



# LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

## Health Department

1260 Ajijaak Avenue

Petoskey, MI 49770

P: 231-242-1700



## CHILD PATIENT REGISTRATION

### REQUIRED DOCUMENTATION

Use this list to ensure you provide the LTBB Health Department with all required documentation. *Failure to do so will result in delay of your care.*

- Tribal Identification Card from a Federally Recognized Tribe (*State Recognized Tribes are not eligible*) **OR** Proof of descendency from a Federally Recognized Tribe.
  - Example of proof of descendency: *Jane's paternal grandmother is a tribal citizen of a federally recognized tribe. Before Jane can use the clinic, she must submit a copy of her grandmother's Tribal ID, her father's birth certificate, and Jane's birth certificate.*
- Birth Certificate
- Social Security Card
- Driver's License **OR** State Identification Card (must include a photo, name, address, and date of birth)
- Two (2) proofs of **physical** residency, no RV parks or P.O. Boxes accepted.
  - Acceptable forms include Driver's License, Tribal ID, Voter Registration, Bills, Automobile Registration, and Leases.
  - If you do have a P.O. Box, please let the Central Registration Clerk know for the Health Department's mailing purposes.
- Completed Registration Packet
  - Adult Registration for ages 18 and older.
  - Child Registration for ages 17 and younger.
- All active insurance cards
  - Medical
  - Dental
  - Vision
- Any legal documentation relevant to patient care
  - Legal guardianship, adoption, or foster care
  - Power of attorney related to medical services



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## Health Department

1260 Ajijaak Avenue  
Petoskey, MI 49770  
P: 231-242-1700



# CHILD PATIENT REGISTRATION

*For the Little Traverse Bay Bands of Odawa Indians (LTBB) to provide efficient health services while following federal regulations, you must complete this form and return it to our Central Registration. If completed, the information provided will assist the LTBB Health Department in the best course of healthcare and available resources.*

**FULL LEGAL NAME:** \_\_\_\_\_

**PREFERRED NAME/ALIAS:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**SEX ON BIRTH CERTIFICATE:** \_\_\_\_\_ **MARITAL STATUS:** \_\_\_\_\_

**CITY AND STATE OF BIRTH:** \_\_\_\_\_

**HOMELESS?** \_\_\_\_\_ **HOMELESS SHELTER** \_\_\_\_\_ **TRANSITIONAL** \_\_\_\_\_ **OTHER:** \_\_\_\_\_

**CURRENT ADDRESS:** \_\_\_\_\_ **ADDRESS 2:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_ **COUNTY:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_

**WORK PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**ARE YOU A DESCENDANT OR CITIZEN OF A FEDERALLY RECOGNIZED TRIBE?** YES NO

**TRIBAL AFFILIATION:** \_\_\_\_\_

**ENROLLMENT NUMBER OR LIST DESCENDANT:** \_\_\_\_\_

**DO YOU SPEAK PROFICIENT ENGLISH?** YES NO

**DO YOU REQUIRE AN INTERPRETOR?** YES NO

**DO YOU IDENTIFY AS HISPANIC OR LATINO?** YES NO

**DO YOU HAVE ACCESS TO THE INTERNET?** YES NO

**IF YES, WHERE?** HOME WORK SCHOOL OTHER: \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**PHONE NUMBER(S):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**NEXT OF KIN CONTACT:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_  
PHONE NUMBER(S): \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

**PARENTAL INFORMATION**

MOTHER'S MAIDEN NAME: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_ DECEASED? \_\_\_\_\_  
FATHER'S LEGAL NAME: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_ DECEASED? \_\_\_\_\_

**MOTHER EMPLOYMENT:** PART-TIME FULL-TIME RETIRED UNEMPLOYED  
MIGRANT OR SEASONAL WORKER SELF EMPLOYED  
EMPLOYER NAME: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_

**FATHER EMPLOYMENT:** PART-TIME FULL-TIME RETIRED UNEMPLOYED  
MIGRANT OR SEASONAL WORKER SELF EMPLOYED  
EMPLOYER NAME: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_

**INSURANCE INFORMATION:**

INSURANCE TYPE? MEDICAL DENTAL VISION  
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: \_\_\_\_\_



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

## **Patient Rights and Responsibilities**

As a patient of the Little Traverse Bay Bands (LTBB) Health Department, 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 or treatment, including information about the risk, benefits and alternative to the proposed procedure or treatment
- Refuse treatment and be told what affect 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, nurse and other staff members responsible for 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 seen at the Clinic. Your cooperation in these responsibilities will help us provide quality care and service. Please....

- Provide accurate and updated information for your file.
- 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 the other Clinic patients.
- Respect the staff of the LTBB Health Department by using considerate communication and behavior at all times. Yelling, cursing, and inappropriate language/behavior will not be tolerated.

If you have any questions about your rights, please contact the  
LTBB Health Director, Jody Werner at 231-242-1612.



## 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.**

The Little Traverse Bay Bands (LTBB) Health Department is required by law to maintain the privacy of every patient's 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. We are required by law to maintain the privacy and security of your protected health information (PHI). This notice applies to the 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 purposes:

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **PAYMENT** means such activities as obtaining reimbursement for our 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 assessment review.

We may also create and distribute unidentified health information by removing all references to individually identifiable information.

We will not use or share your information other than as described here unless you tell us we can in writing. You may revoke such authorization in writing, and we are required to honor and abide by that written request.

Although your health records are the physical property of the LTBB Health Department, the information belongs to you.



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

**As our patient you have the following rights when it comes to your health information:**

- The right to revoke your written authorization to use or disclose health information. This does not apply to health information already disclosed or used or in circumstances where we have acted on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy of the policy itself.
- The right to reasonably request to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and receive a copy of your PHI.
- The right to request an amendment/correction to your PHI.
- The right to receive a listing of certain disclosures the LTBB Health Department has made of your PHI.
- The right to obtain a paper copy of the LTBB Health Department Notice of Privacy Practices from us upon request.

If you would like to exercise any of these rights, please submit a request in writing to our Privacy Officer.

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 June 25, 2020, 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 change 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 of Privacy Practices on an annual basis.

You may file a complaint with us if you believe we have violated your privacy right. This can be done by notifying our Privacy Officer in writing of your complaint. Please use the Little Traverse Bay Bands of Odawa complaint form. We will not retaliate against you for filing a claim. You may file a complaint with the Secretary of Health and Human Services if you believe we have violated your privacy right.

For more information about HIPAA:  
The US Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave SW  
Washington, D.C. 20201



## 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 of Odawa Indians  
**Health Department**  
1260 Ajijaak Ave. Petoskey, MI 49770  
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### Consent for Treatment of a Minor Child

I \_\_\_\_\_, give LTBB of Odawa Indians Health Department  
(Parent/Guardian name)

permission to treat my child, \_\_\_\_\_  
(Child's name)

while I am not present. The individual bringing my child to the appointment is named:

\_\_\_\_\_  
(Adult accompanying child)

and is at least eighteen years of age.

I also give this individual permission to make decisions regarding my child's medical/dental treatment in consultation with the providers and/or if an emergency should arise while at the LTBB Health Department.

#### **Authorization:**

Parent/Legal Guardian Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**This authorization shall be effective until: \_\_\_\_\_ or until  
revoked.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date:

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)

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DATE

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EXPIRATION DATE OF AUTHORIZATION

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WITNESS NAME & SIGNATURE

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**CLINIC USE ONLY - DO NOT WRITE BELOW THIS LINE**

DATE RECEIVED: \_\_\_\_\_

CLINIC INTAKE INITIALS: \_\_\_\_\_

LTBB HEALTH RECORD NUMBER (HRN) \_\_\_\_\_





Little Traverse Bay Bands Health Center  
 1260 Crane Ave  
 Petoskey, MI 49770  
 Phone: (231) 242-1700 Fax: (231) 242-1717

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**I authorize LTBB to:**  Disclose to  Receive from  Both Disclose to and receive from

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

the following information relative to treatment received from \_\_\_\_\_ to \_\_\_\_\_  
start date of services requested End date of Services requested

**PLEASE CHECK REQUESTED ITEM(S):**

- Laboratory Reports  Dental Records  Immunization Record  Complete Medical Record (designated record set)
- Behavioral Health  Alcohol and Substance Abuse Records  Dental Images  Diabetes Management
- Face Sheet  Medication Records  Other: \_\_\_\_\_
- Test Result(s) of: \_\_\_\_\_

**The purpose for this request:**  Legal  Insurance  Personal  Continuation of Care

Other \_\_\_\_\_

**By signing this authorization form, I understand that:**

- My health information may be shared electronically.
- 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.
- The sharing of my health information will follow state and federal laws and regulations.
- I understand that the information in my health record may include information related to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.
- I can withdraw my consent at any time; however, the revocation will not apply to information that has already been released in response to this authorization.
- This authorization of release of information will expire on \_\_\_\_\_ or one year after the date signed if not specified.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
 Signature of Patient/Parent/Guardian/Legal Representative

\_\_\_\_\_  
 Date of Signature

**FOR OFFICE USE ONLY**

Staff Person Releasing Information:

Date Information Released:

Record #: