The Grand Traverse Band of Ottawa and Chippewa Indians

2605 N. West Bay Shore Drive · Peshawbestown, MI 49682-9275 · (231) 534-7211

Date ________________

Dear ______________________________

For us to complete our registration for you and /or your dependents for health or dental services, we need certain information four our records. To be eligible for services we need all the following requested information.

_____________ Copy of Tribal Identification or BIA letters

_____________ Copy of Insurance cards

_____________ Copy of driver's license or state identification

Comments:

____

____

____

If you have any question or concerns, please contact the clinic during our regular hours at (231) 534-7200. If you would like to fax the information you may do so by faxing to (231) 534-7460 attention REGISTRATION. Please bring these completed forms with you to your next appointment or you may drop them at any satellite office.

Thank you,

Grant Traverse Band Family Health Clinics

GRAND TRAVERSE BAND FAMILY HEALTH CLINIC

Last Name___________________First Name________________Middle__________Nick/Maiden Name______

Birth Date: ________________ Social Security Number_______________________ Sex: M F

Tribe:_________________ Enrolled: Y N Enrollment Number:______________

Indian Blood Quantum:_______ GTB Blood Quantum:_________ Religion:________________

City of Birth:______________ State:________ Are you: Married Single Divorced Widowed ?

Physical Address:____
Street City State Zip

Mailing Address: ____
Street City State Zip

Present County:_________________________ Date Moved:_____________________________

Telephone Number: ____________________ Work Number:___________________________

Do you have internet access: Y N ? if yes where, Home Work School Mobile Library

Email address:____

Employer: _________________________________ Full Time Part Time Seasonal

Spouse Employer: ___________________________ Work Number:_________________________

Father's Name____________________________________ City of Birth: ___________ State:________

Mother's Name: __________________________________ City of Birth: ___________ State: ________

Emergency Contact: ____
Name Phone Number Relationship

Address: ____
Street City State Zip

Next of Kin: ____
Name Phone Number Relationship

Address:____
Street City State Zip

Military Service

Veteran: Y N Entry Date (LAST):________________ Date of Discharge:___________

Vietnam Duty: Y N Service Connected: Y N Claim Number:______________

HRN_____

Initial_____

PATIENT NAME: ______

MEDICAL HISTORY UPDATE

Physician's name: ______ Physician's ph# ______
Date of last physical: ______

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

Circle any and explain in next section:

Heart Disease or Attack	Allergies to Anesthetics	History of Bulimia	Nervous Problems
Heart Murmur	Contact Lenses	Kidney Problem	Rheumatic Fever
Heart Pacemaker	Hypoglycemia	Thyroid Disease	Psychiatric Care
Angina Pectoris	Artificial Heart V	Glaucoma	Allergy to Latex
Mitral Valve Prolapse	Artificial Joints	Diabetes	AIDS/HIV Positive
High Blood Pressure	Recent Weight Loss	Arthritis/Rheumatism	Venereal Disease
Low Blood Pressure	General Allergies	Allergy to Dyes	Cancer/Leukemia
Circulatory Problems	Blood Disease	Special Diet	Hemophilia
Asthma	Back Problems	Swollen Neck Glands	Blood Transfusion
Hepatitis/Jaundice	Sinus Problems	Ulcer	Tuberculosis
Liver Disease	Stroke	Respiratory Problems	Tobacco Use
Epilepsy/Seizures	Headaches	Chemical Dependency	Chronic Bleeding Gums

1) Do you take or have you taken any of the following medications for Osteoporosis or Bone Cancer? **Please circle if YES.**
-- Actonel / Boniva / Fosamax / Fosamax plus D / Aredia / Donefos / Zometa / Reclast --

2) Do you have any drug allergies, or have you ever had an adverse reaction to any medication or substance? **If YES, please list.**
______

3) Have you ever responded adversely to medical or dental treatment? ______

4) Are you taking any medication at this time? **Please list:** ______
______

5) Have you ever taken Phen-Fen (diet drug)? **Please circle YES or NO**
If YES, have you seen a cardiologist for a consult since taking it? **Please circle YES or NO**

6) Are you under the care of a physician for anything other than regular check-ups? **Please circle YES or NO**
If YES, for what condition?______

7) **WOMEN**: Are you pregnant, nursing, taking birth control, or had a recent transfusion? ***Please circle any that apply.***

8) Is there anything else we should know about your medical history? ______

Authorization and Release:
The above information is accurate and complete to the best of my knowledge and is only for the sue in treatment, billing, and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment for examination rendered to me or my child during the period of such dental care, to third party payers, and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor: ______ **Date:** ______

Medical *and* **Dental** Insurance

(If you do not have Medical or Dental Insurance, please put "NONE" in the spaces below.)

Medical Insurance Primary Carrier

Insured's Name________________________

Social Security #________________________

Insurance Company_____________________

Address________________________________

City________________State_____Zip_______

Group#______________ID#________________

Birthdate_______________________________

Insured's Employer______________________

Medical Insurance Secondary Carrier

Insured's Name________________________

Social Security #________________________

Insurance Company_____________________

Address________________________________

City________________State_____Zip_______

Group#______________ID#________________

Birthdate_______________________________

Insured's Employer______________________

Medical Insurance Tertiary Carrier

Insured's Name________________________

Social Security #________________________

Insurance Company_____________________

Address________________________________

City________________State_____Zip_______

Group#______________ID#________________

Birthdate_______________________________

Insured's Employer______________________

Medical Insurance Quaternary Carrier

Insured's Name________________________

Social Security #________________________

Insurance Company_____________________

Address________________________________

City________________State_____Zip_______

Group#______________ID#________________

Birthdate_______________________________

Insured's Employer______________________

Dental Insurance Primary Carrier

Insured's Name________________________

Social Security #________________________

Insurance Company_____________________

Address________________________________

City________________State_____Zip_______

Group#______________ID#________________

Birthdate_______________________________

Insured's Employer______________________

Dental Insurance Secondary Carrier

Insured's Name________________________

Social Security #________________________

Insurance Company_____________________

Address________________________________

City________________State_____Zip_______

Group#______________ID#________________

Birthdate_______________________________

Insured's Employer______________________

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. If we have made any changes to the Notice of Privacy on an annual basis.

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Privacy Officer in writing of your complaint. Please use the Grand Traverse Band Family Health Clinic complaint form. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at the Grand Traverse Band Family Health Clinic at telephone (231)534-7200 number or toll-free (866)-534-7750 ext.7200.

Please contact us for more information:

HIPAA Privacy Compliance Office
2300 N Stallman Rd, Suite A
Peshawbestown, Michigan 49682
(231) 534-7200

For Information about HIPAA:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
(202) 619-0527
Toll Free: 1-877-696-6775

PLEASE COMPLETE AND SIGN

Name:____

Address:____

____

Birth Date:__________________________________Phone Number:______________________

SIGNATURE FOR RECEIPT OF THE GRAND TRAVERSE BAND FAMILY HELATH CLINIC NOTICE OF PRIVACY PRACTICES

X____ Today's Date:_______________________

Signature (Relationship to the patient)

For Clinic Use Only

Policy Handed to Patient

Patient not Present

Policy sent to Patient

Refused

Initials:__________________

Chart Number:____________

Revised 4/2022 DSB

NO SHOW CANCELLATION POLICY

It is important to the care of our patients that appointment times be kept as scheduled. By failing to show up for your appointment as schedule, you are not only delaying and avoiding your dental or health care, but you are also occupying a time slot that could have been used for another patient's care. For this reason, we ask that if you are going to miss a scheduled appointment, please call us 24 hours in advance to reschedule. Failure to do so will constitute a "NO-SHOW" appointment. If you fail to show for 3 or more Medical side appointments within a 6-month period, you will be seen as time allows between appointments or toward the end of the day for medical clinic. If you fail to NO SHOW for 3 or more **Dental** appointments within a 6-month period, all future appointments previously made will be cancelled.

The GTB Family Health and **Dental** Clinics provide a courtesy reminder call for appointments approximately 1-2 days in advance. We will leave an appointment reminder voicemail with the phone number on file. However, in the event your phone has been disconnected or unable to accept voicemail messages, it can result in automatic cancellations for all GTB **Dental** Clinic appointments if you fail to keep your scheduled appointment.

WALK-IN POLICY

If you need **non-emergent** medical services during normal office hours, you may be seen as a walk-in patient without an appointment. Since you are being worked in, your wait may be longer that those patients with scheduled appointments. If you have a true dental emergency, you will then be scheduled as soon as possible.

LATE POLICY

If you are more than 10 minutes late for your scheduled appointment, we reserve the right to reschedule and you will be considered a "NO-SHOW."

______________________	____________________________________	__________________
Printed Name	Signature	Date
		HRN _________

Grand Traverse Band Family Health Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We at the Grand Traverse Band Family Health Clinic are required by law to maintain the privacy of individually identifiable health information, as required by the Federal Health Insurance Portability Act (HIPAA) of 1996. This notice describes how medical information about you may be used and how you can get access to this information. This protected health information is referred to a "PHI." We are also required to provide patients with a Notice of Privacy Practices permitted or required to post this Notice in a Prominent place in our facility; we will only disclose your PHI as permitted or required by applicable state law. Federal and state laws further restrict the uses and disclosers of your mental health, substance abuse and infectious disease information. This Notice applies to you PHI in our possession including the medical records generated by us.

A required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how e ma use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and operations.

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and unitization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, and utilization review. An example of this would be an internal quality assessment review.

We may also create and distribute unidentified health information by removing all references to individually identifiable information.
Other uses and disclosures will be made only with written authorization. You may revoke such authorization in writing and we are required to honor and abode by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respects to you PHI, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, closer personal friends, or any other person identified by you. We are however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or alternative locations.
- The right to inspect and copy our PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice form us upon request.

Revised 4/2022 DSB

Patient Rights and Responsibilities

Your rights

As a client of the Grand Traverse band Family Health Clinic and Contract Health you have the right to:

- Receive complete and current information about your diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand.
- Participate actively in determining a course of treatment for yourself.
- Receive information that you need in order to give informed consent for any proposed procedures of treatment, including information about the risks, benefits and alternatives to the proposed procedure or treatment.
- Refuse treatment and be told what effect this may have on your health and to have information of the other potential consequences of refusal.
- Request a second opinion from another physician.
- Receive considerate and respectful care in a clean and safe environment.
- Know by name the physicians, nurses and other staff members responsible for you care.
- Be notified of any medical research of educational projects that may affect your care.
- Refuse to take part in any research or educational projects.
- Have privacy while in the clinic, and confidentiality of al information and records regarding your care.
- Designate an individual to represent you in making decisions regarding your treatment and healthcare.
- Be provided with complete information about the clinic's policies regarding patient rights, patient complaints and advance directives.

Your Responsibilities

Rules and regulations regarding conduct are necessary to ensure that all patients are treated fairly and feel secure while being clients at the clinic or receiving services through Contract Health. Your cooperation in these responsibilities will help us provide quality care and service. Please…

- Cooperate with caregivers and follow the plan of care you, your physician and your health care team have agreed upon.
- Ask questions of your caregivers, and communicate any concerns or wishes you may have,
- Respect the privacy and confidentiality of other patients.

If you have any questions about your rights, need more information, or have a complaint, please contact the Health Administrative Assistant at 231-534-7200.

Grand Traverse Band Family Health Clinic

2023 Client Releases

AUTHORIZATON TO RELEASE INFORMATION AND ASSIGNMET OF BENEFITS

I hereby authorize the release of any or all of my Personal Heal Information, including the diagnosis and records necessary for the completion of all insurance claims. This release is solely for billing and reimbursement directly to Grand Traverse Band Family Health Clinic for any benefits for which I am entitled.

SIGNATURE: ___________________________________ DATE: ________________________

AUTHORIZATION TO RELEASE MEIDCAL INFORMATION

Based on the privacy act of 1974, P.L. 93.579, I hereby authorize the release of my medical information for referrals to health providers outside the Grand Traverse Band Family Health Clinic. By Signing this I understand that any or all information in my medical records may be release, not excluding medical information related to substance abuse, mental health, HIV/IDA, STD;'s etc.

SIGNATURE: ___________________________________ DATE: ________________________

RIGHTS AND RESPONSIBILITES

I have read and acknowledge receipt of the Patient Rights and Responsibilities statement.

SIGNATURE: ___________________________________ DATE: ________________________

HRN:_____________