Indian Health Council
50100 Golsh Rd
Valley Center CA 92082
760-749-1410

Empowering Native Wellness

NEW PATIENT REGISTRATION PACKET (MINOR)

Indian Health Council, Inc. (IHC) would like to take this opportunity to thank you for your interest in registering your minor child with us as a patient.

Patient health and well-being is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. IHC is able to treat a full spectrum of both acute illnesses and chronic conditions and offer a wide variety of services and preventive programs to address your physical, mental, and spiritual being. We strive to “Empower Native Wellness."

To register as an IHC patient, **persons must first provide proof of Indian** in order to determine eligibility. Acceptable proof of Indian documentation includes; Tribal ID Card, documentation from the Bureau of Indian Affairs (CDIB), or letter from one of our 9 consortium Tribes documenting enrollment and or lineal descent to an enrolled member. Minor children (children 18 and under) are covered under their parent’s proof of Indian until the age of 19. Out of State Natives are required to be enrolled members of their tribe to be eligible to register as an IHC patient. Out of State minors are covered under their parent’s proof of Indian until the age of 19.

In addition to proof of Indian, persons need to complete the forms contained within this registration packet in entirety and provide copies of the below listed documents, thereby completing the registration process and becoming an IHC patient.

- ☐ **PROOF OF RESIDENCY** (Water or Electric Bill, DMV Registration, Rental/Lease Agreement)
- ☐ **CURRENT MEDICAL AND DENTAL INSURANCE CARD(S)**
- ☐ **COPY OF SOCIAL SECURITY CARD**
- ☐ **COPY OF BIRTH CERTIFICATE**

Again, thank you for choosing to register your minor child with IHC. We look forward to assisting your family with their healthcare needs.

Sincerely,

Indian Health Council, Inc.
Phone: (760) 749-1410 ext. 5344
Fax: (760) 233-5594

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MINOR PATIENT REGISTRATION
DEMOGRAPHIC INFORMATION

Patient Name: (Last)_____(First)_____(Middle)_____

Other Names: (AKA) _____ Birth Sex:(Male) _____(Female)_____

Date of Birth: (Month)_____(Day)_____(Year)_____ Social Security#_____/_____/_____

Physical Address: _____(City)_____(State)_____(Zip)_____

Mailing Address: _____(City)_____(State)_____(Zip)_____

Home Phone # (_____) _____Cell Phone # (_____)_____

Race: American Indian African American Asian Hispanic Pacific Islander White Decline to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Report

Tribal Affiliation: _____Tribal Enrollment #: _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name: (Last)_____(First)_____(Middle)_____

Date of Birth: (Month)_____(Day)_____(Year)_____ Social Security#_____/_____/_____

Tribal Affiliation: _____ Tribal Enrollment #: _____

Home Ph # (_____) _____Cell Ph # (_____) _____Work Ph# (_____) _____

Physical Address: _____(City)_____(State)_____(Zip)_____

Mailing Address: _____(City)_____(State)_____(Zip)_____

Does the minor live with you: (Yes)_____ (NO)_____

Father/Guardian Name: (Last)_____(First)_____(Middle)_____

Date of Birth: (Month)_____(Day)_____(Year)_____ Social Security#_____/_____/_____

Tribal Affiliation: _____ Tribal Enrollment #: _____

Home Ph # (_____) _____Cell Ph # (_____) _____Work Ph# (_____) _____

Physical Address: _____(City)_____(State)_____(Zip)_____

Mailing Address: _____(City)_____(State)_____(Zip)_____

Does the Minor live with you: (Yes)_____ (NO)_____

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PATIENT INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE

Subscriber Name: _____
Subscriber Date of Birth: _____
Relationship to Patient: _____
Insurance Name: _____
Insurance Phone #: (_____) _____
Policy #: _____
Group #: _____
Employer: _____

SECONDARY MEDICAL INSURANCE

Subscriber Name: _____
Subscriber Date of Birth: _____
Relationship to Patient: _____
Insurance Name: _____
Insurance Phone #: (_____) _____
Policy #: _____
Group #: _____
Employer: _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____
Subscriber Date of Birth: _____
Relationship to Patient: _____
Insurance Name: _____
Insurance Phone #: (_____) _____
Policy #: _____
Group #: _____
Employer: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____
Subscriber Date of Birth: _____
Relationship to Patient: _____
Insurance Name: _____
Insurance Phone #: (_____) _____
Policy #: _____
Group #: _____
Employer: _____

If you are currently uninsured, please complete the following:

Number of Adults in Household: _____ Number of Children in Household: _____

Approximate Annual Income: 0-$10,000 $10,001-$25,000 $25,001-$40,000 $40,001-$55,000
$55,001-$65,000 over $65,000

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge.

_____
Name of Patient (Print)

_____ _____ _____
Name of Responsible Party (Print) Signature of Responsible Party Date

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Chart # _____

Consent for Treatment & Assignment of Benefits

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:
   The undersigned consents to the patient entering the IHC Facility and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include emergency services, laboratory procedures, x-ray examinations, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:
   The IHC Facility will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that the Facility may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient; Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

3. Payment for services rendered:
   I, the undersigned, certify that the information given to the IHC Facility in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me and authorize the IHC Facility to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____
Patient/Legal Representative

Relationship to Patient: _____

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Chart # _____

MEDICAL PATIENT/HEALTH HISTORY (CHILD-Age < 19)

Name of Patient: _____
Last Name First Name Middle Initial

Sex: ☐ Male ☐ Female Age: _____ Birth date: _____ Nickname: _____

What is the name of your child's medical doctor? _____

Has there been any change in your child's general health this past year? ☐ Yes ☐ No

If yes, please describe the changes: _____

List any medications (pills or drugs) that your child is currently taking: _____

List any other medications your child has taken in the last two months: _____

Is your child allergic to anything? ☐ Yes ☐ No If yes, please list drug(s) and reactions(s): _____

Past Medical History

Does your child have any current chronic illnesses such as: Diabetes, Hypertension, Heart Disease, Asthma, ADD/ADHD, etc.?

☐ No ☐ Yes, please list: _____

_____

_____

_____

Has your child had any prior serious illness or surgeries? ☐ No ☐ Yes, please list including dates if known:

_____

_____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes, please explain: _____

_____

_____

_____

Has your child ever had any surgeries? ☐ No ☐ Yes, please explain: _____

_____

_____

Is your child being treated by a physician now? ☐ Yes ☐ No

Date of your child's last medical exam: Month Day Year ☐☐☐☐☐☐☐☐ None ☐

Reason for exam: _____

Is your child being treated by a dentist now? ☐ Yes ☐ No

Date of your child's last dental exam: Month Day Year ☐☐☐☐☐☐☐☐ None ☐

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Family History (Check all that apply):

Please indicate if your mother, father or sibling has any of the following diseases now or if it was their cause of death (COD).

	Mother		Father		Sister(s)		Brother(s)	
	Now	*COD*	*Now*	*COD*	*Now*	*COD*	*Now*	*COD*
CVA (stroke)								
Diabetes								
Heart disease								
Heart disease before 60								
Heart failure								
High blood pressure								
High cholesterol								
Renal disease								

Please indicate if your mother, father or sibling has had any of the following diseases:

Alcoholism								
Allergies								
Alzheimer's disease								
Asthma								
Blood disease								
Cancer								
Circulation Problems								
Depression								
Development delay								
Eczema								
Irritable bowel disease								
Learning disability								
Mental Illness								
Migraines								
Obesity								
Seizure disorder								

Other family history:

Immunizations (Approximate dates are fine):

Date of last flu shot? _____ ☐ None Date of last pneumonia shot: _____ ☐ None

Date of last tetanus shot: _____ ☐ None **PLEASE ATTACH COPY OF IMMUNIZATION RECORD**

Social History (ALL AGES):

Parents Relationship: ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Life Partner

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French Other: _____

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian Other: _____

☐ Native American: Tribe _____

Who lives at home?

Name:	Age:	Relationship:		Name:	Age:	Relationship:

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Social History (ALL AGES): Cont'd

Mother's Occupation: _____

Father's Occupation: _____

Are there any occupational hazards at your place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, please list: _____

Any concerns about lead exposure? ☐ No ☐ Yes

Water source: ☐ Municipal ☐ Well Is water fluoridated? ☐ No ☐ Yes

Tobacco Exposure: Are there smokers in the home? ☐ No ☐ Yes

If yes, amount of exposure: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Child Care? ☐ No ☐ Yes If so, how many hours per week? _____

Social History (BIRTH TO ONE YEAR):

Sleep:	Yes	No		Safety:	Yes	No
Takes Naps:				Car restraints:		
Nightmares/sleep problems:				Carbon monoxide detector:		
Sleeps with parents:				Smoke detectors:		
Sleeps through the night:				Pets/animals at home:		
Minimum 8.5 hrs sleep nightly:						

Sleep position: ☐ Back ☐ Abdomen Car restraints: Front facing: ☐ None: ☐

# of firearms: ☐ Locked Storage: ☐ No ☐ Yes Rear facing: ☐

Social History (1 YEAR TO <5 YEARS):

Sleep:	Yes	No		Safety:	Yes	No
Takes Naps:				Uses bike/skating helmet:		
Nightmares/sleep problems:				Car restraints:		
Sleeps with parents:				Carbon monoxide detector:		
Sleeps through the night:				Smoke detectors:		
Minimum 8.5 hrs sleep nightly:				Pets/animals at home:		

Concerns: _____ Relationship with sibling(s): _____

Activity: Exercise/sports ☐ hours per day TV/Computer games ☐ hours per day

Hand Dominance: Right ☐ Left ☐

Education:		
School Name:		
Grade level in School:		
	Yes	No
Learning Disability?		
Special Needs?		

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Social History (5 YEARS TO <11 YEARS):

Sleep:	Yes	No		Safety:	Yes	No
Takes Naps:				Uses bike/skating helmet:		
Nightmares/sleep problems:				Car restraints:		
Sleeps with parents:				Carbon monoxide detector:		
Sleeps through the night:				Smoke detectors:		
Minimum 8.5 hrs sleep nightly:				Pets/animals at home:		

Sleep position: ☐ Back ☐ Abdomen Car restraints: Front facing: ☐ None: ☐

Of Firearms: ☐ Locked Storage: No ☐ Yes ☐ Hand Dominance: Right ☐ Left ☐

Relationships:	Yes	No		Education:	Yes	No
Cooperates w/family, friends:				School name:		
Cooperates with teachers:				Grade in school:		
Has enough friends:				Grades earned:		
Has friends of both sexes:				Gifted program:		
Concerns about relationship w/family, friends, others:				Learning disability:		
				Special Needs:		

Concerns: _____ Relationship with sibling(s): _____

Activity: Exercise/sports ☐ hours per day TV/Computer games ☐ hours per day

Social History (11 YEARS TO <19 YEARS):

Sleep:	Yes	No		Safety:	Yes	No
Minimum 8.5 hrs sleep nightly:				Uses bike/skating helmet:		
Nightmares/sleep problems:				Car restraints:		
Alcohol Use:				Carbon monoxide detector:		
Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely				Smoke detectors:		
				Pets/animals at home:		

Concerns: _____ Relationship with sibling(s): _____

Activity: Exercise/sports ☐ hours per day TV/Computer games ☐ hours per day

Hand Dominance: Right ☐ Left ☐

Relationships:	Yes	No		Education:	Yes	No
Cooperates w/family, friends:				School name:		
Cooperates with teachers:				Grade in school:		
Has enough friends:				Grades earned:		
Has friends of both sexes:				Gifted program:		
Concerns about relationship w/family, friends, others:				Learning disability:		
				Special Needs:		

The information I have given is correct and to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature of Parent/Guardian *Date*

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Chart # _____

Dental Patient/ Health History (Child)

Name of Minor/Child: _____
Last Name First Name Middle Initial

Sex: M ☐ F ☐ Age: _____ Birth date: _____ Nickname: _____ Hobbies: _____

MEDICAL HISTORY

Minor/Child's Physician: _____ City/State: _____ Phone: _____

Date of last physical examination: _____ Results: _____

Has your child received medical treatment within the last six months? _____ Reason: _____

Does your child have a heart condition or heart murmur? _____ Explain: _____

Have you ever been told that your child should have antibiotics before all dental appointments? _____

Has your child ever been hospitalized? _____ Date: _____ Reason: _____

Has your child ever had a serious illness or operation? _____ Please List: _____

Has your child had a blood transfusion or received any clotting agents? _____ Date: _____ Reason: _____

Does either your family or your child have a history of complication from general anesthesia? _____

If so, what type? _____

Is your child taking any medications? _____ If yes, what? _____

_____

Does your child have any allergies? _____ If yes, to what? _____

_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK ☑

☐ A.I.D.S.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Seizures/Convulsions	☐ Hearing Problems	☐ Latex Allergy	☐ Bleeding Tendencies
☐ Bladder Problems	☐ Diabetes	☐ Alcohol/Drug Abuse	☐ Mumps	☐ Hepatitis
☐ Cancer	☐ Heart Problems/Murmur	☐ Congenital (Born with) Heart Problems		

DENTAL HISTORY

Date of last Visit to a dentist: _____ For what service? _____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc...? ☐ ☐

_____

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____
Signature of Parent/Guardian Date

FOR OFFICE USE ONLY

NOTES: (For Dental Staff) _____ For Office Use Only: Date: _____ Reviewer: _____

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FINANCIAL SCREENING FORM

CHART # _____

Indian Health Council, Inc. is currently participating in the following programs: Medi-Cal, Covered California. Answer the following questions for yourself *OR* for the person being seen to determine which program is appropriate.

Patient Being Screened:	Age:	Phone:
Parent/Person Responsible:		Patient SSN:
Mailing Address:		Patient Birth date:

Number of Household Dependents: Adults _____ Children _____

Household Gross **Monthly** Income (before deductions): $ _____

- ☐ I certify that the above Household Size and income declaration is true and correct. I agree to notify Indian Health Council of any changes.
- ☐ I do not wish to declare my household size and income and understand that it will affect the ability to determine my eligibility for publicly Funded healthcare programs and for Contract Health Services benefits.

SIGNATURE: _____ **DATE:** _____

Are you INDIAN?	Are you a VETERAN?	Do you live in San Diego County?	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Does the patient currently have any of the following? (✔ which apply):

☐ Medi-Cal ☐ Medicare ☐ Private Health Insurance ☐ Dental Insurance ☐ VA Insurance
☐ Pharmacy Insurance

1. List name of coverage: _____
2. Policy Number: _____
3. Insurance Phone Number: (___) _____
4. STOP HERE, AND RETURN TO THE RECEPTIONIST ALONG WITH YOUR CARD.

BELOW FOR IHC OFFICE USE ONLY

MEDI-CAL Eligible ☐ YES ☐ NO ☐ With NO SOC ☐ SOC: $ _____		
FAMILY PACT Eligible ☐ YES ☐ NO Eligibility Date:	CDP Eligible ☐ YES ☐ NO Eligibility Date:	
Signature:		Date:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

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OFFICE POLICY NOTICE TO PATIENTS

IHC strives to provide you the best personalized care available. To make this possible, IHC adheres to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement and understanding by signing at the bottom.

LATE POLICY

☐ Medical Department: Being late more than five (5) minutes for a fifteen (15) minute appointment or seven (7) minutes late for a thirty (30) minute appointment will require you to reschedule your appointment or wait and be placed on the nurse triage list to determine need to be seen. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ Dental Department: Being late more than five (5) minutes for an appointment that is shorter than one hour or fifteen (15) minutes for an appointment greater than or equal to one hour will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations or no-shows are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

TWENTY-FOUR HOUR ADVANCE NOTICE

☐ If you wish to change or cancel an appointment, we would like a 24-hour advance notice. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

NO-SHOWS

☐ Medical Department: "No-Show" is defined as not showing up for your appointment with no notice ***or*** not canceling/rescheduling your appointment ***within 24 hours of your appointment time***. "Appointment" is defined as **1)** a regular scheduled appointment with any Primary Care Provider (PCP) and **2)** any Diabetes or Pain Management Clinic appointment. If a patient has 3 or more No-Show appointments in the previous 3 months, he or she will be put on "Restrictive Access" status for 3 months and notified by letter. During the Restrictive Access period, a patient will not be able to schedule routine visits with any Primary Care Provider (PCP) but can be seen only on a walk-in basis by any PCP based on their availability.

☐ Dental Department: If you fail to show for an appointment without notice, that is considered a no-show. The dental department adheres to a strict policy stating that after 3 no-shows, a patient will have all future appointments removed and will not be rescheduled for a three-month period. If a patient wants to be seen during this period, they must arrive at 8:00am or 1:00pm and wait to see if an opening becomes available. If the patient is seen, they will be removed from the no-show list.

MISSING INDIAN VERIFICATION (PROOF OF INDIAN)

☐ Native Americans coming into the clinic without their Proof of Indian (Tribal ID or CDIB) will be seen one time only and will be required to complete a "One Time Only Visit" form.

ELIGIBILITY FOR IHC HEALTHCARE SERVICES DOES NOT MEAN SERVICES ARE FREE

☐ Fees for services and responsibility for payment are based on the patient's eligibility for care according to the following categories: PRC Native, Direct Native and Non-Native and as governed by federal laws and regulations. There are times that patients will be charged for services rendered by IHC.

SPECIALTY COPAYMENTS ARE DUE AT TIME OF SERVICE

☐ Patients with an eligibility status of Direct, whom do not have insurance, are required to pay a $20 copayment at the time of service for the following specialty services: acupuncture, cardiology, chiropractic, podiatry, and optometry. In addition, uninsured Direct Natives are responsible for copayments for major dental work and shall be given a dental treatment estimate in advance of work being performed.

☐ If you are experiencing financial difficulties and are unable to afford the cost of our services, we offer a sliding fee scale set in accordance with federal poverty guidelines according to household size and income. Proof of income is required to access discounted fees.

CELL PHONES & VIDEO/AUDIO MONITORING

☐ Cell Phones: We realize emergencies may arise and allow you to have your phone with you during your appointment however please set it to silent mode or have it turned off so as not to interrupt your time with your provider and to maximize your quality of care.

☐ Video & Audio Monitoring: IHC prohibits patients from video or audio recording of other patients or employees without their prior consent.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Patient/Legal Representative

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AUTHORIZATION AND CONSENT TO TREATMENT OF A MINOR CHILD UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

To authorize an adult to accompany and consent to IHC treatment or services for your child(ren), please complete the sections below. By completing this authorization, you consent to the sharing of your child(ren)'s protected health information, as related to the appointment, with this individual(s) as outlined in IHC's Notice of Privacy Practices.

AUTHORIZATION (Please print): **I,**
_____authorize the following individual(s):
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to accompany and consent to routine healthcare and/or services for my minor child/children listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Routine healthcare and services may include but are not limited to: necessary medical and dental care, medical examination, physical exam, immunizations, x-rays, lab work, or other care which is deemed advisable by, and to be rendered under the supervision of an IHC provider. This form does not permit the person's listed above to request and/or receive medical record documents from IHC.

LIMITATIONS: Identify any **specific limitations** on the kinds of services for which this authorization is given. (If none, state "none"): _____

I understand that in the event of a major illness or injury, an attempt will be made to contact the parent(s) or legal guardian.

I understand that this form will go into effect upon signature date and that I may revoke this consent at any time, by notifying in writing and submitting to **IHC**.
I have read, understand, and give my consent as stipulated above. I/we further acknowledge that I/we are responsible for any portion of charges not covered by insurance. (Only one signature is required)

Parent/Guardian Name: _____ Relationship: _____

_____ Date: _____
Signature of Parent or Legal Guardian

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Patient Rights and Responsibilities

As a patient, you have the right to:

1. Receive considerate, compassionate and respectful care in a safe and secure environment free from all forms of abuse, harassment, neglect and mistreatment.
2. Be treated with respect and regard for privacy, individuality, personal values, beliefs, spiritual and cultural traditions.
3. Be informed of your rights and the policies regarding them both verbally and in writing in a manner in which you or your representative understands.
4. Personal privacy and confidentiality. Consultation, examination, treatment and case discussion are confidential and will be conducted discreetly.
5. Receive timely and qualified care in a setting appropriate to health care needs.
6. Receive referrals to staff and services in a timely manner consistent with quality professional practice.
7. Access protective and advocacy services in cases of abuse or neglect.
8. Know the professional status of the person(s) directing and/or providing care and those giving medical advice after hours.
9. Participate in decisions affecting your care and treatment according to your desires, needs, and understanding including the choice to have family and friends participate in the process.
10. Receive information regarding your health status, diagnosis, prognosis, the course of treatment, the benefits and risks of treatment, and the prospects for good health in terms you can understand.
11. Refuse care, treatment and services, to the extent permitted by law. You will be fully informed of possible consequences of such refusal.
12. Submit an Advanced Directive and appoint someone to make health care decisions for you if you are unable to. If you do not have an Advance Directive, we can provide you with information and help you complete one. All patients' rights apply to the person whom you elect.
13. Express satisfaction regarding services rendered and to comment and make suggestions for improvement of the quality of care and services.
14. File a complaint and to receive a response in a timely manner without fear of discrimination.
15. Access your medical records, approve and refuse the release of your medical records. Records are maintained private and confidential in a safe and secure environment.
16. Know, in advance of services, the cost of services and any applicable payment policy.
17. Agree or refuse to participate in research/experimental activities.
18. Change your Primary Care or Dental providers if other qualified practitioners are available.

As a patient, you have the responsibility to:

1. Ask questions and actively participate in discussions and decisions regarding your health care.
2. Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospitalizations and medications.
3. Discuss your health care problems, concerns, and personal needs with your provider in an honest manner and to inform the health care provider of any changes occurring in your health.
4. Come to all appointments drug and alcohol free. Patient's believed to be under the influence will be asked to leave.
5. Cooperate with all health care personnel involved in your care and to conduct yourself in a polite and respectful manner.
6. Respect the rights of your health care provider and to exchange information in a non-abusive manner either physically or verbally while receiving care.
7. Follow your provider's health care instructions or inform provider if you cannot or will not follow treatment plan.
8. Accept consequences for refusing care or not following treatment plan.
9. Show consideration and respect the rights and property of all health care professionals, employees, and other patients.
10. Make and keep all scheduled appointments. To assure that all patients are served in a timely manner, patients are responsible for calling and changing appointments 24 hours in advance.
11. Pay for services at the time service is provided and to provide the patient registration office with accurate, complete, and current information pertaining to insurance coverage, home address, telephone number, social security number, and Native American Indian verification. You have a right to receive detailed information regarding your bill.
12. Advise your provider of all changes in decisions concerning advance directives and/or persons designated by you to make health care decisions.

IHC recognizes and adheres to patient rights under HIPAA CFR 164.524. Additional information can be found at www. hhs.gov – Privacy Rule.

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50100 Golsh Rd
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760-749-1410

Empowering Native Wellness

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES

Patient Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of Indian Health Council's current "Patient Rights and Responsibilities." We encourage you to read it in full. I understand that I may request a copy of the "Patient Rights and Responsibilities" at any time. I understand that the document may also be viewed at: www.indianhealth.com under Forms. I understand that "Patient Rights and Responsibilities" are subject to change. I understand that Indian Health Council will inform me of such changes.

_____ _____

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, please print name: _____

If signed by other than patient, please indicate relationship: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Indian Health Council, Inc. has made good faith efforts to obtain your signature. This section will only be completed if no signature is obtained.

Reasons why the Acknowledgement was not signed: _____

Patient refused to sign this Acknowledgement even though the patient was asked to do so and was given the Notice of Patient Rights and Responsibilities.

_____ _____

IHC Employee Name Date

_____

Signature

Indian Health Council
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Empowering Native Wellness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of Indian Health Council's current "Notice of Privacy Practices." The "Notice" describes how we may use and disclose your protected health information and informs you of your rights with respect to your protected health information. We encourage you to read it in full.

I understand that I may request a copy of the "Notice of Privacy Practices" at any time. I understand that the Notice may also be viewed at: www.indianhealth.com.

I understand that the "Notice of Privacy Practices" is subject to change. I understand that Indian Health Council will inform me of such changes.

_____ _____

Signature of Patient or Legal Representative Date

If signed by other than patient, please indicate relationship: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Indian Health Council, Inc. has made good faith efforts to obtain your signature. This section will only be completed if no signature is obtained.

Reasons why the Acknowledgement was not signed:

Patient refused to sign this Acknowledgement even though the patient was asked to do so and was given the Notice of Privacy Practices.

Other: _____

_____ _____

IHC Employee Name Date

_____

Signature

Indian Health Council
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Valley Center CA 92082
760-749-1410

Empowering Native Wellness

ACKNOWLEDGEMENT OF RECEIPT OF ADVANCE DIRECTIVE INFORMATION

PLEASE READ THE FOLLOWING TWO STATEMENTS:

Place your initials after each statement.

1) I have been offered written materials about my right to accept of refuse medical treatments: _____

2) I understand that I am not required to have an **ADVANCE DIRECTIVE** in order to receive medical treatment at this clinic: _____

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

_____ I have executed an **ADVANCE DIRECTIVE** for health care.

_____ I have **not** executed an **ADVANCE DIRECTIVE** for health care.

Patient Date of Birth: _____

Print Name: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Indian Health Council
50100 Golsh Rd
Valley Center CA 92082
760-749-1410

Empowering Native Wellness

Chart # _____

ACKNOWLEDGEMENT OF RECEIPT OF Dental Materials Fact Sheets

"I understand that I can request from Indian Health Council, Inc. Dental Department, a copy of the Dental Materials Fact Sheet dated May 2004, at any time."

_____ _____
Patient Name (Print) Patient's Date of Birth

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Signature and title of IHC Employee Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of "Dental Materials Fact Sheet" packet because:

_____
_____
_____
_____

Signature of IHC Staff: _____ Date: _____