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 our offices during our regular hours at (231) 534-7200 Medical or (231) 534-7211 Dental. If you would like to fax the information you may do so by faxing to (231) 534-7460 attention REGISTRATION.

Thank you,

Grant Traverse Band Family Health Clinics

Grand Traverse Band Family Health & Dental Clinics Registration

Last Name First Name Middle Name 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:_____

Name 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:_____

Revised 1/22

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 Practices you will be notified during your next visit or by mail. It is required that you also sign a copy of the Notice if Privacy Practices 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 number (231) 534-7200 or toll-free at (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 HEALTH CLINIC NOTICE OF PRIVACY PRACTICES

X_____ Today's Date: _____
Signature (Relationship to patient)

FOR CLINIC USE ONLY

Policy Handed to Patient

Policy sent to Patient

Patient not Present

Refused

Initials: _____

Chart Number: _____

NO SHOW AND 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 scheduled, you are not only delaying and avoiding your medical 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 appointment within a 6-month period, you will be seen as time allows between appointments or towards the end of the day.

The GTB Clinic provides a courtesy reminder call for appointments 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 is un-able to accept voicemail messages, it can result in automatic cancellation** for all GTB Clinic appointments if you fail to keep scheduled appointment.

WALK-IN POLICY

If you need **non-emergent** medical care 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 than those patients with scheduled appointments. Patients experiencing true medical emergencies will be seen first.

LATE POLICY

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

Print Name	Signature	Date

HRN:_____

Grand Traverse Band Family Health Clinic

2022 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:_____

Revised 1/22

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 patients health information, as required by the Federal Health Insurance Portability and Accountability 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 regarding PHI. We are 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 disclosures of your mental health, substance abuse, and infectious disease information. This Notice applies to your PHI in our possession including the medical records generated by us.

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 purposed: treatment, payment, and operations.

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care provides. 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 utilization 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 abide 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 your 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, close 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 at alternative locations.
- The right to inspect and copy your 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 from us upon request.

Patient Rights and Responsibilities

Your Rights

As a client of the Grand Traverse Band Family Health 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 procedure 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 be informed 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 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 health care.
- 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 clinics or receiving services through Purchase Referred Care. 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 clinic patients.

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