

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

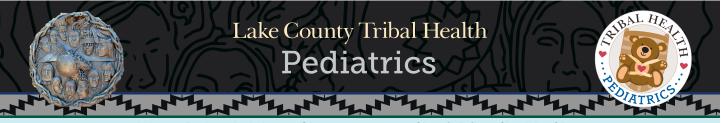
ELIGIBILITY STATEMENT

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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359 Lakeport Boulevard • I	_akeport, CA 95453	14440 Olym	pic Drive • Clearlake,	CA 95422	
P	EDIATRIC REGIS	TRATION	FORM		MRN
Patient's Name Last	First		Full Mic	ldle	
Home Address Street	Ci	ty	State	э	_ Zip
When did you move to this address?	Email Add	ress This will n	ot be shared		
Mailing Address Street	Ci	ty	State	e	_ Zip
Telephone Home ()	Work ()		Cell Messag	ge()_	
Internet Access? Yes No Where?	Home Work	School	Health Care Facility	Library	Community Ctr.
Social Security Number	Male	Female	Married	Single I	Divorced
Date of Birth Pla				State	
Employer/School Name	Full Addres	8			
When did you move to this county?					
RACE Native American/Alaskan Native White Hispanic Asian ETHNICITY Hispanic or Latino Not	Filipino Pac	fic Islander	African American	Other	
Father's Full 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 Insuran	ce Dental Insura	nce Med	dicare Medi-Cal		
Are you a U.S. Veteran? Yes No Do y	ou have VA Medical Be	enefits? Ye	es No		
INCOME INFORMATION This confidential info	rmation is used to seek a	vailable resourc	es for our patients.		
How many are in your family? M	onthly Income		Annual Inc	ome	
IF PATIENT IS UNDER AGE 18					
Guardian Name Last	First		Full Mic	ldle	
Home Address Street					
Telephone Home ()					
Release of Information / Assignment of Benefits insurance processing and for my insurance to re	: Lake County Tribal H	ealth has my e County Trib	permission to release al Health.		
	/			/	
Signature of patient or guardian PRESENT PROOF OF IDENTIFICATION, NATI	VE VERIFICATION, IN	Print your i		NITIALS OF S	Date CREENER

Revised: 01/10/2025



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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

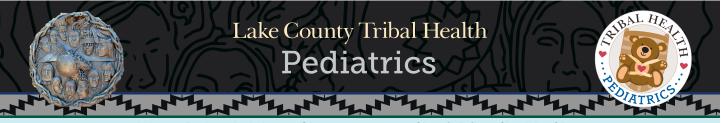
By signing below, I consent to receiving appointment reminders and notifications as per my preferences outlined in this form.

Print Patient Name

Signature _____

Patient/Parent

Date



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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:

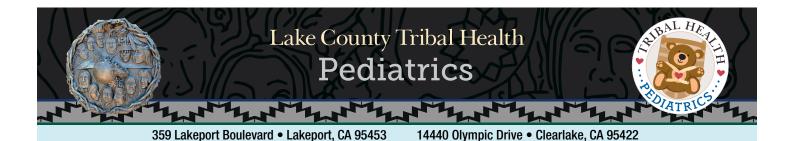
- 1. The patient fails to show up for a scheduled appointment.
- 2. The patient presents more than seven (7) minutes late for a scheduled appointment.
- 3. The patient calls to cancel a scheduled appointment with less than twenty-four (24) hours advance notice.
- 4. Any patient who schedules a same day 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. <u>Acute treatment</u> will be allowed on a walk-in to the clinic ONLY bases. (patient must come into the clinic and be triaged to be seen. <u>Also, transportation services are not available to any patient who has been restricted from making appointments</u>.

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)

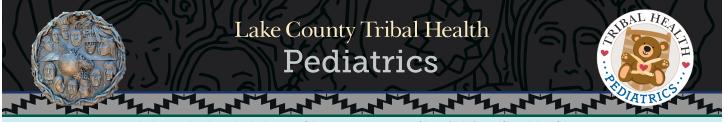
Authorize the Lake County Tribal Health Consortium (LCTHC) / Lake County Tribal Health Pediatrics, to provide medical treatment to the above name child. This authorization includes the consent for examination, treatment, medical and/or surgical diagnosis, medication prescription, and/or immunizations (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



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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:

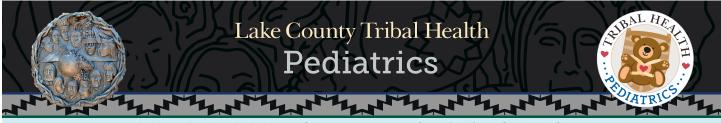
I have no insurance and will be using the sliding scale with current documentation submitted if eligible (bring in your current tax return to determine discount).

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	ubscriber 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 _____

		Tribal Health atrics	ATRICS		
	359 Lakeport Boulevard • Lakeport, CA 95453	14440 Olympic Drive • Cle	earlake, CA 95422		
LCTH USE ONLY	PATIENT ID NAME (Last, First, MI) ADDRESS	CITY / STATE	DATE OF BIRTH RECORD NO.		
	AUTHORIZATION FOR F Complete all sec	RELEASE OF INFORMA tions, date and sign.	TION		
I.	I,, hereby vol Name of patient	untarily authorize the disclosure	e of information from my health record.		
п.	The information is to be disclosed by:	And is to be provided to	0:		
	ame of Facility / Request Records from	Name of Person / Organization			
A	ddress	Address			
С	ty / State	City / State			
PI	none	Phone			
	The purpose or need for this disclosure is: Further Medical Care Personal Use Other Speci	fy			
IV.	The information to be disclosed from my health record Entire Record (does not include sensitive information not mark Only information related to: Specify Only the period of events from: Other: Specify – Billing, CHS, etc.	to:			
	5	S-Related Treatment	Sexually Transmitted Diseases		
V.	Mental Health (Other than Psychotherapy Notes) Psychotherapy Notes ONLY By checking this box, I am waiving any psychotherapist-patient of I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance cover age 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 be 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 treatmer is (1) research related (2) provided solely for the purpose of creating F		-		
	I understand that information disclosed by this authorization, except f re-disclosure by the recipient and may no longer be protected by the 164}, and the Privacy Act of 1974 [5 USC 552a].	-			
	Signature of patient or personal representative	State relationship to patient	/ Date		
			/		

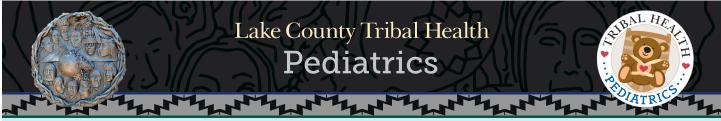
Signature of witness If signature of patient is a thumbprint or mark

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)).

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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 on	ly 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
l,	_ 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.

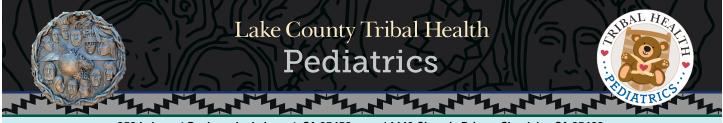
VI. Revocation

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:



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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		
Father's Name	Home Phone	Work Phone	
Home Address (Street, City, State, Zip)			
Child's School			Grade
Previous Physician			State
Reason for Visit			

Aller	gies	Current Medications				
Substance	Reaction	Medication Name	Dosage			
Comment						

Pre-Natal and Infant Health History

Place of birth	Place	of	birth
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Obstetrician

_ Mother's age at birth____

No Breastfed at 6 months

No Breastfed at 12 months

No Formula used at _____ months

DURING CONDITI		NANCY, DID MOTHER HAVE ANY OF THESE	INFANT B Birth weig		
Yes	No	Alcohol use	Length		
Yes	No	Diabetes	Infant disc	harge	weight
Yes	No	Prescription drug use Type	Age (days) when discharged _		n discharged
Yes	No	Non-Prescription drug use Type	BREASTF	EEDI	NG
Yes	No	Edema (swelling)	Yes	No	Ever breastfed
Yes	No	High blood pressure	Yes	No	Breastfed at 6 r
Yes	No	Tobacco use	Yes	No	Breastfed at 12
Yes	No	Other illness / infection	Yes	No	Formula used a

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

OTHER Please describe

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

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

	Но	spitalizations		
Reason	Date	Hospital	City	State

Child Safety Inventory

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

Family History

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

RELATIVE	AGE	GENERAL HEAL	TH 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	<u> </u>	_ 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

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