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 (9) forms that we need you to complete:

Please complete all eight (9) forms and return as soon as possible.

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

When you are done, please return the completed forms to:

MAIN SITE CLINIC	**SOUTHSHORE CLINIC**
925 Bevins Court	14440 Olympic Drive
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 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 (All patients under 18 years of age (must be a certified copy)
6) Marriage Certificate (for 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

MRN

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

PATIENT REGISTRATION FORM

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 _____ ◯ Married ◯ Single ◯ Divorced

Sex at Birth ◯ Male ◯ Female Gender Identity _____ ◯ Prefer Not to Say

Date of Birth _____ Place of Birth City _____ State _____

Employer/School Name _____ Full Address _____

When did you move to this county? _____ Your Pharmacy: _____

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(S)

Name _____ Telephone (____) _____

Full Address _____ Relationship to Patient _____

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 Branch _____ / _____ Date Separated

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 _____

APPOINTMENT CONFIRMATION RELEASE

PURPOSE OF THE FORM
This form authorizes LCTHC to send appointment confirmations, reminders, and other communications related to my healthcare using the contact information I provide below. This may include appointment details, such as the type of service, location, time of appointment, provider information, or rescheduling notices.

I understand that my protected health information (PHI), such as the type of healthcare service I am scheduled to receive, may be communicated through my preferred method of contact. I acknowledge that I am responsible for maintaining the privacy of my own phone, email, and messaging accounts. I understand that I can change or withdraw my consent for these communications at any time by doing so in writing.

PREFERRED METHOD(S) OF CONTACT
Please indicate the methods by which you would like to receive appointment-related information:

☐ **Phone Call**
Preferred Number _____

☐ **Text Message (SMS)**
Preferred Number _____
Note: *Text message rates may apply based on your mobile carrier.*

☐ **Email**
Preferred Email _____

ACKNOWLEDGMENT AND SIGNATURE
By signing below, I consent to receiving appointment reminders and notifications as per my preferences outlined in this form.

Print Patient Name _____

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 call the clinic in order to check same day availability in the schedule, otherwise call and check the next 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. The patient will be seen as a Same Day visit only. Acute treatment will be allowed on a walk-in 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*

CONSENT FOR 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 one year from this date, _____
unless I cancel it in writing at an earlier date.

_____ _____
Signature of patient Date

_____
Name of patient

Lake County Tribal Health
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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.

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.

PLEASE CHECK the following that apply:

- ☐ 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.
- ☐ **If you are covered by insurance please complete the following:**

Name of Insurance_____

Address _____

Group #_____ Policy #_____

Subscriber Name_____ SS# _____

Subscriber DOB_____ Relationship to Subscriber_____

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# _____

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 _____

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LCTH USE ONLY

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

ADDRESS	CITY / STATE

AUTHORIZATION FOR RELEASE OF INFORMATION

Complete all sections, date and sign.

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

II. The information is to be disclosed by:

Name of Facility / Request Records from
Address
City / State
Phone

And is to be provided to:

Name of Person / Organization / Facility / Provide Records to
Address
City / State
Phone

III. The purpose or need for this disclosure is:

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

IV. The information 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, etc.* _____

_____

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 upon me 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 Drug 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)).

STAFF USE ONLY Method of Delivery: ❍ Patient Pick-up (_____) ❍ Certified Mail (_____)
Patient received on Date mailed

3RD PARTY CONSENT

Purpose of this form: *Allows a patient to authorize another individual to access their medical information or act on their behalf regarding healthcare matters.*

I. Patient Information

Full Name of Patient: _____ Date of Birth: _____

II. Parent/Guardian Information (complete only if the patient is a minor)

Full Name of Parent/Legal Guardian: _____

Relationship to Minor: _____ Phone Number: _____

Address: _____

III. Authorized Third Party Information

Full Name of Authorized Third Party: _____

Relationship to Patient: _____ Phone Number: _____

Address: _____

IV. Authorization of Medical Decision-Making and Access

I, _____ hereby authorize _____ to:

Full Name of Parent/Guardian if patient is a minor, or Full Name of Patient if an adult

Full Name of Third Party

SELECT ALL THAT APPLY:

- ☐ Make medical decisions/consent to medical treatment, including vaccinations, on behalf of the patient.
- ☐ Schedule/Cancel medical appointments for the patient.
- ☐ Request/pick-up the patient's medical records and information.
- ☐ Communicate with healthcare providers regarding the patient's care.
- ☐ Other (please specify):_____

V. Duration of Consent

This authorization is valid one year from date of signature.

VI. Revocation

I understand that I may revoke this authorization at any time by providing written notice to the healthcare provider or institution. Revocation will not affect any actions taken based on this authorization before the receipt of the written revocation.

VII. Signature of Parent/Guardian/Patient

By signing below, I affirm that I have the legal authority to authorize the individual named in this form to act on behalf of the patient, and I consent voluntarily.

Patient/Guardian Signature: _____ Date: _____

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

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 _____