GRAND TRAVERSE BAND FAMILY HEALTH CLINIC

Last Name_____ FirstName_____ Middle_____
Birth Date: _____ Social Security Number_____ Sex: M F
Tribe:_____ Enrolled: Y N Enrollment Number:_____
Are you: Married Single Divorced Widowed?
Telephone Number: _____ Work Number: _____
Employer: _____ Full Time Part Time Seasonal

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# _____ Birthday_____ Insured's Employer _____	**Medical insurance secondary Carrier** Insured's name _____ Social security #_____ Insurance company_____ Address _____ City _____state _____Zip _____ Group # _____ID# _____ Birthday_____ Insured's Employer _____
Dental insurance Primary Carrier Insured's name _____ Social security #_____ Insurance company_____ Address _____ City _____state _____Zip _____ Group # _____ID# _____ Birthday_____ Insured's Employer _____	**Dental insurance Secondary Carrier** Insured's name _____ Social security #_____ Insurance company_____ Address _____ City _____state _____Zip _____ Group # _____ID# _____ Birthday_____ Insured's Employer _____

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 the 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 / Denosumab (Prolia, Xgeva) / 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. It is only for the treatment, billing, and processing of insurance for benefits to 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 for the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the service bill. 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:** _____

Grand Traverse Band Family Health Clinic

Non-GTB/ *Non-Native* Employee/*Non-Native* Spouse Medical 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 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-Indian member of an eligible Indian's household may be seen at the GTB 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 INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize releasing any or all my Personal Health Information, 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.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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 Family Health Clinic. By Signing this, I understand that any or all information in my medical records may be released, not excluding medical information related to substance abuse, mental health, HIV/IDA, STDs, etc.

RIGHTS AND RESPONSIBILITIES

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

SIGNATURE: _____ DATE: _____

HRN: _____

INITIALS: _____

Grand Traverse Band Family Health Clinic

2024 Client Releases

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize releasing any or all my Personal Health Information, 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.

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RIGHTS AND RESPONSIBILITIES

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

SIGNATURE: _____ DATE: _____

NO-SHOW CANCELLATION POLICY

It is essential for the care of our patients that appointment times be kept as scheduled. By not showing up for your appointment as planned, you are not only delaying and avoiding your dental or health care but 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 "NO-SHOW" for three or more appointments within a 3-month period, you will be seen **as time allows**.

The GTB Family **Health** and **Dental** Clinics will provide a courtesy reminder call for appointments approximately 1 to 2 days in advance. We will leave an appointment reminder voicemail with the phone number on file. However, suppose your phone has been disconnected or unable to accept voicemail messages. In that case, it can result in automatic cancellations for all GTB **Dental** Clinic appointments if you do not keep your scheduled appointment. Please be aware that some **Dental** appointments must be completed in a specific order, and if you cancel/no-show one appointment, it could also affect others.

WALK-IN POLICY

If you need **non-emergent medical** services during regular 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 than 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

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 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 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 your consent in writing, and we are required to honor and abode by that written request, except for the 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.

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

We must 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 make the new notice provisions effective for all PHI we maintain if we have made any changes to the Notice of Privacy on an annual basis.

You may complain to us or 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 (231)534-7478 or toll-free (866)-534-7750 ext.7478.

Don't hesitate to get in touch with us for more information: HIPAA Privacy Compliance Office Attn: Judy Stott 2300 N Stallman Rd, Suite A Peshawbestown, Michigan 49682 (231) 534-7478	Information about HIPAA: The U.S. Department of Health & Human Services Office of Civil right 200 Independence Avenue, SW Washington, D.C. 20201 (202) 619-0527 Toll Free: 1-877-696-6775

For Clinic Use Only

Policy Handed to Patient Patient Not Present.

The policy sent to Patient Refused

Patient Rights and Responsibilities

Your rights

As a client of the Grand Traverse Band Family Health Clinic, Dental Clinic, and PRC 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 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.
- Refuse treatment, be told what effect this may have on your health, and have information on 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 your care.
- Be notified of any medical research or 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 all 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 get in touch with the Health Administrative Assistant at 231-534-7200.

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