Dear New Clients,

Welcome and thank you for choosing the Grand Traverse Band Health Services for your health care needs. We are dedicated to providing you with the best quality care possible. For new clients, the following documents are REQUIRED before scheduling a visit with GTB health services.

☐ Registration- MUST be filled out completely.

☐ Valid TRIBAL identification card from a federally recognized tribe- MUST be up to date.

☐ Valid Driver's License/State ID.

☐ Any active insurance card(s) you have.

☐ Any legal documents relevant to patient care:

- Legal guardianship, adoption, or foster care.
- Power of attorney related to medical services.

☐ Signed Release of Records Form- if you have/had a previous primary care provider.

☐ Two residency verification documents- current physical address only:

- Drivers License;
- State ID;
- Voter Registration Card;
- Lease Agreement;
- Vehicle Title;
- Envelope postmarked within the past 90 days. (including enrollee's name)

Once we receive your registration and all required documents, we will get you registered into our system, this process can take 24-48 hours. Our scheduler will contact you for an appointment.

ATTENTION:

INCOMPLETE REGISTRATION WILL NOT BE ACCEPTED – WE NEED ALL DOCUMENTS.

GRAND TRAVERSE BAND FAMILY HEALTH SERVICES

First Name: _____ Last Name: _____ Middle: _____ Preferred Name: _____

Date of Birth: _____ Social Security Number: _____ Religion: _____ Sex: **M | F**

Gender Identity: _____ Pronouns: _____ Marital Status: Single | Married | Divorced | Separated | Widow/er

Tribe: _____ Enrolled: **Y | N** Enrollment Number: _____ Ethnicity: Hispanic|non-Hispanic|Unknown

Race: American Indian/Alaska Native|Asian|Black /African American|Native Hawaiian/Pacific Islander|White|Other

City of Birth: _____ State of Birth:_____ Preferred Language: English | Spanish | Interpreter | Other

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Main Phone Number: _____ ALT number: _____ Work Number: _____

Do you have health/dental insurance: **Y | N** Insurance provider/s: _____

Do you have internet access: **Y | N** If yes, where at: Home | Work | School | Mobile | Library | Other

E-mail address:_____

Employed: **Y | N** Employer: _____ FT | PT | Disabled | Seasonal | Retired | Student

Spouse Employer: _____ Work Number:_____

Father's Name: _____ City of Birth: _____ State:_____

Mother's Name: _____ City of Birth: _____ State: _____

Emergency Contact: _____
Name Phone Number Relationship

Emergency Contacts Address: _____
Street City State Zip

Next of Kin: _____
Name Phone Number Relationship

Next of Kin Address:_____
Street City State Zip

How would you like GTB services to contact you about your appointments: MAIN PHONE | EMAIL | TEXT

MILITARY SERVICE

Veteran: **Y | N** Last Entry Date: _____ Service Separation Date: _____

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

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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 currently? **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:** _____

CLIENT RELEASES

AUTHORIZATION TO RELEASE HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize releasing any or all my Personal Health Information (PHI), including the diagnosis and records necessary to complete all insurance claims. This release is solely for billing and reimbursement directly to Grand Traverse Band Family Health Clinic for any benefits I am entitled to.

Based on the Privacy Act of 1974, P.L. 93.579, I authorize the release of my medical information for referrals to health providers outside the Grand Traverse Band Health Department and Behavioral Health Services. By Signing this, I understand that any or all information in my medical records may be released, not excluding substance abuse, mental health, HIV/AIDS, STDs, etc.

RIGHTS AND RESPONSIBILITIES

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

_____	_____	_____
Print Name	Signature	Date

HRN: _____

INITIALS: _____

NON-GTB/ NON-NATIVE CLIENT RELEASES

FINANCIAL POLICY

Our billing department will send a medical claim to your insurance company for the services you received here. We do take part with most billable insurance companies. You will, however, be financially responsible for the full payment of your co-pay before receiving services not covered by your insurance policy.

I understand I am Financially responsible for full payment of my co-pay before receiving services and for all deductibles not covered by your insurance policy.

*A non-Native member of an eligible Native's household may be seen at the GTB Clinic, Dental Clinic when it has been determined, in consultation with the Health Administrator, that services are necessary to control a public health hazard or an acute infectious disease, as stated in 42 C.F.R. § 136.12(a).

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize releasing any or all my Personal Health Information (PHI), including the diagnosis and records necessary to complete all insurance claims. This release is solely for billing and reimbursement directly to Grand Traverse Band Family Health Clinic for any benefits I am entitled to.

Based on the Privacy Act of 1974, P.L. 93.579, I authorize the release of my medical information for referrals to health providers outside the Grand Traverse Band Health Department. By Signing this, I understand that any or all information in my medical records may be released, not excluding substance abuse, mental health, HIV/AIDS, STDs, etc.

RIGHTS AND RESPONSIBILITIES

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

_____ _____ _____

Print Name Signature Date

HRN: _____

INITIALS: _____

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 Health Services at telephone (231)534-7200 number or toll-free (866)-534-7750 ext.7200, or in writing at:

Please contact us for more information:

HIPAA Privacy Compliance Office
Grand Traverse Band Health Department
2300 N Stallman Rd, Suite A
Peshawbestown, Michigan 49682

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:_____

I HAVE READ AND AKNOWLEDGE RECEIPT OF THE GRAND TRAVERSE HEALTH SERVICES NOTICE OF PRIVACY PRACTICES

_____ _____
Signature Date

HRN:_____
INITIALS:_____

NO-SHOW/CANCELLATION POLICY

To ensure effective patient care, it is important to keep scheduled appointments. Missing an appointment without notice delays your treatment and prevents other patients from receiving care during that time slot. If you need to cancel or reschedule, please notify us at least 24 hours in advance. Failure to do so will be considered a "no-show."

DENTAL PATIENTS who accumulate three or more no-shows within a 3-month period may only be seen on a walk-in basis as time permits. Additionally, some dental treatments must follow a specific sequence, and canceling or missing an appointment may impact subsequent visits.

As a courtesy, our offices will attempt to remind you of your appointment 1 to 2 days prior. Appointment reminders will be left via voicemail or text message at the phone number on file. Please note that if your phone service is disconnected or unable to receive voicemails, you risk automatic cancellation of future appointments.

WALK-IN POLICY

Patients seeking non-emergent medical services during regular office hours may be seen as walk-ins. However, wait times may be longer compared to scheduled appointments. In the case of a true dental emergency, we will prioritize scheduling you as soon as possible.

LATE POLICY

If you arrive more than 10 minutes late for your scheduled appointment, we reserve the right to reschedule your visit, and your appointment will be recorded as a "no-show."

_____	_____	_____
Print Name	Signature	Date

HRN: _____

INITIALS: _____

Grand Traverse Band Health Services

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 legally required 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 as "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 your PHI in our possession, including the medical records we generated.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may 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 providers. An example of this would include a physical examination.
- ***PAYMENT*** means obtaining service reimbursement, 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 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 make revoke your consent in writing, and we are required to honor and abide by that written request, except for the extent that we have already taken actions relying on your authorization. You have the following rights concerning your PHI, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on specific 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 decide on a limitation, 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 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 upon request.

CLIENT RIGHTS AND RESPONSIBILITIES

The Grand Traverse Band (GTB) Health Department is committed to providing you with caring, quality services. As a client you have specific rights and responsibilities

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.
- To participate actively in determining a course of treatment for yourself.
- To receive information, you need to give informed consent for any proposed treatment procedures, including information about the risks, benefits, and alternatives to the proposed procedure or treatment.
- To refuse treatment, be told what effect this may have on your health and have information on the other potential consequences of refusal.
- To request a second opinion from another physician.
- To receive considerate and respectful care in a clean and safe environment.
- To know by name the physicians, nurses, and other staff members responsible for your care.
- To be notified of any medical research or educational projects that may affect your care.
- To refuse to take part in any research or educational projects.
- To have privacy while in the clinic, and confidentiality of all information and records regarding your care.
- To designate an individual to represent you in making decisions regarding your treatment and healthcare.
- To be provided with complete information about the clinic's policies regarding patient rights, patient complaints, and advance directives.

Rules and regulations regarding conduct are necessary to ensure that all patients are treated fairly and feel secure while receiving services. Your cooperation in following through with these responsibilities will help us provide you and others with quality services.

You are Responsible:

- To confirm scheduled visits and appointments by responding to confirmation calls/texts.
- To keep contact information such as phone numbers and addresses up to date.
- To come to all appointments with your correct and current insurance cards and tribal ID.
- To cooperate with your caregivers and follow the plan of care you, your physician, and your health care team have agreed upon.
- To please try to understand and follow instructions concerning your treatment and ask questions if you do not understand or need further explanation. Your overall health is important.
- To respect the privacy and confidentiality of other patients.
- To cooperate with all people providing you with care.
- Respect the property and the environment.
- To inform outside providers (e.g. urgent care, emergency room, and referral offices) of the clinic's name, your primary care provider, and our fax number to ensure all records are sent to us. This will help us provide you with quality care in a timely manner. Our fax number is 231-534-7460.

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