Clinton Service Unit New Patient Registration Application

Please complete one Clinton Service Unit New Patient Application for each new patient.
Present this completed form along with original eligibility documents in order to establish a new record.

Section A Patient Demographic Information

Last (Legal) ______ First (Legal) ______ Middle ______ Date of Birth ______

Sex ______ Social Security No. ______ Religious Preference ______

Place of Birth (City/State) ______ Tribal Affiliation ______ Degree (Full, 1/2, etc.) ______

Address (PO Box or Street Address) ______ City ______ State ______ Zip ______

How long have you lived at this address? ______

Primary Phone Number ______ Work Phone Number ______ Alternate Phone Number ______

Section B Employement Information

Are you currently employment? Yes No

Are you a student? Yes No

Are you retired? Yes No Retirement Date: ______

Employer Name ______ Address ______ City ______ State ______ Zip ______

Section C Language and Martial Status

Do you have an Advance Directive or Medical Living Will? (Circle one) Yes No

Primary Language? ______ Do you require an interpreter? Yes No

Ethnicity? ______

Martial Status? (Circle one) Single Married Divorced Widow Other______

Migrant work? Yes No Homeless? Yes No

Section D Parental Information

Mother's Maiden Name: Last, First, Middle ______ Place of Birth (City/State) ______

Father's Name: Last, First Middle ______ Place of Birth (City/State) ______

Section E Third Party Resources

Please indicate if you have the following:

Medicaid ______

Medicare ______ Medicare ID No.: ______

Private Insurance ______ Insurer: ______

Policy No.: ______

Tricare ______ Tricare ID No.: ______

None ______

Section F Veteran Status

Have you ever served in the Military? Yes No

Branch: ____________________ Service Connected? Yes No

Entrance Date: ____________________ Vietnam Service Indicated? Yes No

Separation Date: ____________________ Claim Number: ____________________

Section G Emergency Contact Information

Last First Middle Relationship

Address (PO Box or Street Address) City State Zip

Phone Number Work Phone Number

Section H Next-of-Kin Information

If the Patient is a Minor (17 years and younger), the next-of-kin **must** be a parent or legal guardian. All legal guardians **must** have legal documentation on file.

Last First Middle Relationship

Address (PO Box or Street Address) City State Zip

Phone Number Work Phone Number

Section I Signature

I certify that the information provided on this form is true to the best of my knowledge.

Print Patient's Legal Name

Signature of Patient/Parent/Legal Guardian/Representative Date

CSU Staff Only

Please indicate which of the following have been obtained.

- ________ Certificate of Indian Blood (CDIB)
- ________ Picture Identification Card
- ________ Social Security Number
- ________ State Birth Certificate
- ________ Immunization Records (Out of State)
- ________ Legal Documents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

ACKNOWLEDGEMENT OF RECEIPT OF IHS NOTICE OF PRIVACY PRACTICES

Form Approved:
OMB No. 0917-0030
Expiration Date:
December 31, 2026
See OMB Statement Below

By signing this form, you acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by logging onto https://www.ihs.gov/sites/hipaa/themes/responsive2017/display_objects/documents/NoticePrivacyPracticePamphlet.pdf or by contacting the IHS Privacy Officer at (240) 479-8521.

If you have any questions about our Notice of Privacy Practices, please contact the IHS Privacy Officer at (240) 479-8521.

NAME OF PATIENT

SIGNATURE OF PATIENT	DATE *(mm/dd/yyyy)*

IF PATIENT IS UNABLE TO SIGN:

NAME OF LEGAL REPRESENTATIVE AND STATE RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT REPRESENTATIVE	DATE *(mm/dd/yyyy)*
SIGNATURE AND TITLE OF CSU STAFF	DATE *(mm/dd/yyyy)*

STAFF ONLY: FOR PATIENTS UNABLE TO ACKNOWLEDGE RECEIPT

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

SIGNATURE OF IHS STAFF	DATE *(mm/dd/yyyy)*

IHS STAFF USE ONLY:

HEALTH RECORD NUMBER	D.O.B. *(mm/dd/yyyy)*

OMB STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

INDIAN HEALTH SERVICE
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 IT CAREFULLY."

SUMMARY OF YOUR PRIVACY RIGHTS

A. Understand Your Medical Record/Information. Each time you visit an Indian Health Service (IHS) facility for services, a record of your visit is made. If you are referred by the IHS through the Purchased/Referred Care (PRC) program, the IHS 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 medical record, serves as a:
1) Plan for your care and treatment.
2) Communication source between health care professionals.
3) Tool with which we can check results and continually work to improve the care we provide.
4) Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
5) Tool for education of health care professionals.
6) Source of information for public health authorities charged with improving the health of the people.
7) Source of data for medical research, facility planning, and marketing.
8) Legal document that describes the care you receive.

B. Understanding what is in your medical record and how the information is used helps you to:
1) Ensure its accuracy.
2) Better understand why others may review your health information.
3) Make an informed decision when authorizing disclosures.

C. Your Medical Record/Information Rights. Your medical record is the physical property of the IHS, but the information belongs to you. You have the right to:
1) Inspect and receive a paper or electronic copy of your health information.
2) Receive notification of a breach of your unsecured protected health information.
3) Request a restriction on certain uses and disclosures of your health information to include certain disclosures of protected health information to your health plan. The IHS is not required to agree to the requested restriction except when the disclosure would be for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI relates solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.
4) Request a correction or amendment to your health information. The IHS may amend your record or include your Statement of Disagreement.
5) Request confidential communications about your health information.
6) Request and obtain a listing of certain disclosures the IHS has made of your health information.
7) Revoke your written authorization to use or disclose health information.
8) Request and obtain a paper or electronic copy of the IHS Notice of Privacy Practices
9) Request and obtain a paper or electronic copy of the patient's medical record from the IHS Medical, Health and Billing Records, System Notice Number 09-17-0001.

D. Indian Health Service Responsibilities. The IHS understands that health information about you is personal and is committed to protecting your health information. The IHS is required by law to:
1) Maintain the privacy of your health information.
2) Inform you about our privacy practices regarding health information we collect and maintain about you.
3) Notify you if we do not agree to a requested restriction.
4) Notify you of our decision regarding a request for correction or amendment.
5) Accommodate reasonable requests you may have to communicate health information by alternate means or to an alternate location.
6) Promptly notify you of a breach of unsecured protected health information (PHI).
7) Honor the terms of this Notice or any subsequent revisions of this Notice.

REVISED NOTICE OF PRIVACY PRACTICES

The Indian Health Service (IHS) reserves the right to change its privacy practices and to make the new provisions effective for all PHI it maintains. The IHS will post any revised Notice of Privacy Practices at public places within its facilities and on the IHS web site at:: http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm

1) How the IHS may use and disclose health information about you. The IHS will not use or disclose your health information without your permission, except as described in this Notice and as permitted by the HHS Privacy Act regulations, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, Genetic Information Nondiscrimination Act (GINA) of 2008, and the IHS Medical, Health, and Billing Records, System Notice 09 17 0001. The following categories describe how we may use and/or disclose your health information.

A. Treatment. We will use and/or disclose your health information to provide your treatment. For example:
1) Your personal information will be recorded in your medical record and used to determine the course of treatment for you. Your health care provider will document in your medical record their 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 medical record so your health care provider will know how you are responding to treatment.
2) If you are referred or transferred to another facility or provider for further care and treatment, the IHS may disclose information to that facility or provider to enable them to know the extent of treatment you have received and other information about your condition.
3) Your health care provider(s) may give copies of your health information to others, including health care professionals or personal representatives, to assist in your treatment.

B. Payment Purposes. We will use and disclose your health information for payment purposes. For example:
1) If you have private insurance, Medicare, or Medicaid, 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.
2) If you are referred to another health care provider under the Purchased/Referred Care (PRC) program, the IHS may disclose your health information to that provider for health care payment purposes.

C. Health Care Operations. We will use and disclose your health information for health care operations. For example:
1) 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.

D. Health Information Exchange (HIE). The IHS HIE may make your health information available electronically through an information exchange network to other providers involved in your care who request 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 IHS HIE to the national eHealth Exchange, you must authorize this use and disclosure. More information is available at http://www.ihs.gov/hie/

E. Personal Health Record. The 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 IHS facility and requests a PHR account.

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

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

H. Directory. If you are admitted to an IHS inpatient facility, the IHS may use your name, general condition, and location within our facility, for facility directory purposes, unless you notify us that you object to this information being listed. If an individual asks for you by name, the IHS may disclose your name, general condition, and location within our facility, unless you notify us that you object to this information being listed. The IHS may provide your religious affiliation only to members of the clergy.

I. Notification. The IHS may use or disclose your health information to notify or assist in the notification of a family member, personal representative, or other authorized person(s) responsible for your care, unless you notify us that you object.

J. Communication with Family. All IHS health providers may use or disclose your health information to others involved with and/or responsible for your care unless you object. For example, the IHS may provide your family members, other relatives, close personal friends, or any other person you identify, with health information that is relevant to that person's involvement with your care or payment for such care.

K. Adults and Emancipated Minors with Personal Representatives. The IHS may disclose health information to a personal representative of an individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction.

HIPAA
Health Insurance Portability and Accountability Act

PRIVACY RULE

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

INDIAN HEALTH SERVICE

DIVISION OF REGULATORY AFFAIRS

NOTICE OF PRIVACY PRACTICES

SUMMARY OF YOUR PRIVACY RIGHTS

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

M. Research. The IHS may use or disclose your health information for research purposes when approved by an IHS Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The IHS may also use or disclose your health information for non-IRB approved research purposes based on your written authorization.

N. Organ Procurement Organizations. The IHS 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.

O. Uses and Disclosures about Decedents. The IHS may use or disclose health information about decedents to 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. The IHS also may disclose health information to funeral directors consistent with applicable law as necessary to carry out their duties. In addition, the IHS may disclose health information about decedents where required under the Freedom of Information Act or otherwise required by law.

P. Treatment Alternatives and Other Health Related Benefits and Services. The IHS may contact you 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.

Q. Food and Drug Administration. The IHS may disclose your health information to the Food and Drug Administration (FDA) in connection with a 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 look-backs (including locating people who have received products that have been recalled or withdrawn), or post-marketing surveillance.

R. Appointment Reminders. The IHS may contact you with a reminder that you have an appointment for medical care at an IHS facility or to advise you of a missed appointment.

S. Workers Compensation. The IHS may disclose your health information for workers compensation purposes as authorized or required by law.

T. Public Health. The IHS may use or disclose your health information to public health or other appropriate government authorities (Federal, State, local or Tribal) as follows:

1) To government authorities that are authorized by 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;

2) To government authorities that are authorized by law to receive reports of child abuse or neglect, and

3) To government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic violence, or as authorized by law if the IHS believes it is necessary to prevent serious harm. Where authorized by law, the IHS may disclose your health information 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. In some situations or if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public), the IHS may disclose to your employer health information concerning a work related illness or injury or a workplace related medical surveillance. (for example, if you are employed by IHS or another component of the Department of Health and Human Services (HHS))

U. Correctional Institution. If you are an inmate of a correctional institution, the IHS may disclose to the institution, health information necessary for your health and the health and safety of other individuals such as officers, employees, or other inmates.

V. Law Enforcement. The IHS may disclose your health information for law enforcement activities as authorized by law or in response to an order of a court of competent jurisdiction.

W. Health Oversight Authorities. The IHS may disclose your health information to health oversight agencies for activities authorized by law. These oversight activities may include: investigations, audits, inspections, and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance. The IHS is required by law to disclose health information to the Secretary, HHS to investigate or determine compliance with the HIPAA privacy standards.

X. Members of the Military. If you are a member of the military services, the IHS may disclose your health information if necessary to the appropriate military command authorities as authorized by law.

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

1) The IHS may disclose limited health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;

2) 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 circumstances, we may disclose the requested information if we determine that such disclosure would be in your best interests;

3) The IHS may use or disclose health information that we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person;

4) The IHS may disclose health information in the course of judiciary and administrative proceedings if required or authorized by law;

5) The IHS may disclose health information to report a crime committed on IHS health facility premises or when the IHS is providing emergency health care; and

6) The IHS may use or disclose health information during a disaster and for disaster relief purposes.

Z. Required by Law. The IHS may use or disclose health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

AA. Non-Violation of this Notice. The IHS is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses health information under the following circumstances:

1) Disclosures by Whistleblowers. If an IHS employee or business associate in good faith believes that the IHS has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by the IHS has the potential of endangering one or more patients, members of the workplace, or the public and discloses such information to:

a. A Public Health Authority or Health Oversight Authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions, or the suspected violation, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the IHS; or

b. 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.

2) Disclosures by Workforce Member Crime Victims. Under certain circumstances, an IHS workforce member (either an employee or contractor) who is a victim of a crime on or off the IHS facility premises may disclose information about the suspect to law enforcement officials provided that:

a. The information disclosed is about the suspect who committed the criminal act.

b. The information disclosed is limited to identifying and locating the suspect.

BB. Any Other Uses and Disclosures. Most uses and disclosures of psychotherapy notes (where appropriate) require authorization. Other uses and disclosures of PHI not listed in this Notice will be made only with your written authorization, which you may later revoke in writing at any time. Such revocation would not apply where the health information already has been disclosed or used or in circumstances where the IHS has taken action 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.

Rights under this Notice or to Request Information or Report a Problem

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

____

Facility name

____

Address

____

Phone number

____

If you believe your privacy rights have been violated, you may file a written complaint with the above individual or the Secretary, Department of Health and Human Services, Washington, D.C. 20201.
There will be no retaliation for filing a complaint.

Effective Date: **April 09, 2014**

Clinton

INDIAN HEALTH SERVICE

PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the Right to:

- Be treated with consideration, respect and equality.
- Receive, upon request, the name of the person in charge of your care.
- Current information concerning your diagnosis, treatment and expected outlook.
- Receive information necessary to give informed consent prior to treatment.
- Refuse treatment and to be informed of alternative treatment methods and/or the medical consequences.
- Privacy and confidentiality of all records pertaining to your treatment except as otherwise provided by law or third party payment contract.
- Expect reasonable continuity of care and to be informed of possible continuing health care requirements.
- Treatment without discrimination.
- Access patient complaint procedures and the right to file a complaint.
- Be evaluated for the presence of pain. Information about pain and pain relief are available for patient review.

Patients have the Responsibility to:

- Treat the staff with consideration, respect and equality.
- Verify eligibility and keep your registration information up-to-date.
- Keep your appointment (*including follow up appointments*).
- Take an active part in your health care.
- Provide accurate and complete information about symptoms, past illnesses, hospitalizations, medications, advance directives and other matters of care.
- Tell us when you do not understand your treatment plan.
- Understand that your lifestyle does affect your health.
- Consider the rights of other patients and employees & conduct yourself in a respectful manner.
- Respect the property of others and the Clinton Service Unit.

CLINTON SERVICE UNIT

POLICY OF ADVANCE DIRECTIVES

It is the policy of the Clinton Service Unit (Clinton Indian Health Center, El Reno Indian Health Center and Watonga Indian Health Center) to inquire with all competent adult patients about an active Advance Directive or Medical Living Will.

It is the patient's right to make decisions about his/her medical care, including the right to accept or refuse medical/surgical treatment and the right to formulate an Advance Directive or Medical Living Will. Generally, these are written documents that are executed before a person becomes seriously ill and states the type of health care measures he/she does or does not want to receive, as well as, listing a health care proxy; someone to make medical decisions on behalf of the patient if they are unable to.

Patients presenting to any facility under the Clinton Service Unit will be provided with information regarding Advance Directives. If he/she requires additional assistance, they will be referred to the Patient Benefits Coordinator.

Yes _____ No _____ Has the patient executed an Advance Directive?

Yes _____ No _____ If so, does the patient wish to have it scanned to their Medical Record?

Yes _____ No _____ Does the patient wish to receive additional information and/or need assistance with an Advance Directive?

Yes _____ No _____ Does the patient refuse the Advance Directive information?

______________________________	______________________________
Print Patient's Name	Patient's Date-of-Birth
______________________________	______________________________
Signature of Parent/Legal Guardian/Representative	Date
______________________________	
Health Record Number	

Clinton Service Unit

Text Message Appointment

Reminder Request Form

The Clinton Service Unit offers appointment reminders via phone call or TEXT message. Please indicate below if you would like to sign up for our TEXT message appointment reminder service. (Please print.)

Patient Name: ____

Date of Birth: ____

Health Record Number: ____________________________________

Cell Phone Number:_______________________________________

Please be advised, if you opt in for out TEXT messaging service, we will no longer contact you via phone call for appointment reminders.

There is no charge for this service, but standard TEXT messaging rates from your carrier may apply.

____ I would like to receive my appointment reminders, via TEXT message.

____ I do not and/or opt out of TEXT message reminders and would prefer to receive my appointment reminders, via phone call.

For Minors: If you would like a TEXT message reminder for your child's appointments, please ensure your name and current cell phone number are listed in your child's patient record, as well as, completion of a separate Appointment Reminder Request Form with your cell phone number listed. These numbers will be crossed-checked to ensure privacy and accuracy. All HIPAA, Privacy and Consent to Treatment policies apply. ***Only parents or legal guardians (with legal documents on file) may fill out this form to receive TEXT messages.***

____

Print Parent/Legal Guardian's Name

____ ____________________

Parent/Legal Guardian's Signature Date