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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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: _____

HRN #: _____

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: _____

HRN #: _____

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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:

_____

_____

_____

_____

_____

_____

_____

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)_____

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Health Department
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231.242.1700

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.

You are receiving health care at the LTBB Health Department (LTBBHD), which is part of the Little Traverse Bay Bands of Odawa Indians. LTBBHD includes the following clinics: LTBB Health Clinic, Behavioral Health, Dental Clinic, Pharmacy, Community Health and the Crooked Tree Wellness Clinic (CTWC). These are referred to collectively as "LTBBHD" or "we" in this document.

We are required by law to maintain the privacy of individually identifiable patient health information (this information is "protected health information" and is referred to as PHI). LTBBHD substance use disorder (SUD) treatment program are subject to the confidentiality requirements of 42 C.F.R. Part 2 (Part 2), and SUD treatment information refers to those records protected by Part 2.We are also required to provide patients with a copy of our Notice of Privacy Practices (NOPP) upon request, and to offer a copy of the Notice at least one time during registration. We will only use or disclose your PHI as permitted or required by applicable state law.

This notice applies to your PHI in our possession including your medical records.

LTBBHD understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how LTBBHD will use and disclose your PHI, and your rights under HIPAA.

This notice applies to the delivery of health care by LTBBHD and its staff in each of its clinics.

Permitted use or disclosure

LTBBHD uses or discloses PHI for a variety of purposes. We have the right to use or disclose your PHI for purposes of treatment, payment and health care operations, except for SUD treatment information, for which we must have your written authorization.

Treatment: LTBBHD will use and disclose your PHI in the provision and coordination of health care to carry out treatment functions.

LTBBHD will disclose all or any minimally necessary portion of your patient medical record information to your primary care physician, consulting physician(s), nurse, pharmacist, technicians, dieticians, and other health care providers who have a legitimate need for PHI in your care and continued treatment.

LTBBHD also will disclose PHI to people or entities outside of LTBBHD who will be involved in your medical care after you leave LTBBHD, such as other care providers and family who will provide services that are part of your care to coordinate treatment.

LTBBHD records and transmits health information, including prescription information, electronically. Health information is shared through local, state and national health information exchanges (HIE). HIEs are subject to HIPAA compliance and have rules regarding how health information can be accessed and impose limits on use and disclosure of that information.

LTBBHD will use and disclose your PHI to inform you of or recommend possible treatment options or alternatives that will be of interest to you.

LTBBHD will use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at LTBBHD. With respect to a group health plan, LTBBHD may also disclose PHI to a health plan sponsor.

If you are an inmate or a correctional institution or under the custody of a law enforcement office, LTBBHD will disclose your PHI to the correctional institution or law endorsement official.

Payment: LTBBHD will disclose your PHI for the purposes of determining insurance coverage and eligibility, billing, claims management, medical data processing, and reimbursement.

The medical information will be disclosed to any insurance company, third party payer, third party administrator, health plan, or other health care provider (or their duly authorized representatives) involved in the payment of your medical bill and will include copies or excerpts of your medical records which are necessary for payment of your account. It will also include sharing the necessary information to obtain pre-approval of payment for treatment from your health plan.

Operations: LTBBHD will use and disclose your PHI during routine health care operations including quality review, utilization review, medical review, internal auditing, accreditation, certification, licensing, or credentialing activities of LTBBHD.

SUD Treatment Information: We must have your written authorization (42CFR-Part 2 complaint) to use or disclose your SUD treatment information for treatment, payment, and health care operations purposes. You may provide a single consent for all future uses or disclosure for treatment, payment, and health care operation purposes. Records that are disclosed to a part 2 program, covered entity, or business associate based on your written consent for treatment, payment, and health care operations may be further disclosed by that part 2 program, covered entity, or business associate, without your written consent, to the extent the HIPAA regulations permit such disclosure.

Permitted use or disclosure with an opportunity for you to agree or object

LTBBHD may disclose PHI about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps you pay for your care.

Use or disclosure requiring your authorization

Marketing: LTBBHD will not provide your information to any other person or company for marketing any products or services other than LTBBHD products or services unless you have signed an authorization. LTBBHD will not sell your information without your authorization. LTBBHD will not send treatment communication to you concerning treatment alternative unless you have signed an authorization. You have a right to opt out of receiving such communications.

Research: With your prior authorization to participate in research, LTBBHD may use or disclose your information as part of research. For example, if you are part of a research study that includes treatment, LTBBHD may require that you sign and authorize to allow the researchers to use or disclose your information for this research.

Psychotherapy Notes: LTBBHD must obtain your authorization for any use or disclosure of psychotherapy notes, except as permitted by policy or law. Psychotherapy notes are not part of the electronic medical record.

Other uses: any uses or disclosures that are not for treatment, payment or operations and that are not required for public policy purposes or by law, and other uses and disclosures not described in this Notice will be made only with your written authorization.

Revocation: You have the right to revoke an authorization at any time, by putting your request in writing and submitting the request to the appropriate Health Information Management (Medical Records) department.

Breach Notification: LTBBHD will notify you if a breach of your unsecured protected health information occurs, if their information is shown to be at more than low risk of compromise.

Use or disclosure permitted by public policy or Law without your authorization

Law Enforcement Purposes: LTBBHD will disclose your PHI for law enforcement purposes as required by law, such as responding to a court order or subpoena, disclosing information for purposes of identifying a criminal suspect or a missing person, or providing information about a crime victim or possible criminal conduct as part of a criminal investigation, as permitted by HIPAA privacy exceptions.

Required by Law: LTBBHD will disclose PHI about you when required by applicable law to make reports or other disclosures. LTBBHD also will make disclosures for judicial and administrative proceedings such as lawsuits or other disputes in response to a court order or subpoena. LTBBHD will disclose your PHI to government agencies when required by law, such as reporting child abuse or neglect or abuse, neglect, or domestic violence to public health authorities. LTBBHD will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies. Specialized government functions will warrant the use and disclosure of your health information. These government functions will include military and veteran's activities, national security and intelligence activities, and protective services for the President.

LTBBHD may only disclose SUD treatment information to law enforcement when the patient commits a crime on the premises of the SUD treatment program or against the program staff or threatens to commit a crime. SUD treatment records or testimony cannot be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless you sign a written authorization permitting the release of the information requested or there is a court order that complies with 42 C.F.R Part 2. For court orders, SUD treatment records can only be used or disclosed based on a court order after notice and an opportunity to be heard is provided to your or the holder of the record as required by law and there is a subpoena requiring disclosure accompanying the court order before the records is used or disclosed. LTBBHD will make certain disclosures that are required in order to comply with workers' compensation or similar programs.

Coroners, Medical Examiners, Funeral Directors: LTBBHD will disclose your information to a coroner or medical examiner. For example, this will be necessary to identify a deceased person or to determine a cause of death. We will also disclose your medical information to a funeral director as necessary to carry out their duties.

Organ Procurement: LTBBHD will disclose your information to an organ procurement organization or entity for organ, eye or tissue donation purposes when donation has been authorized or to verify that appropriate organ procurement procedures are followed.

Health or Safety: LTBBHD will use and disclose your information to avert a serious threat to health and safety of a person or public. LTBBHD will use and disclose PHI to Public Health Agencies for immunizations, communicable diseases, etc. LTBBHD will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA-regulated products or activities, including collecting and reporting adverse events, tracking and facilitating product recalls, etc. and post marketing surveillance. You may opt out of the opportunity to receive information about a medical device subject to FDA tracking requirements, i.e. you may decline to disclose, or refuse permission to disclose, your name, address, telephone number and social security number, or other identifying information for the purpose of tracking the FDA device.

Research purposes: in certain limited circumstances, we may disclose your PHI for research purposes. For example, a research project may involve the care and recovery of all enrolled persons who received one medication for the same condition. All research projects are subject to a special approval process.

Your Health Information Rights

You have the following rights concerning your PHI.

Right to inspect and copy: You have the right to access your PHI and to inspect and have a paper or electronic copy made of your PHI as long as LTBBHD maintains it, except for: Psychotherapy notes (those notes kept in a personal file by a therapist or physician and not part of the formal medical record), information that may be used in anticipation of, or that will be used in a civil, criminal or administrative action or proceeding, and where prohibited or protected by law. LTBBHD will deny your request to access your PHI without giving you an opportunity to review that decision if:

- You don't have the right to inspect the information; or it is otherwise prohibited or protected by law
- You are an inmate at a correctional institution and obtaining a copy of the information would risk the health, safety, security, custody or rehabilitation of you or other inmates
- The disclose of the information would threaten the safety of any officer, employee or other person at the correctional institution or who is responsible for transporting you
- You are involved in a clinical research project and LTBBHD created or obtained the PHI during that research. Your access to information will be temporarily suspended as long as the research is in progress
- LTBBHD obtained the information from someone other than the health care provider under a promise of confidentiality and your access request is likely to reveal the source of the information

LTBBHD will respond to your request within 30 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which LTBBHD will act on your request. In any event, LTBBHD will act on your request within 60 days of its receipt.

Right to Amend: You have the right to request an amendment to your PHI for as long as LTBBHD maintains it. However, we will deny your request for amendment if:

- LTBBHD did not create the information
- The information is not part of the designated record set
- The information would not be available for your inspection (due to its condition or nature)
- The information is accurate and complete.

If LTBBHD denies your request for changes in your PHI, we will notify you in writing with the reason for a denial. We will also inform you of your right to submit a written statement disagreeing with the denial. You may ask that we include your request for amendment and denial any time that LTBBHD discloses the information that you wanted changed. LTBBHD may prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal.

You must make your request for amendment of your PHI in writing to LTBBHD, including your reason for amendment. LTBBHD will respond to your request within 60 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act to your request. In any event, we will act on your request withing 90 days of its receipt.

Right to an accounting: You have a right to receive an accounting of the disclosures of your PHI that LTBBHD made, except for the following disclosures:

To carry out treatment, payment or health care operations
To you
For national security or intelligence purposes
To correctional institutions or law enforcement officials in custodial situations

For each disclose, you will receive: the date of the disclosure, the name of the receiving organization and address if known, a brief description of the PHI disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for the information, if there was one.

You must make your request for an accounting of disclosure of your PHI in writing to the Health Information Management (Medical Records) department at the clinic you were treated. You must include the time period of the accounting, which may not be longer than six years. We will respond to your request within 60 days of its receipt. If we cannot, we will notify you in writing to explain the delay and the date by which we will act to your request. In any event, we will act on your request within 90 days of its receipt.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI:

To a health plan with respect to health care for which you have paid out of pocket in full prior to service being initiated. The request must be in writing.

Right to Confidential Communications: You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that we only contact you at work or by mail.

Right to receive a copy of this notice: You have the right to receive a paper copy of this Notice of Privacy Practices, upon request.

Sharing and Joint user of your Health Information

LTBBHD Staff: The LTBBHD participate together in an organized health care arrangement to deliver health care to you. LTBBHD and its affiliated staff have agreed to abide by the terms of this Notice with respect to PHI created or received as part of delivery of health care services to you in LTBBHD. Physicians and allied health care providers are members of the LTBBHD staff and will have access to and use your PHI for treatment, payment and health care operations purposes related to your care within LTBBHD.

Business Associates: LTBBHD will use and disclose your PHI to business associates contracted to perform business functions on its behalf, including LTBBHD.

LTBBHD is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of LTBBHD, OCHIN supplies information technology and related services to LTBBHD and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish the best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your PHI may be shared by LTBBHD with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

Whenever an arrangement between LTBBHD and another company involves the use or disclosure of your PHI, that business associate is required by HIPAA law to keep your information confidential.

Changes to this notice: LTBBHD will abide by the terms of the Notice currently in effect. LTBBHD reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all PHI that it maintains. LTBBHD will provide you with a revised Notice at your first visit following the revision of the Notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with LTBBHD and/or with the Secretary of the Department of Health and Human Services, Office of Civil Rights.

For more information, or to voice a privacy complaint about an incident, please contact the Privacy Officer at the LTBBHD Health Department.

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(231) 242.1700

General Consent for Care and Treatment Consent

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 rights 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 LTBBHD 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 LTBBHD 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 is 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
- LTBB will make decisions based on available medical records; if all medical records are not available, this may result in decisions made from incomplete records.
- 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 LTBBHD 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: LTBBHD 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 all providers within the LTBB Health Department (which includes LTBB Clinic, Crooked Tree Wellness Clinic and Pharmacy, Behavioral Health, Dental, Community Health and LTBB Pharmacy.) 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.

TEXT MESSAGING COMMUNICATIONS:
Text (SMS) messaging service is designed to provide you with helpful information, reminders, and notifications via text messages sent to your mobile device. LTBBHD may use text (SMS) message to communicate with you for a variety of purposes, including but not limited to:

- Announcements and reminders of upcoming events/appointments
- Reminders for health screenings
- Surveys and polls
- Medication information

Possible Risks: While every effort will be made to protect the security and confidentiality of information transmitted through text (SMS) messages, there are inherent risks associated with all electronic communication. These risks include unauthorized access, loss of privacy, and potential breach of sensitive information. It is important to be aware that text (SMS) message may not be entirely secure and could be intercepted or accessed by unintended recipients.

Potential Costs: Participation in the text (SMS) messaging service may involve standard text messaging charges applied by your mobile service provider. Please consult your mobile service provider regarding any applicable fees or charges.

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 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
_____