SHINGLE SPRINGS
Health & Wellness Center
Health Care for All

ADULT Registration

SECTION 01 | Patient Demographics

Required field *

Service(s) of Interest* *(Circle all that apply)* Medical Dental Behavioral Health

First Name* _____ **Last Name*** _____

Middle Name _____ **Suffix** _____

Preferred Name _____ **Preferred Pronouns** _____

Biological Sex* *(Circle One)* Male Female

Date of Birth*
_____/_____/_____

Social Security Number*
_____-_____-_____

Street Address* _____

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

Home Phone* (_____)_____ **Cell Phone*** (_____)_____

May we leave a message/voicemail?* *(Circle One)* Yes No

Are you eligible for Indian Health Services (IHS) benefits (i.e. person of American Indian or Alaska Native descent)? * *(Circle One)* Yes No Unsure

If Yes, please provide a copy of your Tribal ID and/or other applicable documentation*

What month and year did you move to your current residence?* _____

Current County* _____

Marital Status* *(Circle One)*
Single Married Widowed
Divorced Separated Decline to Answer

Place of Birth *(City & State)** _____

Can you access the internet? *(Circle One)* Yes No

Religious Preference _____

SECTION 02 | Emergency Contact

First Name* _____ **Last Name*** _____

Street Address* _____

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

Phone No.* (_____)_____ **Relationship to patient*** _____

SECTION 03 | Patient Information

Are you employed? *(Circle One)* Yes No

Employer Name _____ **Employer Phone** (_____)_____

Are you a veteran?* *(Circle One)*

Yes

No

Ethnicity* *(Circle One)*:

Hispanic / Latino

Non-Hispanic / Non-Latino

Decline to Answer

Race* *(Circle One)*:

American Indian / Alaska Native

Asian

Black / African American

Native Hawaiian / Other Pacific Islander

White

Other _____

Number of individuals living in your household* _____

Annual household income $_____

SECTION 04 | Next of Kin Information

First Name* _____ **Last Name*** _____

Street Address* _____

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

Phone No.* (_____)_____ **Relationship to patient*** _____

SECTION 05 | Health Insurance

Do you have health insurance?* *(Circle One)* Yes No

If yes, what types of insurance do you have? *(Circle all that apply. Documentation Required)*

Medical

Dental

Vision

Uninsured / Cash Pay

SECTION 06 | Household Questionnaire

Do you have an advance directive? *(Circle One)* Yes No

Are you homeless or unhoused?* *(Circle One)* Yes No

Email _____

SECTION 07 | Patient Authorization for Treatment

I hereby authorize and consent to the administration of healthcare treatment, diagnostic procedures, and related services as deemed necessary by the healthcare providers of the Shingle Springs Health and Wellness Center.

I understand that this consent includes, but is not limited to, routine diagnostic procedures, laboratory testing, medical or surgical treatment, and other healthcare services provided under the general and special instructions of my treating provider(s).

I acknowledge that no guarantees or promises have been made to me regarding the results of any treatments or procedures.

I understand that I have the right to ask questions and receive a full explanation of any procedures or treatment before they are performed.

This consent shall remain valid for the duration of my care at the Shingle Springs Health and Wellness Center, unless revoked by me in writing.

Print Name* _____

Signature* _____ **Date*** _____

SHINGLE SPRINGS
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Patient Rights & Responsibilities

Rights:

- Be informed of your rights and review the policies regarding them.
- Receive services without regard to age, race, color, sexual orientation, religion, marital status, gender, national origin, or sponsorship status.
- Express your concerns and/or satisfaction regarding the services received and to comment or make suggestions for improvement of quality of care.
- File a complaint and receive a response in a timely manner without fear of discrimination or reprisal.
- Receive considerate and compassionate care in a safe and secure environment with respect and regard for your privacy, individuality, personal beliefs, and cultural traditions.
- Receive accessible services and timely referrals to staff and services consistent with quality professional practice.
- Receive complete information about your illness, the course of treatment, and the prospects for good health in terms you can understand.
- Participate in fully informed decisions affecting your care and treatment, including denying recommended treatment according to your own desires, needs, and understanding. You may also choose to have family and friends participate in this process.
- Have the privacy and confidentiality of your records maintained in a secure and safe environment. You may approve and refuse the release of your own medical records or request an accounting of access to your medical record(s).
- Know the name and professional status of the person(s) treating you and those giving medical advice after hours.
- Know, in advance of service, the cost of service and any applicable payment policies.
- Receive timely and qualified care in a setting appropriate to your health care needs.
- Appoint a legal representative to make decisions regarding your health care.

Responsibilities:

- Inform your health care provider of information related to past illness, treatments, and medications.
- Actively participate in decisions regarding your health care to the degree that you choose and reasonably follow your provider's health care instructions and advice.
- Let your provider know if you cannot or will not follow a certain treatment plan.
- Respect the rights and property of health care professionals, employees, and other patients.
- Schedule and keep all scheduled appointments. To ensure that all patients are served in a timely manner, please call to cancel or change appointments at least 24 hours in advance.
- Pay for services at the time they are provided and provide the patient registration office with accurate, complete, and current information regarding insurance coverage, home address, telephone number, social security number, and, if applicable, Native American Indian verification.
- Discuss your health care problems, concerns, and personal needs with your provider(s) in an honest manner and inform them of any changes in your health. Ask questions when you need further instructions or a better understanding.
- Cooperate with various providers involved in your care and conduct yourself in a polite and respectful manner.
- Respect the rights of your health care provider(s) and exchange information in a non-abusive manner, either physically or verbally, while receiving care.
- Advise your provider(s) of any changes in decisions concerning advanced directives and/or persons designated to make health care decisions for you.

Print Name* _____

Signature* _____ **Date*** _____

SHINGLE SPRINGS Health & Wellness Center
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Notice of Privacy Practices

EFFECTIVE DATE: MARCH 1, 2026

Your Information. Your Rights. Our Responsibilities.

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.**

We are required by law to maintain the privacy of PHI and to abide by the terms of this Notice currently in effect.

WHO MUST FOLLOW THIS NOTICE

This notice applies to all workforce members, employees, medical staff, behavioral health providers, dental providers, pharmacy staff, trainees, students, volunteers, business associates, and other authorized agents of the Shingle Springs Health & Wellness Center (SSHWC), including its Healthcare components as a Tribal Health Program operating as a hybrid entity.

OUR LEGAL DUTIES

We are required by law to:

- Maintain the privacy and security of your Protected Health Information (PHI);
- Provide you with this Notice of our legal duties and privacy practices;
- Abide by the terms of this Notice currently in effect;
- Notify you following a breach of unsecured PHI without unreasonable delay and no later than 60 days after discovery.

HOW WE MAY USE AND DISCLOSE YOUR PHI

1. **Treatment, Payment, and Health Care Operations (TPO)**
   We may use and disclose your PHI for:
   - Treatment by providers involved in your care.
   - Payment for services provided.
   - Health care operations (quality improvement, auditing, training, credentialing, compliance)

   We may share PHI with pharmacies, specialists, laboratories, and other providers involved in your care.
2. **Individuals Involved in Your Care**
   We may disclose relevant PHI to family members, close friends, or others involved in your care or payment for care unless you object.
3. **Public Health and Legal Requirements**
   We may disclose PHI when required by law, including:
   - Public health reporting
   - Health oversight activities
   - Law enforcement purposes
   - Organ procurement
   - Workers' compensation programs
   - Abuse or neglect reporting
   - Judicial or administrative proceedings
   - Coroners, medical examiners, funeral directors
   - National security and military authorities

REPRODUCTIVE HEALTH INFORMATION (RHI)

We will not use or disclose your PHI for the purpose of conducting a criminal, civil, or administrative investigation into, or imposing liability on, any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.

When required by federal law, we will obtain a signed attestation from the requestor before disclosing PHI potentially related to lawful reproductive health care for law enforcement, coroners/medical examiners, health oversight, or judicial purposes.

SUBSTANCE USE DISORDER (42 CFR PART 2)

As a Tribal Health Program operating as a HIPAA hybrid entity, we maintain substance use disorder (SUD) treatment records protected under 42 CFR Part 2.

SUD records may be used or disclosed for treatment, payment, and health care operations if you have provided written consent consistent with federal law.

Once disclosed pursuant to your consent, such information may be redisclosed in accordance with HIPAA and other applicable federal law unless otherwise restricted. Violations of federal confidentiality protections for substance use disorder records may result in civil and criminal penalties.

You have the right to:

- Provide or withhold written consent for disclosure;
- Revoke consent at any time (except to the extent action has already been taken);
- Receive an accounting of disclosures of your SUD records.

Unauthorized redisclosure may be prohibited under federal law.

SHINGLE SPRINGS Health & Wellness Center

USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

We must obtain your written authorization for:	
❖ Most uses and disclosures of psychotherapy notes;	❖ Most marketing communications;
❖ Sale of PHI;	❖ Other uses not described in this Notice.
You may revoke authorization in writing at any time.	

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- ❖ You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- ❖ We will provide a copy or summary of your health information, usually within 30 days of your request.

Ask us to correct your medical record

- ❖ You can ask us to correct health information about you that you think is incorrect or incomplete.
- ❖ We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communication

- ❖ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- ❖ We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- ❖ You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- ❖ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- ❖ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- ❖ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- ❖ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- ❖ We will make sure the person has this authority and can act for you before we take any action.

BREACH NOTIFICATION

If a breach of unsecured PHI occurs, we will notify you without unreasonable delay and no later than 60 days after discovery. The notice will describe:

- ❖ What happened
- ❖ Steps you should take
- ❖ Contact Information
- ❖ What information was involved
- ❖ What we are doing

File a complaint if you feel your privacy rights have been violated:

HIPAA Privacy & Security Officer
Shingle Springs Health & Wellness Center
5168 Honpie Rd
Shingle Springs, CA 95682
PH: (530) 387-8088

OR:
U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
www.hhs.gov/ocr/privacy/hipaa/complaints/ or by calling 877-696-6775

CHANGES TO THIS NOTICE
We reserve the right to change the Notice. Revised Notices will be posted in our facility and available upon request.

You will not be retaliated against for filing a complaint.

Print Name* _____

Signature* _____ **Date*** _____

SHINGLE SPRINGS
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Assignment of Benefits

Thank you for choosing us for your Healthcare needs. We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read the following:

Payment
Payment in full is due at time of service. Our practice accepts cash, checks, Visa, MasterCard and Discover cards.

Insurance
Insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company, if the insurance company does not remit payment, you are responsible for the entire balance, and it will be due in full.

Assignment of Insurance Benefits
The Undersigned authorizes, whether they sign as agent of patient, direct payment to SSHWC any insurance benefits otherwise payable to or on behalf of the patient for any/all services rendered at a rate not to exceed SSHWC to this authorization, by an insurance company shall discharge said insurance company of any/all obligations under policy to the extent of such payment. The undersigned understands that they personally are financially responsible for charges both paid pursuant to this agreement.

Release of Information
The Undersigned agrees to the extent necessary to determine liability for payment and obtain reimbursement. SSHWC may disclose portions of the client records, including their health record to any person/agency that is or is not limited to, insurance companies, health care service plans, or workers' compensation carriers. The undersigned understands that special permission is needed for SSHWC to release this information if the patient is treated for alcohol abuse, drug abuse, or HIV related illnesses.

Minors
Payment for services for the treatment of minors is the responsibility of the parent/guardian of the minor.

Financial Consent
The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement.

Print Patient Name* _____ **Patient's Date of Birth*** _____

Patient/Responsible Party Signature* _____ **Date*** _____

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Medications & Allergies

Medications | Please list all medications/supplements and dosage			□ NONE
Drug	**Dosage**	**Drug**	**Dosage**

Allergies | Please list medication and reaction(s)			□ NONE
Drug	**Reaction**	**Drug**	**Reaction**

Print Patient Name* _____ **Patient's Date of Birth*** _____

Patient / Responsible Party Signature* _____ **Date*** _____