Lake County Tribal Health
Pediatrics

359 Lakeport Boulevard • 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. Treatment Authorization for Minors
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. Pediatric Health History Form

When you are done, please return this packet to any of our clinic locations:

MAINSITE	SOUTHSHORE CLINIC	PEDIATRICS
925 Bevins Court	14440 Olympic Drive	359 Lakeport Blvd.
Lakeport, CA 95453	Clearlake, CA 95422	Lakeport, CA 95453

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.

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PEDIATRIC REGISTRATION FORM

MRN

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

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*

TREATMENT AUTHORIZATION FOR MINORS

I / we the undersigned parent(s) / person having legal custody or guardianship of

Name of Child _____

Date of Birth (Child) _____

Authorize the Lake County Tribal Health Consortium (LCTHC) / Lake County Tribal Health Pediatrics, to provide medical treatment to the above name child. This authorization includes the consent for examination, treatment, medical and/or surgical diagnosis, medication prescription, and/or immunizations (as required by State or Federal Law); it is further acknowledged that informed consent for the LCTHC provision of immunizations may be revoked by the parent(s) /person having legal custody or guardianship, under California State Law, at any time. Revocation must, however, be in writing and acknowledged by receipt of the LCTHC.

This Authorization for Treatment will remain effective one year from this date _____ or until either cancelled via a written notice by the undersigned is provided to the LCTHC; or the child turns 18 years of age; and/or the patient is discharged from treatment at the LCHTC, whichever may come first.

Signature _____ _____

Parent or legal guardian *Date*

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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PEDIATRIC HEALTH HISTORY

Please fill out this form as completely and as accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated as confidential.

Child's Name _____ ◯ M ◯ F Date of Birth_____ Age_____

Mother's Name _____ Home Phone_____ Work Phone _____

Father's Name_____ Home Phone_____ Work Phone _____

Home Address *(Street, City, State, Zip)* _____

Child's School_____ Grade_____

Previous Physician_____ City_____ State _____

Reason for Visit_____

Allergies

Substance	Reaction

Comment _____

Current Medications

Medication Name	Dosage

Pre-Natal and Infant Health History

Place of birth_____ Obstetrician _____ Mother's age at birth_____

DURING PREGNANCY, DID MOTHER HAVE ANY OF THESE CONDITIONS?

◯ Yes ◯ No Alcohol use
◯ Yes ◯ No Diabetes
◯ Yes ◯ No Prescription drug use *Type* _____
◯ Yes ◯ No Non-Prescription drug use *Type*_____
◯ Yes ◯ No Edema (swelling)
◯ Yes ◯ No High blood pressure
◯ Yes ◯ No Tobacco use
◯ Yes ◯ No Other illness / infection _____

_____

INFANT BIRTH HEALTH

Birth weight_____
Length _____
Infant discharge weight_____
Age (days) when discharged _____

BREASTFEEDING

◯ Yes ◯ No Ever breastfed
◯ Yes ◯ No Breastfed at 6 months
◯ Yes ◯ No Breastfed at 12 months
◯ Yes ◯ No Formula used at _____ months

Pre-Natal and Infant Health History

Please check if child has had any of the following:

GENERAL

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Whooping Cough
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Tiredness
- ☐ Weight loss/gain

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Bloody/dark stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Rectal bleeding
- ☐ Stomachaches
- ☐ Vomiting
- ☐ Worms

GENITO-URINARY

- ☐ Bed wetting
- ☐ Blood in Urine
- ☐ Diaper rash, persistent
- ☐ Vaginal/penile discharge
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Unusual urine odor

OTHER *Please describe*

CARDIOVASCULAR

- ☐ Breathing problems
- ☐ Chest pain
- ☐ Irregular heart beat

EYES

- ☐ Eye irritation
- ☐ Headaches
- ☐ Vision problems

HEARING/SPEECH

- ☐ Difficulty hearing
- ☐ Earache
- ☐ Ear infections
- ☐ Speech problems

DENTAL

- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Sensitivity to hot/cold
- ☐ Thumb sucking
- ☐ Brush – How often

  _____
- ☐ Last Dental Appointment

  _____

MUSCLE/JOINT/BONE

- ☐ Broken bones/sprains
- ☐ Poor coordination
- ☐ Posture problems

NOSE/THROAT/CHEST

- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Mouth-breathing
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Strep throat
- ☐ Tonsil infections
- ☐ Wheezing

SKIN

- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Hospitalizations

Reason	Date	Hospital	City	State

Child Safety Inventory

- ◯ Yes ◯ No Smoke alarms in house
- ◯ Yes ◯ No Car seat – seatbelt use
- ◯ Yes ◯ No Syrup of Ipecac in home
- ◯ Yes ◯ No Safety gate for stairs
- ◯ Yes ◯ No Guns are in locked cabinet in home
- ◯ Yes ◯ No Know dangers of peeling paint in home
- ◯ Yes ◯ No Know dangers of pests (mice/rats) in home
- ◯ Yes ◯ No Household cleaners are out of reach
- ◯ Yes ◯ No Medicine is out of reach
- ◯ Yes ◯ No Child knows how to swim
- ◯ Yes ◯ No Know emergency numbers
- ◯ Yes ◯ No Water heater below 120 degrees
- ◯ Yes ◯ No Bicycle helmet used
- ◯ Yes ◯ No *Mister Yuk* stickers used in home

Family History

Please provide health information about the child's immediate family.

RELATIVE	AGE	GENERAL HEALTH *CHOOSE ONE*				
Father	Age _____	◯ Excellent	◯ Good	◯ Fair	◯ Poor	◯ Other _____
Mother	Age _____	◯ Excellent	◯ Good	◯ Fair	◯ Poor	◯ Other _____
Sibling	Age _____	◯ Excellent	◯ Good	◯ Fair	◯ Poor	◯ Other _____
Sibling	Age _____	◯ Excellent	◯ Good	◯ Fair	◯ Poor	◯ Other _____
Sibling	Age _____	◯ Excellent	◯ Good	◯ Fair	◯ Poor	◯ Other _____

Please check conditions that any of the child's blood relatives have had. *Include parents and siblings.*

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
☐ Alcoholism	_____	☐ HIV/Aids	_____
☐ Allergies	_____	☐ Kidney disease	_____
☐ Anemia	_____	☐ Lung disease	_____
☐ Arthritis	_____	☐ Mental disorder	_____
☐ Asthma/Emphysema	_____	☐ Muscle disorder	_____
☐ Birth defects	_____	☐ Seizures/convulsions	_____
☐ Bone/joint disorders	_____	☐ Sickle Cell Anemia	_____
☐ Cancer	_____	☐ SIDS	_____
☐ Genetic defects	_____	☐ Skin disease	_____
☐ Hemophilia	_____	☐ Stroke	_____
☐ High blood pressure	_____	☐ Thyroid disease	_____
☐ Hearing loss / blindness	_____	☐ Tuberculosis	_____

OTHER *Please describe*

Signature _____ / _____

Parent / Guardian *Date*