**DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.**

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

## PATIENT INFORMATION

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

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

| Home Phone: | Work: | Cell: |
|---|---|---|

Internet Access: ❑ Yes ❑ No Email Address:

Home Address: City: State: Zip Code:

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

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

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

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

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

**Ethnicity:** ❑ **Not Hispanic or Latino** ❑ **Hispanic or Latino** ❑ **Declined to specify** ❑ **Unknown by Patient** ❑ **Other**_____

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

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

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

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

## PHARMACY INFORMATION

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

## EMPLOYMENT INFORMATION

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

**Employer Name**: **Employer Address**:

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

## HOUSEHOLD INCOME

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

## INSURANCE INFORMATION

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

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

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## EMERGENCY CONTACT

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

## CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATON

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

❑ Home Phone_____ ❑ Cell Phone _____ ❑ Work Phone_____

May we leave message on the phone number listed above: ❑ Yes ❑ No

**The type of information can be disclosed:**

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

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

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

_____ _____
Patient Name Date

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

_____ _____
Staff Signature Date

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**I give permission to Denver Indian Health and Family Service** to release my protected health information (lab results, medication and other health related information, etc.) to the following person:

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

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

_____ _____
Patient Name Date

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

_____ _____
Staff Signature Date

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

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

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

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

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

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

## NOTICE OF PRIVACEY PRACTICE (HIPAA)

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

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

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

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

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

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

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

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## CLIENT RIGHTS

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

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

## CLIENT RESPONSIBILITIES

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

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

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

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

**PLEASE PRINT INFORMATION CLEARLY ● <u>ALL INFORMATION IS CONFIDENTIAL</u>** ASFORM03(Rev.08/09/2019)

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# NO SHOW, LATE & CANCELLATION POLICY

Denver Indian Health and Family Services is proud to be able to provide basic Medical, Dental, and Behavioral Health services to our community. There is a great need for these services. Clinic services are valuable to our community and can be costly.

We, at Denver Indian Health and Family Services, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. However, when patients do not notify our office prior to missing the appointment it effects both the community and the clinic.

If you are unable to keep your appointment, please call us as soon as possible (with at least a 4-hour notice). You can cancel appointments by calling the following number: (303-953-6600)

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time and if your phone number changes to call DIHFS to update new phone number.

We have instituted a policy for our programs.

**PLEASE REVIEW THE FOLLOWING POLICY**

## CLINIC POLICY:

- Only two “No Shows” per 6 months will be allowed for services at DIHFS.
- All clients are requested to sign the No Show policy at the time of registration.
- 1st No Show: Patients account is noted of first “No Show-1
- 2nd No Show: Patients account is noted of second “No Show-2” and restricted from scheduling future appointments.
- If you are more than 15 Minutes for your late for your appointment, you will be considered as a No Show and you will need to reschedule your appointment.

## Notification Requirements and Penalties:

***Medical and Behavioral Clinic:*** Cancellation of appointments must be made 4 hours prior to the appointment. After the second No Show the patient will be placed on a “same-day call status” for a period of 6 months. Any patient on the “same-day call status” will not be allowed to schedule appointments in advance and must call the day they want to be seen by a provider. If there is no appointment available, the patient may come into the clinic and wait to be worked into the schedule but no guarantee of being seen.

***Dental Clinic****:* Cancellation of appointments must be made 24 hours prior to the appointment, due to the complexity of filling a lengthier dental appointment. After the second No Show, you will not be able to schedule an appointment in dental for the next 6 months and can only be seen as “emergency basis only”. ***If you NO SHOWS appointment you will automatically lose your $20.00 dental copay***.

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

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