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 nine (9) forms that we need you to complete:

Please complete all nine (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
925 Bevins Court
Lakeport, CA 95453

SOUTHSHORE CLINIC
14440 Olympic Drive
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

Lake County Tribal Health

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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

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# ____________

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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:	**And is to be provided to:**
Name of Facility / Request Records from	*Name of Person / Organization / Facility / Provide Records to*
Address	*Address*
City / State	*City / State*
Phone	*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

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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	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 _________________