consent to photograph as necessary for clinical documentation.*
- *I understand that NVIH participates in medical education and training programs and my healthcare services from NVIH may be provided, assisted or observed by medical students, postgraduates fellows, residents, associates or other healthcare professional trainees as part of such program.*
- *I understand that my care may be provided by a non-physician medical practitioner.*
- *This authorization is effective until revoked in writing by myself or my authorized representative.*

By signing the below, I am verifying that I have legal rights to authorize medical care for this patient.

Signature: _____ **Date:** _____
(Patient or Parent/Guardian if patient is a minor)

For NVIH Use Only: Patient Name: _____ **ACCT/HRN:** _____

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

ADULT INTAKE

Name: _____Age:_____DOB:_____Date:_____

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____

Tribal Affiliation: _____

Psychological History:

Have you been in therapy before? Yes_____ No_____ If yes, please list previous providers and approximate dates of treatment: _____

Provider	Date of treatment

Is there a family history of psychological treatment? Yes_____ No_____

Medical History:

Describe any illnesses, surgeries, hospitalizations or other medical conditions you are or have experienced: _____

_____

_____

Are you currently taking any medications? Yes_____ No_____

If yes, please list name and dosage of medication: _____

_____

_____

Spiritual Beliefs: (if this is important to you and you feel comfortable sharing):_____

_____

_____

Presenting Problem(s): Please describe the reasons you are seeking therapy:

_____

_____

Please check all that apply to you currently:

Eating habits changed_____
- Eating more_____
- Eating less_____
- Severe dieting or throwing-up_____
- Noticeable weight change_____

Sleep changes_____
- Trouble falling asleep_____
- Trouble staying asleep_____
- Trouble waking up_____

Suicidal thoughts_____
Suicide attempts_____
Self harm behavior_____
Decreased Energy_____
Change in sexual functioning_____
Loss of interest in activities_____
Tearful_____
Hopeless_____
Decreased attention span_____
Inattentive/distractible_____
Memory changes_____
Difficulty planning ahead_____
Anger outbursts_____
Difficulty controlling impulses_____
Mood changes_____
Anxious/Nervous_____
Worries/fears_____
Stealing_____
Lying_____
Police/probation involvement_____
Spending sprees_____
Rapid Heartbeat_____
Phobias_____
Sweating_____
Trouble breathing_____
Flashbacks_____
Nightmares_____
Racing thoughts_____
Hearing voices_____
Seeing things that aren't there_____

Name:_____ HRN: _____

Please rate how the problems you are currently experiencing are affecting the areas of your daily life:
1-no effect 2-mild effect 3-moderate effect 4-severe effect
Marriage/relationship_____
Work/school_____
Family_____
Friends _____
Financial Situation_____
Physical health_____
Social interests_____
Leisure activities_____
Legal_____
Housing_____
Personal Hygiene_____
Spirituality_____
Other_____

Substance Use History: Please check all that apply.
Coffee_____(#_____ cups a day)
Cigarettes_____(#_____per day)
Alcohol___(# drinks per week)
Street drugs_____
Type_____
Amount _____
Frequency_____
Date last used_____
Have you had difficulty controlling substances in your life? Yes____ No___
Have you ever been in treatment for substance abuse? Yes_____ No_____
If yes, please list where and when:_____
_____
_____
Is there a history of substance abuse in your family? Yes_____ No_____

Strengths
Please list your strengths:_____
_____
_____

Goals
What are your goals for therapy?_____
_____
_____
_____

Name: _____ HRN:_____

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

CONSENT and CONTRACT FOR BEHAVIORAL HEALTH THERAPY

PART I: Client Rights

1. All information communicated within a therapeutic context will be confidential and will not be revealed to any agency or other person without your permission within certain legal limits.

Under certain legally defined situations, I am required to reveal information you tell me during the course of therapy to other agencies or persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

a. If you reveal information to me about child abuse or neglect or elder physical abuse, I am required by law to report this to the appropriate authority.

b. If you threaten physical harm or death to another person, I am required by law to warn the intended victim and notify the appropriate law enforcement agencies.

c. If you threaten physical harm or death to yourself, to an unidentifiable other, or to others' property, I may break confidentiality to avert this action.

d. If you are in therapy or being tested by order of a court of law, the results of the treatment or tests ordered must be revealed to that court.

e. If a court of law issues a legitimate subpoena, I will assert privilege to protect your confidentiality. The court, however, may order me to provide the information specifically described in the subpoena and I must comply.

2. You have the right to choose NOT to receive therapy from me. If you choose this, I will attempt to provide you with names of other qualified professionals whose services might suit your current needs.

3. You have the right to terminate therapy with me at any time without financial, legal, or moral obligation other than those you have already incurred. Most terminations, however, involve a mutually agreed upon process between the client and the therapist.

"For Office Use Only"

Client Name: _____DOB:_____Date:_____HRN#:_____

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

CONSENT and CONTRACT FOR BEHAVIORAL HEALTH THERAPY

PART II: The Therapy Process

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Remembering and resolving unpleasant events through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can lead to discomfort and may result in changes that were not originally intended.

PART III: Fees and Payment

I agree to pay for each therapy session (if not covered by insurance or as a direct service) or any co-payment required by my insurance. I understand that payment will be collected in advance of each therapy session.

PART IV: Consent for Treatment

I hereby authorize and request that _____carry out psychological/psychiatric examinations, treatments, and/or diagnostic procedures which now or during the course of my (or my child's) care as a client are advisable. My signature below serves as consent to treatment and indicates that I have read and understand the information contained in this contract.

☐ I, the Patient/Legally Authorized Person, am able to communicate effectively in English.

_____ _____

Client(s) Name | Client(s) Signature(s)

_____ _____

Parent/Legal Guardian (if Client is a minor) | Parent/Legal Guardian Signature (if Client is a minor)

_____ _____ _____

Client DOB | Date | HRN#

_____ _____

Psychiatrist/Psychologist/Therapist's Name | Psychiatrist/Psychologist/Therapist's Signature

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Clinic Appointment Policy

PURPOSE

In order to maintain quality patient care and timely access to care, the following established guidelines regarding appointments with NVIH healthcare clinics are to be followed:

POLICY

New Patient Appointments:

1. New patients unable to keep their scheduled initial appointment must notify the Clinic staff Notification must be made by no later than 12:00 p.m. one business day in advance of the intended cancellation. Failure to do so is considered a missed (no-show) appointment.

2. New patients who miss their scheduled initial appointment twice will not be rescheduled.* (Exceptions may be authorized by the Lead Provider or Department Director.)

Established Patient Appointments:

1. Patients unable to keep a scheduled appointment must notify the Clinic staff no later than 12:00 p.m. one business day in advance of the scheduled appointment of the intended cancellation. Failure to do so is considered a missed (no-showed) appointment.

2. Arriving more than ten minutes late for a scheduled appointment may result in the Clinic Site Manager determining the patient has missed (no-showed) the scheduled appointment.

3. Late arrival for any same day appointment scheduled for 15 minutes or less will not be seen by the provider due to limited length of time and will be considered a no-show.

4. Patients will be considered a high risk no-show patient if patient misses two appointments within a 12-month period and may receive a notification from NVIH with information of future inability to reserve individual scheduled appointments time slots. Notification will inform patient the option of being seen as a stand-by or same-day patient appointment as available.

5. If after three missed appointments in a 6-month period a patient continues to miss appointments, the patient may be dismissed from the associated clinical services altogether as a direct result of being “noncompliant to treatment,” at the Clinic Provider’s discretion. A stand-by or same-day work-in option will be considered for Native American patients. **

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

6. If patient is allowed to continue after three missed appointments in a 6-month period and continues to miss future appointments, patient will be dismissed from the associated clinical services at the discretion of the Department Director. A stand-by or same-day work-in option will be considered for Native American patients. **

DEFINITIONS

New Patient: A person who has not previously been registered within the NVIH system; or, a patient who has been registered within the NVIH system but has not had an established care visit; or, a patient who has been registered within the NVIH system but has not been an active patient for at least three years.

Stand-by: Patient will be scheduled in a time slot that would be considered a double-booked space. Staff will work efficiently to seat/room the patient in a timely fashion. Patient should expect to have some delay in seeing the provider. Visit type will likely be limited in focus depending on available time (e.g.: Dental treatment may be limited to limited exam/minor treatment).

Same-day: Patient will call in the same day and be advised on availability/arrival time for a same-day work in appointment as available at associated site. Staff will work efficiently to seat/room the patient in a timely fashion but minor delays may occur.

* Native American patients will be placed on a stand-by or same day work-in option.
**Dismissal of patients will be considered, in accordance with the Patient Termination Policy.

Patient Acknowledgement:
I hereby acknowledge that I have been given the opportunity to review the Clinic Appointment Policy and receive a copy if requested.

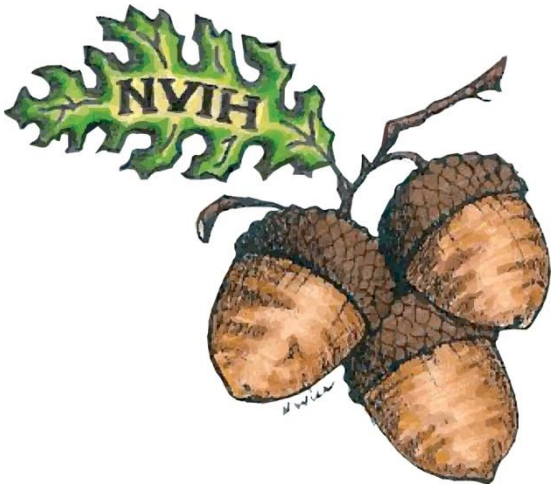
Patient Printed Name: _____Patient DOB:_____

Patient/Parent Signature:_____Date:_____

****

NVIH Use Only:
HRN: _____

Northern Valley Indian Health, Inc.



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING INFORMATION CAREFULLY.

Understanding Your Health Information

Each time you visit a Northern Valley Indian Health (NVIH) facility for services, a record of your visit is made. If you are referred by NVIH through the Purchased Referred Care (PRC) program, NVIH also keeps a record of your PRC visit. 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, and as a communication source between health care professionals.
- Tool we can use to check results and continually work to improve care.
- Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
- Tool for education of health care professionals.
- Source of information for public health authorities charged with improving health.
- Source of data for medical research, facility planning, and marketing.
- Legal document that describes your care.

Understanding what is in 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.

Your Health Information Rights

Although your health record is the physical property of NVIH, the information belongs to you. You have the following rights with respect to your health information:

To Inspect and Copy. You have the right to inspect and copy certain health information. If you request a copy of the information, we may, as permitted by applicable law, charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information you may, with limited exceptions, request that the denial be reviewed by submitting a written request to the Chief Executive Director or HIPAA Privacy Officer.

To an Electronic Copy of Electronic Records. If your health information is maintained in an electronic form, such as an electronic health record, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the form or format you request, if it is readily producible in such form or format. If it is not, then your information will be provided to you in our standard electronic format (unless you prefer a hard copy).

To Notice of Breach. You have the right to be notified if there was unauthorized access to or disclosure of your health information.

To Request a Restriction. You have the right to request a restriction on information we use or disclose about you: (1) for treatment, payment, or health care operations; or (2) to someone who is involved in your care, such as a family member or friend. NVIH is not required to agree to your request, but if we do we will comply with your request unless the information is needed to provide you with emergency services. Also, if you paid out-of-pocket in full for a specific item or service, you may ask that your health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

To Request Amendment. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as it is kept by us. To request an amendment, your request must be made in writing and submitted to the Chief Executive Director or HIPAA Privacy Officer, along with a reason that supports your request. We may deny your request for an amendment in certain limited situations. If we deny your request, you have the right to file a statement of disagreement with us.

To Request Confidential Communications. You have a right to ask to receive confidential communications in a different manner or at a different place (for example, you may ask that we communicate with you at a location other than your home or by a different means of communications such as telephone or mail). Such a request must be submitted in writing to the Chief Executive Director or HIPAA Privacy Officer.

To a List of Disclosures. You have the right to request a list and description of certain disclosures by NVIH of your health information. Such request must be made in writing. The first list you request within a 12-month period will be provided free of charge, but subsequent requests within the same period may be subject to a fee (in which case we will notify you of the cost and you may choose to withdraw or modify your request.) This information is maintained for six years or the life of the record, whichever is longer.

To Obtain a Paper Copy of the NVIH Notice of Privacy Practices one will be available upon request, even if you have agreed to receive this Notice electronically.

NVIH's Responsibilities

NVIH 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 alternate means or at alternate locations.
- Honor the terms of this Notice or any subsequent revisions of this Notice.

NVIH reserves the right to change its privacy practices and to make the new provisions effective for all health information it maintains. NVIH will post any revised Notice of Privacy Practices at public places in its health care facilities and on its web site at www.nvih.org.

How NVIH may use and disclose health information about you:

We may use and disclose your health information without your permission to facilitate your medical treatment, payment of any medical treatment, and for any other health care operation, as described in this Notice. We may also use and disclose your health information without your permission as allowed or required by applicable law. Otherwise, we must obtain your written authorization for any other use and disclosure of your health information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given. The following categories describe how we may use and disclose health information about you:

For Treatment. We will use and disclose your health information to provide medical treatment or help other providers to treat you. For example:

- Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider will document in your health record his/her instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your health record so your health care provider will know how you are responding to treatment.
- If NVIH refers you to another health care facility, NVIH may disclose your health information to that health care provider for treatment decisions.
- If you are transferred to another facility for further care and treatment, NVIH may disclose information to that facility to enable them to know the extent of treatment you have received and other information about your condition.

- Your health care provider(s) may give copies of your health information to others to assist in your treatment.

For Payment Purposes. We will use and disclose your health information for payment purposes. For example:

- If you have private insurance, Medicare, or Medicaid coverage, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
- If NVIH refers you to another health care provider, NVIH may disclose your health information with that provider for health care payment purposes.

For Health Care Operations. We will use and disclose your health information for health care operations. For example, we may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under PRC program.

Health Information Exchange (HIE) HIE services are planned in the future for NVIH and once active HIE may make your health information available electronically through an information exchange network to other providers involved in your care who requests your electronic health information. Participation in the national eHealth Exchange network is voluntary. If you want your health information to be accessible to authorized health care providers through the HIE to the national eHealth Exchange, you must authorize this use and disclosure. More information is available at http://www.ihs.gov/hie/

Personal Health Record. The ability for you to access to your Personal Health Record electronically is planned in the future**.** Personal Health Record (PHR) is a secure web based application that provides patient access to their health care information. The PHR is accessible to any patient who receives care at an NVIH and requests a PHR account.

Direct. NVIH may share your health information between healthcare providers, patients and/or patients' authorized representatives, using the DIRECT secure, web-based messaging service.

To Business Associates: NVIH provides some healthcare services and related functions through the use of contracts with business associates. For example, NVIH may have contracts for medical transcription. When these services are contracted, NVIH may disclose your health information to business associates so that they can perform their jobs. We require our business associates to protect and safeguard your health information in accordance with all applicable federal laws.

To Persons Involved in Your Care: NVIH may notify your family of your location or general condition. NVIH may also provide your health information to a person involved in your care or who helps pay for your care, such as a family member or friend, unless you notify us that you object, or when you are incapacitated or in an emergency. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. We may also make similar professional judgments about your best interests that allow another person to pick up such things as your filled prescriptions, medical supplies, and x-rays. There may also be circumstances when we can assume, based on our professional judgment, that you would not object, such as when your spouse comes with you into an exam room during treatment.

Adults and Emancipated Minors With Personal Representatives or Legal Guardians: NVIH shall treat a personal representative or legal guardian of an individual, who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction, as the individual for the purposes of the use and disclosure of the individual's health information, as such use and disclosure relates to such personal representation.

Interpreters: In order to provide you proper care and services, NVIH may use the services of an interpreter. This may require the use or disclosure of your personal health information to the interpreter.

Research: NVIH may use or disclose your health information for research purposes that has been approved by an NVIH Institutional Review Board that has reviewed the research proposal and established protocols to ensure

the privacy of your health information. NVIH may also use or disclose your health information for research purposes based on your written authorization.

Uses and Disclosures about Decedents: When an individual is deceased, NVIH may disclose health information about the decedent when required by applicable law, and to the following categories of individuals:

- A family member, personal representative, or other authorized person(s) responsible for the decedent's care, as relevant to his or her responsibility for such care, unless we know that doing so would be inconsistent with the decedent's prior-expressed preferences.
- A coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- Funeral directors consistent with applicable law as necessary to carry out their duties.

Organ Procurement Organizations: Consistent with applicable laws, NVIH may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of facilitating organ, eye, or tissue donation and transplant.

Appointment Reminders, Treatment Alternatives and Other Health-related Benefits and Services: We may contact you to remind you that you have an appointment with us or to discuss a missed appointment, and to provide information about treatment alternatives or other types of health-related benefits and services that may be of interest to you. For example, we may contact you about the availability of new treatment or services for diabetes.

Food and Drug Administration (FDA): NVIH may use or disclose your health information to the FDA in connection with an FDA-regulated product or activity. For example, we may disclose to the FDA information concerning adverse events involving food, dietary supplements, product defects or problems, and information needed to track FDA-regulated products, or to conduct product recalls, repairs, replacements, or lookbacks (including locating people who have received products that have been recalled or withdrawn), or post marketing surveillance.

Worker's Compensation: NVIH may use or disclose your health information for workers compensation purposes as authorized or required by applicable law.

Public Health: NVIH may use or disclose your health information for public health activities as follows:

- To a public health authority authorized by applicable 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.
- To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect.
- To a government authority authorized by applicable law to receive reports of other abuse, neglect, or domestic violence (other than child abuse).
- To an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, where authorized by applicable law.
- To the individual's employer (for example, if you are employed by NVIH, or if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public), concerning a work-related illness or injury or a workplace-related medical surveillance, or as otherwise required or permitted by applicable law.
- To the individual's school or prospective school for proof of immunization, if such proof is required by applicable law, and we obtain the agreement of either a parent, guardian, or other person legally responsible for the individual (or from the individual if he or she is an adult or emancipated minor).

Correctional Institution: If you are an inmate of a correctional institution, NVIH may use or disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement: NVIH may use or disclose your health information for law enforcement activities as required or authorized by applicable law. Such situations include the following:

- To report certain types of wounds or injuries.
- In response to a court order, subpoena, warrant, or other similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- If you are believed to be a victim of a crime and a law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency and if we determine that such disclosure would be in your best interests.
- About a death we believe may have been the result of criminal conduct.
- To report a crime committed on NVIH premises.
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description, or location of the person who committed the crime.

Military and Veterans: If you are a member of the armed forces, NVIH may use or disclose your health information, if necessary, to the appropriate military command authorities or to determine eligibility for benefits, as authorized by applicable law.

Health Oversight Authorities: NVIH may use or disclose your health information to health oversight agencies for activities authorized by applicable law. These oversight activities include: investigations, audits, inspections, and other actions. These are necessary for the government to monitor the health care system and government benefit programs, among other requirements. NVIH is required by applicable law to disclose health information to the Secretary of HHS to investigate or determine compliance with the HIPAA privacy standards.

Compelling Circumstances: NVIH may use or disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances:

- We may disclose health information we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person.
- We may use or disclose health information in the course of judiciary and administrative proceedings if required or authorized by applicable law.
- We may use or disclose health information during a disaster and for disaster relief purposes.
- We may release health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by applicable law.
- We may make any other disclosures that are required by applicable law.

For Data Breach Notification Purposes. We may use or disclose your health information to provide legally-required notices of unauthorized access to or disclosure of your health information.

Authorization Required. NVIH will use or disclose your health information only with your written authorization in the following circumstances:

- Any use or disclosure of your psychotherapy notes; except that we do not need your written authorization to use such notes for treatment, payment, or health care operations, nor in other limited circumstances required or permitted by applicable law.
- Any use or disclosure of your health information for marketing; except that we do not need your written authorization for face-to-face communications or to give you promotional gifts with nominal value.
- The sale of your health information.

Non-Violation of this Notice: NVIH 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:

- *Disclosures by Whistleblowers*: If an NVIH employee or contractor (business associate) in good faith believes that NVIH has engaged in conduct that is unlawful or otherwise violates clinical and professional

standards, or that the care or services provided by NVIH has the potential of endangering one or more patients, members of the workplace, or the public, and discloses such information to:
  - A Public Health Authority or Health Oversight Authority authorized by applicable law to investigate or otherwise oversee the relevant conduct, conditions, or suspected violations, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by NVIH; or
  - An attorney on behalf of the workforce member, or contractor (business associate), or hired by the workforce member or contractor (business associate) for the purpose of determining their legal options regarding the suspected violation.
- *Disclosure by Workforce Member Crime Victims:* Under certain circumstances, a NVIH workforce member (either an employee or contractor) who is a victim of a crime, on or off the NVIH premises, may disclose information about the suspect to law enforcement official provided that the information disclosed is about the suspect who committed the criminal act and the information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures not described in this Notice will be made only with your written authorization, which you may later revoke in writing at any time. To revoke your authorization, deliver a written revocation to the Chief Executive Director or HIPAA Privacy Officer. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent we have already used or disclosed your health information in reliance on your authorization, or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

To exercise your rights under this Notice, to ask for more information, or to report a problem contact the Chief Executive Director or HIPAA Privacy Officer at:

Chico W. East Ave
(530) 896-9400

Children's Health Center
(530)781-1440

Dental and Maternal Health Center
(530) 433-2500

Willows
(530) 934-4641

Red Bluff
(530) 529-2567

Woodland
(530) 661-4400

Woodland-Gibson
(530)650-4500

If you believe your privacy rights have been violated, you may file a written complaint with the above individual(s) 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.

Effective Date: [September 2013, January 27, 2014]

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Acknowledgement of Receipt of NVIH Notice of Privacy Practices

I hearby acknowledge receipt of Northern Valley Indian Health (NVIH) Notice of Privacy Practice Information.

___I, The Patient/Legally Authorized person am able to communicate effectively in English.

_____ _____ _____

Signature of Patient DOB Date

_____ _____

Signature of Patient Representative Date
(State relationship to patient)

For Patients unable to Acknowledge Receipt or Refuses NVIH Notice of Privacy Practices

I hereby certify that the patient was unable to acknowledge receipt of the NVIH Notice of Privacy Practices because:

_____ _____

Signature and Title of NVIH Employee Date

_____ _____

Signature of NVIH Employee (Witness)

Patient Name _____ Acct# _____

Date of Birth: _____