Lake County Tribal Health

925 Bevins Court • Lakeport, CA 95453 14440 Olympic Drive • Clearlake, CA 95422

Thank you for choosing us!

Enclosed are all the things that you need to get started.

A) We have eight (8) forms that we need you to complete:

Please complete all eight (8) forms and return as soon as possible.

1. Patient Registration Form
2. Patient History Form
3. Consent for Treatment
4. Authorization for Disclosure *(to get information from your last medical provider)*
5. Financial Responsibility Form
6. Notice of Privacy Practice Acknowledgement Form (NPP)
7. Appointment Confirmation Release Form
8. Missed Appointment Policy Form

When you are done please return the completed forms to:

Main Site Clinic	**Southshore Clinic**
925 Bevins Court	14440 Olympic Dr.
Lakeport, CA 95453	Clearlake, CA 95422

or mail the documents to:

LCTHC / Attn: New Patient Registration
P.O. Box 1950
Lakeport, CA 95453

B) You will need to supply the following items prior to making your first appointment (front and back color copies if mailing):

1) Insurance Card(s)
2) Driver's License or Valid Picture ID
   (if patient is under 18, please provide parent's or guardian identification)
3) Social Security Card
4) Tribal Verification (if American Indian/Alaska Native)
5) Birth Certificate (Newborns and Native patients (must be a certified copy))
6) Marriage Certificate (for Native females, name change)

C) Please read and review the LCTHC Informational Packet

Let us know if you have any questions.

ELIGIBILITY STATEMENT

All American Indians/Alaska Natives from federally recognized tribes throughout the U.S. or a tribe that is native to California are eligible for direct services. Direct services include all services provided by the Lake County Tribal Health / Lake County Tribal Health Pediatric and Obstetrics that are available on-site, unless otherwise noted.

Non-Indians and members from non-federally recognized tribes outside of California may be registered and are eligible for services, but are required to pay for services with insurance, or may qualify for our sliding fee scale. Payment or co-pays are due at the time of service.

Lake County Tribal Health

PATIENT REGISTRATION FORM

MRN

925 Bevins Court • Lakeport, CA 95453 14440 Olympic Drive • Clearlake, CA 95422

Patient's Name Last _____ First _____ Full Middle _____

Home Address Street _____ City _____ State _____ Zip _____

When did you move to this address? _____ Email Address *This will not be shared* _____

Mailing Address Street _____ City _____ State _____ Zip _____

Telephone Home (____) _____ Work (____) _____ ◯ Cell ◯ Message (____) _____

Internet Access? ◯ Yes ◯ No Where? ☐ Home ☐ Work ☐ School ☐ Health Care Facility ☐ Library ☐ Community Ctr.

Social Security Number _____ ◯ Male ◯ Female ◯ Married ◯ Single ◯ Divorced

Date of Birth _____ Place of Birth City _____ State _____

Employer/School Name _____ Full Address _____

When did you move to this county? _____

RACE ☐ Native American/Alaskan Native Tribe _____ Roll # _____

☐ White ☐ Hispanic ☐ Asian ☐ Filipino ☐ Pacific Islander ☐ African American ☐ Other _____

ETHNICITY ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown What is your primary language? _____

Father's Full Name _____ Mother's Full Maiden Name _____

EMERGENCY CONTACT

Name _____ Telephone (____) _____

Full Address _____ Relationship to Patient _____

NEXT OF KIN

Name _____ Telephone (____) _____

Full Address _____ Relationship to Patient _____

FINANCIAL RESPONSIBILITY

Select which one(s) you have ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare ☐ Medi-Cal

Are you a U.S. Veteran? ◯ Yes ◯ No Do you have VA Medical Benefits? ◯ Yes ◯ No

INCOME INFORMATION *This confidential information is used to seek available resources for our patients.*

How many are in your family? _____ Monthly Income _____ Annual Income _____

IF PATIENT IS UNDER AGE 18

Guardian Name Last _____ First _____ Full Middle _____

Home Address Street _____ City _____ State _____ Zip _____

Telephone Home (____) _____ Work (____) _____ ◯ Cell ◯ Message (____) _____

Release of Information / Assignment of Benefits: Lake County Tribal Health has my permission to release information as needed for insurance processing and for my insurance to release payment to Lake County Tribal Health.

I HEREBY AUTHORIZE TREATMENT

_____ / _____ / _____

Signature of patient or guardian *Print your name here* *Date*

PRESENT PROOF OF IDENTIFICATION, NATIVE VERIFICATION, INSURANCE CARDS

INITIALS OF SCREENER

Lake County Tribal Health

925 Bevins Court • Lakeport, CA 95453 14440 Olympic Drive • Clearlake, CA 95422

ADULT MEDICAL HISTORY QUESTIONNAIRE

Thank you in advance for taking the time to complete the detailed confidential questionnaire.

Name _____ Previous Physician

Date _____ Height _____ Age _____ Handedness ○ Right ○ Left

Reason for Visit

Past Medical History

Please check all previous or current medical problems.

- ☐ Diabetes
- ☐ Heart
- ☐ Cancer
- ☐ Arthritis
- ☐ Liver
- ☐ Lung
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Seizure
- ☐ Blood Clot
- ☐ Kidney
- ☐ Stomach Ulcer
- ☐ Thyroid Problem

Previous Surgeries/Injuries *(List dates and types)*

Family History

Has anyone in your immediate family (parents, grandparents and siblings) had or have any of the following diseases?

	YES	NO	WHO?
Blood Clots	○	○	_____
Cancer	○	○	_____
Dementia	○	○	_____
Diabetes	○	○	_____
Heart Disease	○	○	_____
High Blood Pressure	○	○	_____
High Cholesterol	○	○	_____
Mental Illness	○	○	_____
Obesity	○	○	_____
Stroke	○	○	_____

Age, Health Status or Cause of Death

Mother _____

Father _____

Brothers _____

Sisters _____

Medications

List current medications, including over the counter, herbal medications and vitamins.

Name	Amount/Dose	Frequency	Reason	Last time taken

Medication Allergies/Reactions

_____

_____

_____

_____

Social History

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Stresses ☐ Home ☐ Relationship ☐ Work

Do you live in a ☐ House ☐ Apartment ☐ Other _____ Are there stairs? ◯ Yes ◯ No

Do you smoke ◯ Yes ◯ No Packs per day _____ Date quit _____

Do you chew/dip tobacco ◯ Yes ◯ No

Do you drink alcohol ◯ Yes ◯ No Drinks per day _____

Recreational drug use ◯ Yes ◯ No Date of last use _____

Regular exercise ◯ Yes ◯ No Type? _____ How often? _____

Diet *(describe)* _____

Sleep *(hours per night)* _____

Seatbelt use ◯ Yes ◯ No Bike helmet use ◯ Yes ◯ No Advance directive ◯ Yes ◯ No

Personal Health Review

Have you had any of the following in the past month?

GENERAL — **MD NOTES**

◯ Yes ◯ No Weight Change
◯ Yes ◯ No Fatigue
◯ Yes ◯ No Fever
◯ Yes ◯ No Sexual Problems
◯ Yes ◯ No Family Concerns

SKIN

◯ Yes ◯ No Change in Moles
◯ Yes ◯ No Rashes

EYE/EAR/NOSE/THROAT

◯ Yes ◯ No Vision Change
◯ Yes ◯ No Hearing Loss
◯ Yes ◯ No Ear Ringing
◯ Yes ◯ No Hey Fever/Sinus
◯ Yes ◯ No Hoarseness

GASTROINTESTINAL — **MD NOTES**

◯ Yes ◯ No Poor Appetite
◯ Yes ◯ No Abdominal Pain/Bleed
◯ Yes ◯ No Heartburn
◯ Yes ◯ No Trouble Swallowing
◯ Yes ◯ No Diarrhea/Constipation
◯ Yes ◯ No Bloody/Black Stools
◯ Yes ◯ No Hemorrhoids

URINARY TRACT

◯ Yes ◯ No Bladder/Kidney Infections
◯ Yes ◯ No Painful Urination
◯ Yes ◯ No Difficulty with Stream
◯ Yes ◯ No Nighttime Urination
◯ Yes ◯ No Urine Leakage
◯ Yes ◯ No Kidney Stones

Personal Health Review Continued

Have you had any of the following in the past month?

CARDIOVASCULAR **MD NOTES**

- ◯ Yes ◯ No Chest Pain
- ◯ Yes ◯ No Irregular Heartbeat
- ◯ Yes ◯ No Ankle Swelling
- ◯ Yes ◯ No Heart Murmurs
- ◯ Yes ◯ No Congestive heart Failure

RESPIRATORY

- ◯ Yes ◯ No Shortness of Breath
- ◯ Yes ◯ No Cough
- ◯ Yes ◯ No Wheezing
- ◯ Yes ◯ No Phlegm

BLOOD/LYMPH

- ◯ Yes ◯ No Anemia
- ◯ Yes ◯ No Easy Bruising
- ◯ Yes ◯ No Excessive Bleeding
- ◯ Yes ◯ No Blood Clots

FEMALE

- ◯ Yes ◯ No Breast Lumps
- ◯ Yes ◯ No Vaginal Discharge
- ◯ Yes ◯ No Irregular Periods/Cramps

MUSCLE AND BONES **MD NOTES**

- ◯ Yes ◯ No Joint Pain/Swelling
- ◯ Yes ◯ No Gout
- ◯ Yes ◯ No Back Pain
- ◯ Yes ◯ No Osteoporosis/Fractures
- ◯ Yes ◯ No Muscle Weakness/Pain

ENDOCRINE

- ◯ Yes ◯ No Hot/Cold Intolerance
- ◯ Yes ◯ No Hair Growth or Loss

NERVOUS SYSTEM

- ◯ Yes ◯ No Dizziness
- ◯ Yes ◯ No Numbness/Tingling
- ◯ Yes ◯ No Tremors
- ◯ Yes ◯ No Headache
- ◯ Yes ◯ No Depression/Anxiety

MALE

- ◯ Yes ◯ No Testicular Lumps
- ◯ Yes ◯ No Prostate Problems

Last Menstrual Period _____

Number of pregnancies _____ Miscarriages _____ Abortions _____ Living Children _____

Birth Control Method _____

Results/Dates of Tests and Vaccinations

Last Eye Exam _____ Pap Smear _____ TB Skin Test _____

Cholesterol _____ Mammogram _____ Tetanus _____

Blood Pressure _____ Bone Density _____ Flu _____

Blood Sugar _____ Prostate _____ Pneumonia _____

Testicular _____ Hepatitis B _____

Patient Signature _____ Date _____

Medical Provider Signature _____ Date _____

CONSENT TO TREATMENT

I, the undersigned patient, _____ provide consent and permission for examination; treatment, medical or surgical diagnoses and/or medications; including immunizations advised by a Physician, Physician Assistant, Nurse Practitioner, Dentist, Dental Hygienist, or his/her designee of Lake County Tribal Health Consortium, Inc. for myself.

This Consent will remain effective for three years from this date, _____ unless I cancel it in writing at an earlier date.

_____ _____
Signature of patient Date

_____
Name of patient

Lake County Tribal Health

925 Bevins Court • Lakeport, CA 95453 14440 Olympic Drive • Clearlake, CA 95422

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Complete all sections, date and sign.

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record.

Name of patient

Method of Delivery: ☐ Patient Pick-up (Staff use only _____) Patient received on ☐ Certified Mail (Staff use only _____) Date Mailed

II. The information is to be disclosed by:

Name of Facility _____

_____

Address _____

City / State _____

Phone

And is to be provided to:

Name of Person / Organization / Facility _____

_____

Address _____

City / State _____

Phone

III. The purpose or need for this disclosure is:

○ Further Medical Care ○ Personal Use ○ Other *Specify* _____

IV. The information is to be disclosed from my health record: *Check appropriate box(es)*

○ Entire Record (does not include sensitive information not marked below)

○ Only information related to: *Specify* _____

○ Only the period of events from: _____ to: _____

○ Other: *Specify – Billing, CHS* _____

If you would like any of the following sensitive information disclosed, check applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-Related Treatment ☐ Sexually Transmitted Diseases

☐ Mental Health *(Other than Psychotherapy Notes)* ☐ Psychotherapy Notes ONLY

By checking this box, I am waiving any psychotherapist-patient privilege.

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. *Specify new date:*

I understand that Lake County Tribal health will not condition treatment or eligibility of care on my providing this authorization except if such care is (1) research related (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drub Abuse is defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 V Part 164}, and the Privacy Act of 1974 [5 USC 552a].

_____ / _____

Signature of patient or personal representative *State relationship to patient* *Date*

_____ / _____

Signature of witness *If signature of patient is a thumbprint or mark* *Date*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

LCTH USE ONLY

PATIENT ID	NAME (Last, First, MI)	DATE OF BIRTH	RECORD NO.

ADDRESS	CITY / STATE

Lake County Tribal Health

925 Bevins Court • Lakeport, CA 95453 14440 Olympic Drive • Clearlake, CA 95422

FINANCIAL RESPONSIBILITY FORM

Lake County Tribal Health follows the regulations and laws as set by the Indian Health Service and the State of California. Depending on your billing status, you may be financially responsible for all, part, or none of the services performed.

Minor Patients: The parent/guardian of a minor is responsible for payment of the minor's account balance. Payment of treatment of minor children including copays, deductibles, coinsurance or any additional fees are due at the time of service regardless of which parent/guardian is responsible for medical expenses. It is our policy to collect payment at the time of service from the parent, guardian or caretaker who brings the child in for the appointment. We are not a party to your divorce or separation agreement. If a divorce or other court decree requires the other parent/guardian to pay all or part of the treatment costs, it is the parent's responsibility to collect from the other parent. Should the issues that come between parents/guardians become disruptive to Lake County Tribal Health, we reserve the right to refuse service to the patient and discharge the patient from the practice.

Please refer to the Billing Department Policy. A copy of the policy can be available upon request. A sliding fee scale is available when a completed application is turned in with the required documentation and a patient is eligible due to the guidelines described on the application. If you have an outstanding balance with our clinic, you will be expected to pay all or part of this bill before any further services are received. LCTHC will bill your insurance company for services rendered at our facility as a courtesy.

If you are Native American/Alaska Native, you must have valid and current tribal verification on file or you will be financially responsible for any services provided to you.

If you are covered by insurance please complete the following:

Name of Insurance_____

Address _____

Group #_____ Policy #_____

Subscriber Name_____ SS# _____

Subscriber DOB_____ Relationship to Subscriber_____

–OR –

PLEASE CHECK which of the following applies:

- ◯ I have no insurance and will be using the sliding scale with current documentation submitted if eligible **(bring in your current tax return to determine discount).**
- ◯ I have no insurance and will be paying for my services in full.
- ◯ I am of Native American descent with legal proof submitted to PRC.

I am under full understanding that it is my responsibility to supply LCTHC with the most current insurance information before each appointment.

Print Name _____ _____
Patient/Parent *Date*

Signature _____ _____
Patient/Parent *Date*

If you are signing this document, but are not the subscriber, please provide the following information:

Your California driver's license # _____Your date of birth _____

Your SS# _____

Lake County Tribal Health
925 Bevins Court • Lakeport, CA 95453
14440 Olympic Drive • Clearlake, CA 95422

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

By signing this form, you acknowledge you have received a copy of our Notice of Privacy Practices.

Patient Name _____

Signature _____
Patient/Parent

Date _____

APPOINTMENT CONFIRMATION RELEASE

Patient Name: _____

I, _____ hereby authorize Lake County Tribal Health (LCTHC) to leave message at my home regarding confirmation of my dental/medical appointment. Lake County Tribal Health has my permission to leave message with anyone who answers the phone at my home or on my voicemail or any on my answering machine. The information to be given out by LCTHC will include only the date and time of my appointment. No information of type of treatment I am receiving will be given. I have the opportunity to rescind this authorization at any time by doing so in writing. The reason for this message is to remind me of my appointment.

Signature _____ _____
Patient/Parent *Date*

MISSED APPOINTMENT POLICY

We want to thank you for choosing Lake County Tribal Health Consortium, Inc. (LCTHC) as your health care provider. In order to offer you and other patients the best care possible, we require that you follow our guidelines regarding missed appointments. Please remember, we have set up an appointment time especially for you. LCTHC makes courtesy reminder calls regarding your appointment. We consider these appointments to be your responsibility to keep or cancel. We realize that unforeseen circumstances occur; therefore, we request at least 24 hours' notice to reschedule your appointment. This will enable us to offer your cancelled time to another patient who is in need of health care. When you miss or cancel your appointment at the last minute, everyone loses – you, Tribal Health and other patients that would like to have taken advantage of this appointment time.

LCTHC does not allow any missed appointments. We will; however, tolerate three (3) missed appointments in a six month period. An appointment is considered to have been missed if any of the following occur:

1. The patient fails to show up for a scheduled appointment.
2. The patient presents more than seven (7) minutes late for a scheduled appointment.
3. The patient calls to cancel a scheduled appointment with less than twenty-four (24) hours advance notice.
4. Any patient who schedules a same day appointment and fails to show after 3 such no shows, will not be allowed to schedule any appointment, but must come to the clinic in order to be added to the schedule, if there is an available opening in the schedule, otherwise be triaged and the provider will determine if the patient needs to be seen that day.

Patients who accumulate three missed appointments in a six (6)-month period will not be allowed to schedule any future routine care appointments for a period of four (4) months following the third missed appointment. Acute treatment will be allowed on a Show to the clinic ONLY bases. (patient must come into the clinic and be triaged to be seen. Also, transportation services are not available to any patient who has been restricted from making appointments.

Signature _____ _____
Patient/Parent *Date*