LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

Purchased/Referred Care Program
1260 Ajijaak Avenue
Petoskey, MI 49770
P: 231-242-1600
F: 231-242-1617
E: prcfax@ltbbodawa-nsn.gov

CENTRAL REGISTRATION
YEARLY UPDATE

FULL LEGAL NAME: ______________________________

DATE OF BIRTH: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

HOME PHONE: ____________________ **CELL PHONE:** ____________________

CURRENT ADDRESS: ______________________________

____

EMERGENCY CONTACT: ______________________________

PHONE NUMBER: ______________________________

ADDRESS: ______________________________

NEXT OF KIN CONTACT: ______________________________

PHONE NUMBER: ______________________________

ADDRESS: ______________________________

ARE YOU EMPLOYED?

YES - PART-TIME
YES - FULL-TIME
NO

EMPLOYER INFORMATION:

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INSURANCE INFORMATION:

MEDICARE? IF YES, ID#: ______________________________

MEDICAID? IF YES, ID#: ______________________________

PRIVATE INSURANCE? IF YES, NAME: ______________________________

POLICY #: ____________________ GROUP #: ____________________

POLICY HOLDER'S NAME: ______________________________

POLICY HOLDER'S DATE OF BIRTH: ______________________________

HRN #: ____________

Little Traverse Bay Bands of Odawa Indians
Health Department
1260 Ajijaak Ave. Petoskey, MI 49770
Telephone: 231.242.1700

PATIENT CONSENT FORM

The Little Traverse Bay Bands Health Department is committed to providing highly qualified services and ensuring a holistic approach for all Anishinaabe by respecting and intertwining both modern and traditional healing.

We want you to understand your right and responsibilities while receiving care within our organization. If you have any questions about this form, please ask prior to signing. If you are a parent/legal guardian of a child, please read this agreement with the understanding that “I” and “me” means the child.

AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREAT:

I consent to outpatient care from the Little Traverse Health Clinic (Mina-Mskiki-Gumik) including medical treatment, examination, and routine diagnostic procedures—including routine laboratory work and administration of medication as deemed medically necessary in the professional judgement of my medical provider. I also understand that I have the option to refuse any health care services at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

TELEMEDICINE:

I understand that the Little Traverse Bay Bands Health Department may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a remote site at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Possible Risks: Just like any other medical procedure, there are potential risk associated with the use of telemedicine. These risks include but may not be limited to:

- Information being transmitted may have poor sound or image quality to allow for appropriate medical decision making by the provider
- Delays in medical evaluation and treatment could occur due to equipment failure
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;
- In very rare instances, there could be a security breach causing your PHI information to be leaked

AUTHORIZATION TO RELEASE INFORMATION: Based on the Privacy Act of 1974, P.L. 93-579, I hereby authorize the release of my personal health information (PHI) for referral to health care providers outside of the Little Traverse Bay Bands Health Department for the purposes of healthcare, treatment, and insurance claims, and any other community resources that assist me with my healthcare

needs; not excluding substance abuse, mental health, HIV/AIDS, STD's, etc. I authorize the release of my PHI to my insurers as necessary for determination and payment of benefits, including Medicare and Medicaid.

HEALTH INFORMATION EXCHANGE: The Little Traverse Bay Bands Health Department endorses, supports, and participates in Health Information Exchange (HIE) as a patient-centered care approach to improve the overall well-being of our patients. HIE allows us to efficiently share clinical information among the other providers within the LTBB Health Department (which includes Behavioral Health, Dental, and Community Health programs) to be able to treat the mind, body, and soul of our patients. This model helps foster communication and shared decision-making among your care team about treatment options that will best address your healthcare needs. I understand that I can submit a written request for restrictions with the Privacy Officer or Health Information Management (HIM) staff at any time.

NOTIFICATION OF PRIVACY: I have read and acknowledge receipt of the Notice of Privacy Practice.

PATIENT RIGHTS AND RESPONSIBILITIES: I have read and acknowledge receipt of the Patient Rights and Responsibilities

CONSENT TO TREAT: I have read and understand the information provided above regarding my care here at the Little Traverse Health Department, and all of my questions have been answered to my satisfaction.

Signature:____________________________________Date:_____________ Time:___________AM/PM
Patient or Patient Representative

If Not the patient: Relationship to Patient

____

FOR OFFICE USE ONLY

☐Patient Rec'd Copy of NPP ☐Patient Rec'd Copy of PRR

CHART__________________

LITTLE TRAVERSE BAY BANDS HEALTH DEPARTMENT

RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or other disclosures. I also have the right to authorize the release of my protected health information to members of my family, friends, and/or any person that is involved in my care.

I authorize the following person(s) to obtain my health information:

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SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE
(IF LEGAL REPRESENTATIVE, STATE RELATIONSHIP TO PATIENT)

______________________ ______________________

DATE EXPIRATION DATE OF AUTHORIZATION

____

WITNESS NAME & SIGNATURE

____

CLINIC USE ONLY – DO NOT WRITE BELOW THIS LINE

DATE RECEIVED:______________________
CLINIC INTAKE INITIALS:______________

LTBB HEALTH RECORD NUMBER (HRN)__________