`

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

PATIENT REGISTRATION

PATIENT INFORMATION:	
Last Name: First Name: Middle Initial:	
Patient's Previous Name:	
Patient's Preferred Name:	
Patient's Home Phone: Cell Phone:	
Mailing Address: ____ City: __________________ State: ________ Zip: _________ County:	Physical Address (If different than mailing address): ____ City: __________________ State: ________ Zip: _________ County:
Email:	☐ Check if Homeless
Would you like to be Web enabled for the patient portal? *If yes, we will use your email above unless otherwise indicated.* ☐ Yes or ☐ No	
How would you like us to notify you for appointment reminders? PLEASE SELECT AT LEAST ONE OPTION: ☐ 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	
Is the patient 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 Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated	
Preferred Language: Interpretation Services Requested: Yes / No	
Patient's Race: ☐ American Indian ☐ Black or African American ☐ Declined to Specify ☐White or : ______________________________ (Please fill in blank)	
Patient's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic ☐ Declined to Specify or: ______________________________ (Please fill in blank)	
Are you Native American: ☐ Yes or ☐ No	Tribe of Membership:

(NVIH Use Only) Patient Name:____**HRN:**___________________

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR OR DEPENDENT ADULT:

Name: Circle One: Father / Mother / Other Phone:

Name: Circle One: Father / Mother / Other Phone:

Guardian's Name: Phone:

PATIENT EMERGENCY CONTACT INFORMATION:

Relationship to patient: ____

First Name: ________________________ Last Name: ________________________ MI: __________

Address: ____

City: ____________________________ State: __________________ Zip: ___________________

Home Phone: ______________________________ Work Phone: ____________________ EXT: ___________

Cell Phone:

PATIENT EMPLOYER INFORMATION:

Employer name: ____

Employer Address: ____

City: State: Zip:

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: Group No:

Policy Holder Name: ☐ SELF Policy Holder's DOB:

Medicaid ID No:

#2 Secondary Insurance:

Policy Holder's Name: ☐SELF Policy Holder's DOB:

Group No:

#3 (Tertiary)- Third Policy:

GUARANTOR/ PERSON RESPONSIBLE FOR PAYMENT

☐ SELF ☐ Another patient or person *if so complete this portion. If not, mark SELF.*

Name: ____ DOB: ______________________________

Address: ____

Phone: ____ Work: ____

Relationship to Patient:

(NVIH Use Only) Patient Name:____**HRN:**____________________

TERMS AND CONDITIONS OF SERVICE
CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

1. NVIH: Northern Valley Indian Health, Inc. (NVIH) is a non-profit 501(c)(3) tribal organization and Tribal Federally Qualified Health Center (FQHC) system with federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. 25 U.S.C. 5301 et seq.

2. CONSENT FOR TREATMENT: I wish to receive health care services at NVIH. I consent to the medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment related photographs, videotaping, laboratory procedures, dental services, clinical services, behavioral health services, care and case management services or other services rendered to me under the general and special instructions of the provider or other health care professionals assisting in my care. I am aware that the practice of medicine, surgery, and therapy is not an exact science. I acknowledge that NVIH has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my provider or other health care professionals any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

3. TEACHING ACTIVITIES: I understand that residents, interns, medical students, associate behavioral health clinicians, students of ancillary health care professions (e.g., nursing, social work), post-graduate fellows, and other learners and trainees may observe, examine, treat, and participate in my care at NVIH under the supervision of the attending health care professional as part of an approved external education/training program. .

4. CONSENT FOR COMMUNICATIONS: I understand that I may receive messages and calls from or on behalf of NVIH, at the contact information provided, including my cell phone number and email address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I understand that if I email or text NVIH providers and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods as unencrypted messages could be intercepted. I acknowledge that all such communications may become part of my medical records.

5. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT: In consideration of the health care services provided, I the undersigned, whether signing as a patient or legal guardian, irrevocably (without the right to revoke) and expressly assigns and transfers to NVIH all insurance benefits including government programs, private insurance, and any other health plan otherwise payable to or on my behalf for NVIH services. I hereby authorize the release of all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection

bear interest at the current legal rate.

6. TELEHEALTH CONSENT: Telehealth visits involve the use of telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering services. I understand that during my care at NVIH, I may be offered a telehealth visit if clinically appropriate. These services may include consultation, diagnosis, treatment recommendation, prescriptions, and/or referral to in-person care if further evaluation is needed. This service is offered to me as a convenience. I understand that I always maintain the option of choosing an in- person appointment if I prefer. If I am experiencing difficulty in accessing in person services due to transportation, Medi-Cal provides coverage to beneficiaries for transportation services to in-person services when other resources have been reasonably exhausted. I understand that not all services will be clinically appropriate to complete via a telehealth visit and the option may be limited as determined by my provider. Should I agree to a telehealth visit, I consent to have my insurance billed for the services and will pay any relevant copays, coinsurances or for services not covered by insurance. I understand that during the telehealth visit, sensitive personal health information may be discussed, and it will be my responsibility to locate myself in a location that ensures privacy. I will also be expected to participate in a location that will not cause danger to myself or those around me (such as while driving). If my provider is concerned about my safety, they may terminate the visit. Telehealth visits are not appropriate for medical emergencies. If I believe I am having an emergency, I will call 911 and/or go to my nearest emergency room.

7. BEHAVIOR: NVIH has a zero tolerance for abuse, intimidation, harassment, or violence in our facilities. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. NVIH is committed to maintaining a safe workplace that is free from threats and acts that are disrespectful, discriminatory, hostile, or harassing. It is the expectation of NVIH that you and your visitors conduct yourselves in a respectful, non-violent, non-discriminatory, and non-abusive manner. I understand that any violation of NVIH's patient rights and responsibilities with unwelcome words or actions may lead to removal from NVIH premises and immediate termination as a patient of NVIH.
   I also understand that under California law I and my visitors cannot film, record, or disclose any images or sounds of our/my conversation with a NVIH employee or provider without the written consent of NVIH and all parties to the conversation, and that violation of this law may result in criminal and/or civil liability, and immediate removal/termination as a patient of NVIH.

8. AUDIO/VIDEO RECORDING CONSENT: I hereby consent to the use and transcription of audio and video recordings by NVIH and its providers and staff for treatment and service purposes. I understand that NVIH uses recording technology to capture and record my visits and other communications with NVIH and its providers and staff for treatment and services. I understand that NVIH uses third-party vendor(s) to process the recordings to generate clinical documentation and related activities. I expressly consent to NVIH and its third-party vendor(s) to audio or video record my visits, transcribe and document my treatment and services, and permanently destroy the recordings. I understand that any use of my medical information will be in accordance with applicable law, including all applicable laws and regulations governing patient confidentiality, in the manner outlined in the NVIH Notice of Privacy Practices. I understand that I may request cessation

of recordings at any time by written request to NVIH. I understand that my withdrawal of consent will not affect recordings made prior to receipt of the written request to stop recording.

9. RELEASE OF MEDICAL INFORMATION: I understand that my medical information, photographs, and/or video in any form may be used for other NVIH purposes, such as quality improvement, patient safety and education. NVIH will obtain my written authorization to release information about my medical treatment, except in those circumstances when NVIH is permitted or required by law to release information (see NVIH Notice of Privacy Practices for a description of the specific circumstances under which NVIH may release this information). I understand that any use of my medical information will be in accordance with applicable state and federal law, including all applicable laws and regulations governing patient confidentiality, in the manner outlined in the NVIH Notice of Privacy Practices. I understand that NVIH providers are mandated to report to the appropriate authorities, as required by State and/or Federal laws, when (1) my provider believes I may hurt myself or someone else, (2) my provider suspects child, dependent adult, or elder abuse, (3) or by a specific order of the Courts.

10. NOTICE OF PRIVACY PRACTICES: I have received and reviewed a copy of the Notice of Privacy Practices of NVIH which is also available at https://nvih.org. I understand that NVIH reserves the right to change its practices and the terms of this Notice of Privacy Practices for all medical information that NVIH maintains. NVIH will make available the revised Notice of Privacy Practices by posting it in all patient registration areas, where copies will also be available. The revised Notice of Privacy Practices will also be posted on our website at https://nvih.org.

Signature of Agreement: I have read this Terms and Conditions of Service agreement. On my own behalf, or on behalf of the patient, I accept and agree to be bound by all of the terms in this agreement until I revoke my agreement, consent, or authorization in writing to NVIH.

______________________________	____________	__________ ☐ AM ☐ PM
Signature of Patient or Patient Representative	Date	Time

____
Relationship of Representative to Patient

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Assignment of Benefits and Financial Agreement (Paragraph 5) set forth above.

______________________________	____________	__________ ☐ AM ☐ PM
Signature of Financially Responsible Party	Date	Time

____
Print Name of Financially Responsible Party

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

CONSENT TO TREATMENT FOR BEHAVIORAL HEALTH SERVICES

I, the undersign, hereby consent to behavioral health services at Northern Valley Indian Health.

I understand that any proposed treatment will be explained to me by my provider, including the anticipated risks, benefits, and reasonable alternatives to the services offered. My signature below indicates that I understand the nature of services, risks involved, and alternatives to treatment and that I wish to obtain behavioral health services from Northern Valley Indian Health. I have had the opportunity to ask questions and have received answers to my satisfaction. I understand that I have the right to ask questions about the services and treatment at any time.

I acknowledge that no guarantee or assurance has been, nor can be, made by Northern Valley Indian Health and its professional providers, staff, and associates as to the result of the prescribed treatment or the risks and complications that I may sustain.

I understand that Northern Valley Indian Health provides clinical experiences for a variety of behavioral health associates. I understand that these individuals, who are under the direction of the supervising clinician may provide treatment to me. I understand that I may ask questions about the qualifications of staff at any time.

I understand that my treatment records are confidential and may be disclosed only as outlined in the Notice of Privacy Practices. I understand Northern Valley Indian Health providers are mandated to report to the appropriate authorities, as required by state and/or federal laws, when (1) my provider believes that I may hurt myself or someone else, (2) my provider suspects child, dependent adult, or elder abuse, (3) or by a specific order of the courts.

I have read this consent, received a copy, and accept its conditions. I also understand that I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician or directly to the NVIH Behavioral Health Department. I understand that my revocation of treatment will not be valid to the extent Northern Valley Indian Health has already used or allowed for the consent of care in reliance upon this consent.

By signing below, I agree that I have read and understand the information described above, and I voluntarily give my consent to Northern Valley Indian Health and its professional providers, staff, and associates, to render behavioral health services necessary, appropriate, and beneficial to me, or my minor child or ward. I have had the informed consent discussion with my provider and I accept the risks, if any, which may be associated with any phase of the therapeutic process, in hopes of accomplishing treatment goals, which may or may not be achieved.

Patient Name: _____________________ Patient Signature: _________________________ Date: ______
Parent / Legal Guardian Name (Minor Patients - Only): ____________________________
Patient / Legal Guardian Signature (Minor Patients – Only): ________________________ Date: ______

Practitioner Attestation: I attest that the risks, benefits, consequences, and alternatives of Behavioral Health Services have been discussed with the patient who has had the opportunity to ask questions, and I believe that the patient understands what has been explained.

Provider Name: ____________________ Provider Signature: _______________________ Date: ______
Patient DOB: _____________________ Patient HRN#: _________________________

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

ENGLISH

BBS COMPLAINT NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors).

You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

SPANISH

BBS AVISO DE QUEJAS

La Junta de Ciencias del Comportamiento (BBS por sus siglas en Ingles) recibe y responde a las quejas sobre los servicios prestados dentro del alcance de la práctica de (terapeutas matrimoniales y familiares, psicólogos educativos con licencia, trabajadores sociales clínicos o consejeros clínicos profesionales).

Puede comunicarse con la junta en línea en www.bbs.ca.gov o llamando al (916) 574-7830.

Date ______________________________

PATIENT/PARENT/PERSONAL REPRESENTATIVE SIGNATURE

FOR NVIH USE ONLY:

____

PATIENT NAME DOB HRN

NORTHERN VALLEY INDIAN HEALTH
BEHAVIORAL HEALTH – Adult Patient Intake Questionnaire

Name:	Date:
Parent/Legal Guardian (if under 18):	
Referred By (if any):	

PRESENTING CONCERNS:

What brings you to therapy (briefly describe)?

During the past year, what kind of stressors have you had?

Approximately, how long has this concern been bothering you?
☐ Day ☐ Week ☐ Month ☐ Several months ☐ Year ☐ Several years ☐ Most of my life

Approximately, how many therapy sessions do you think you will need?
☐ 1-3 sessions ☐ 4-6 sessions ☐ 7-9 sessions ☐ 10+ sessions

BEHAVIORAL HEALTH HISTORY:

Have you received counseling or therapy in the past? ☐ Yes ☐ No

Please provide previous therapist(s)/treatment facility(s):

Have you ever been diagnosed with a Mental Health condition? ☐ Yes ☐ No
If yes, describe:

Have you ever been prescribed psychiatric medications? ☐ Yes ☐ No
If yes, please list:

Has anyone in your family been diagnosed with a mental health condition? ☐ Yes ☐ No
If yes, please provide relationship and diagnosis:

Have you ever injured yourself without suicidal intent? (e.g., cutting, hitting, burning, etc.): ☐ Yes ☐ No
If yes, please explain:

Have you ever made a suicide attempt? ☐ Yes ☐ No
If yes, please describe when and the nature of the attempt:

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If yes, please provider additional information including dates and location:

SUBSTANCE USE HISTORY:			
Have you ever used alcohol or drugs? ☐ No ☐ Yes			
Check all the substances that you have used in the last 12 months:			
	Frequency		Frequency
☐ Alcohol		☐ Methamphetamine	
☐ Caffeine (coffee, energy drinks, soda, etc.)		☐ Cocaine/Crack	
☐ Designer Drugs (GHB, PCP, ecstasy)		☐ Inhalants (paint, gas, aerosols)	
☐ Marijuana		☐ Opiates (heroin, opium, methadone)	
☐ Hallucinogens (LSD, mushrooms, peyote)		☐ Tobacco products (cigarettes, vaping, chewing)	
☐ Pain Medications (Oxy, Norco, Vicodin)		☐ Fentanyl	
☐ Over the Counter (Benadryl, Nyquil, etc.)		☐ Other (list)	

Have you ever received treatment for a Substance Use Disorder? ☐ Yes ☐ No
If yes, please provide additional information:
☐ Detox ☐ Residential/inpatient ☐ Intensive Outpatient ☐ Outpatient ☐ Medication Assisted Treatment (MAT)
Detail (dates/location):

MEDICAL HISTORY:		
Check all that apply:		
☐ None	☐ Heart Attack	☐ Osteoporosis
☐ Anemia	☐ Heart Arrhythmia	☐ Pregnant (provide due date)
☐ Arthritis	☐ Hepatitis	☐ Stroke
☐ Asthma	☐ High Cholesterol	☐ Thyroid Problems
☐ Cancer	☐ HIV	☐ Traumatic Brain Injury
☐ Chronic Pain	☐ High Blood Pressure	☐ Tuberculosis
☐ COPD/emphysema	☐ Thyroid Disease	☐ Other (Please list)
☐ Diabetes	☐ Kidney Disease	
☐ Digestive Problems	☐ Liver Disease	
☐ Epilepsy	☐ Overweight/Underweight	

MEDICATIONS (Including non-psychiatric medications)		
Medication Name	Current	Comments (Reason prescribed, response. etc.)
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

ALLERGIES

☐ No Reported Drug or Food Allergies ☐Other/Describe:

Additional History/Comments: (Diagnosis, hospitalizations, surgeries, status of conditions, injuries, developmental history, etc.)

PSYCHOSOCIAL FACTORS (Family, social and life circumstances, and cultural considerations)

Cultural Considerations: (Cultural factors, LGBTQ+ and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality/religious beliefs, cultural practices)

1. How would you identify your sexual orientation?

2. How would you identify your gender identity?

3. What are your preferred pronouns?

4. What are your spiritual or religious beliefs?

5. How would you describe your race and ethnicity?

6. Have you faced any challenges due to your race or ethnicity? If so, please describe.

7. What is your primary language? Are there other languages spoken in the home?

8. Are there any specific practices that you would like to incorporate into your care?

9. Please provide any additional information you would like to share.

Education/Employment Status:

1. Highest level of education:

☐ Did not complete High School ☐ High School Diploma or equivalent ☐ Technical or Occupational Certificate

☐ Some college ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

2. Special Education Services received: ☐ 504 ☐ Individualized Education Plan
3. Difficulties with reading or writing: ☐ Yes ☐ No
4. Assistive devices utilized or required: ☐ Yes ☐ No
5. Military Veteran: ☐ Yes ☐ No If yes, please provide branch and service dates:
6. Employment status: ☐ Unemployed ☐ Employed (full-time) ☐ Employed (part-time) ☐ Other
7. Occupation:

Family Status:

1. Who is in your family? (Parents, caregivers, siblings, partner, children, etc.)

2. What is your current living situation?

3. Significant life events within family? (e.g., loss, divorce, births)

4. Marital Status: Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed ☐

Legal Issues:

☐ None ☐ Probation ☐ Parole ☐ Charges Pending ☐ Court Mandated Treatment

Previous charges or convictions: ☐ Yes ☐ No Detail (dates/location):

Previous incarceration: ☐ Yes ☐ No Detail (dates/location):

Social Status:

1. Who do you consider to be in your support system? (Friends, colleagues, family members, etc.)

2. Please share your hobbies, interests, and daily activities:

3. Are you connected to or affiliated with any community organizations?

STRENGTHS
What do you consider your strengths? What would you like to accomplish out of your time in therapy?

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 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 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. **

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. **

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Clinic Appointment Policy

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: ________________________________

Notice of Privacy Practices

YOUR INFORMATION.
YOUR RIGHTS.
OUR RESPONSIBILITIES.

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

www.nvih.org

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.**

YOUR RIGHTS

See "Your Health Information Rights" on page 4 for more details.

You have the right to:

- Inspect and copy certain health information
- An electronic copy of electronic records
- A notice of breach
- Request a restriction on how your information is used or disclosed
- Request an amendment
- Request confidential communications
- A list of disclosures
- Obtain a paper copy of the NVIH Notice of Privacy Practices
- Choose someone to act on your behalf
- File a complaint if you feel your rights are violated

OUR RESPONSIBILITIES

See "NVIH's Responsibilities" on page 5 for more details.

NVIH is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests for alternate communications
- Honor the terms of this notice or any subsequent revision

OUR USES AND DISCLOSURES

See "How NVIH May Use and Disclose Health Information About You" on page 6 for more details.

We may use and share your information:

- For your treatment
- For payment purposes
- For health care operations
- With NVIH's Business Associates
- With your personal representative or legal guardian
- For interpretation services
- To respond to organ procurement requests
- For appointment reminders and other health-related benefits and services
- For worker's compensation purposes
- To assist with public health activities
- To comply with law enforcement activities
- For activities conducted by health oversight agencies
- For data breach notification that is legally-required
- For other activities, per your authorization

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 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 HIPAA Privacy Officer.

Electronic Records if your health information is maintained in an electronic form. We will make every effort to provide access to your health information in the form or format you request.

Notice of Breach if there was unauthorized access to or disclosure of your health information.

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.

Request Amendment if you feel that the health information we have about you is incorrect or incomplete. 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.

Request 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).

A List of Disclosures made by NVIH of your health information. 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.

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

Choose Someone to Act for You if you have given someone medical power of attorney or if someone is your legal guardian. We will make sure the person has the authority to exercise your rights and make choices about your health information before we take any action.

File a Complaint if You Feel Your Rights are Violated. You can complain if you feel we have violated your rights by contacting us using the information on the last page of this booklet. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

NVIH'S RESPONSIBILITIES

NVIH is required by law to:

- Maintain the privacy of your health information.
- Inform you about our legal duties and privacy practices with respect to protected health information
- 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 medical treatment, other health care operations, and as allowed or required by applicable law. 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.

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.

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. .

Health Information Exchange (HIE) NVIH may participate in HIE services. You can authorize NVIH to make your health information available electronically through an information exchange network to other providers involved in your care who request your health information. More information is available at http://www.ihs.gov/hie/

Personal Health Record. NVIH offers the ability for you to access to your Personal Health Record (PHR) electronically through the Patient Portal. PHR is a secure web based application that provides patient access to their health care information.

Direct. NVIH may share your health information, as allowed, using the Provider-to-Provider communication network.

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.

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.

Medical Transcription: To improve clinical documentation, you may authorize NVIH to record audio and other data during your healthcare encounter. Information is transcribed, stored in your patient record, and referenced for your treatment.

Research: NVIH may use or disclose your health information for research purposes 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 for appointment reminders, to discuss a missed appointment, and to provide information about treatment alternatives or other health-related benefits and services that may interest you.

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, 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 to a public health authority or other government authority authorized for public health activities as follows:

- To prevent or control disease, injury, or disability, or conduct public health surveillance, investigations, and interventions.
- For reporting of child abuse or neglect.
- For reporting 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, 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 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 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 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 HIPAA Privacy Officer at:

HIPAA Privacy Officer
257 N Butte Street
Willows, CA 95988
(530) 330-8800

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: February 1, 2024

EIGHT LOCATIONS TO SERVE YOU

• MEDICAL • BEHAVIORAL HEALTH • DENTAL

CHICO

Chico – Cohasset Road • • •

DENTAL AND WOMEN'S HEALTH CENTER

500 Cohasset Road, Suite 15 | (530) 433-2500

Chico – Concord Ave • •

1990 Concord Ave. | (530) 809-3300

Chico – East Ave • • •

845 W. East Ave. | (530) 896-9400

Chico – Springfield Drive • •

CHILDREN'S HEALTH CENTER

1515 Springfield Drive #175 | (530) 781-1440

Mobile Dental Clinic •

(530) 520-6913

RED BLUFF

Red Bluff •

2500 N. Main St. | (530) 529-2567

WILLOWS

Willows • • •

207 N. Butte St. | (530) 934-4641

WOODLAND

Woodland – Court Street • •

175 W. Court St. | (530) 661-4400

Woodland – Gibson Road • •

1280 E. Gibson Rd. | (530) 650-4500

This guide is provided by Northern Valley Indian Health, Inc.

Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

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