INDIAN HEALTH COUNCIL, INC.
Eligibility and Patient Registration

50100 Golsh Rd.
Valley Center, CA 92082
www.indianhealth.com
(760) 749-1410

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. 5285 or 5297
Fax: (760) 233-5594

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MINOR PATIENT REGISTRATION DEMOGRAPHIC INFORMATION

Patient Name: (Last)____________________(First)__________________________(Middle)__________________

Birth Sex:(Male) _________(Female)___________ Social Security#_______/_____/______

Date of Birth: (Month)_____________(Day)________(Year)___________ Preferred Language:_______________

Physical Address: __________________________(City)__________________(State)________(Zip)___________

Do you live on the Reservation: (Yes) _____ (No) _____ If yes what reservation: ___________________________

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 #: ________________________

Preferred method of appointment reminders: __Text __Voice reminders __Email __Patient Portal __None

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 AND SCREENING 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: _________________________________

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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

Printed name of Parent/Guardian/Legal Rep ______________________________

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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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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 & Dental Department: Being more than ten (10) minutes late to an appointment may require you to reschedule your appointment. For more information on our late policy please refer to the Late/No-Show Policy Acknowledgement.

TWENTY-FOUR HOUR ADVANCE NOTICE

☐ Medical & Dental Department: If you wish to change or cancel an appointment, we would like 24-hour advance notice. If we do not receive 24-hour advance notice, then it is considered a no-show. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. For more information on this policy please refer to the Late/No Show Policy Acknowledgement.

NO-SHOWS

☐ Medical & Dental Department: If you fail to show up for an appointment without notice, that is considered a no-show. The departments adhere 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. For more information on this policy please refer to the Late/No-Show Policy Acknowledgement.

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, who 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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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 of Signature

Printed name of Parent/Guardian/Legal Rep____

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 of Signature

____

Signature

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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

______________________________ Printed name of Parent/Guardian/Legal Rep

______________________________ Signature and title of IHC Employee

______________________________ Date

<u>For Patients Unable to Acknowledge Receipt</u>

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

____
____
____
____

Signature of IHC Staff: ______________________________ Date: ________________

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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

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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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PATIENT LATE/NO-SHOW POLICY ACKNOWLEDGEMENT- MEDICAL & DENTAL DEPARTMENT

Patient Name: ________________________________ Date of Birth: __________________

Purpose:

The purpose of the Late/No-Show policy is to ensure that our patients maintain a standard of care for their health and well-being. Our providers are better able to monitor health or dental conditions, manage medication(s) appropriately, and give optimal care when our patients keep their scheduled appointments. Implementing a Late/No-Show policy will help to decrease unfilled appointment slots which could have been scheduled for other patients. It is our goal to try and accommodate everyone in a fair and efficient manner.

Policy:

Late arrivals- A patient is considered late if the patient arrives 10 minutes after their appointment time. The patient will be notified that their arrival is late and will need to be rescheduled. The visit will be recorded as a no-show, and information will be given to the patient about future late arrivals and consequences.

Appointment Change/Cancellation- 24-hour advance notice is required to change or cancel an appointment, if not provided then it is recorded as a no-show.

No-Show Process- After 3 no-shows in a department in a 3-month period, all the patient's future appointments will be removed for that department and will not be rescheduled for a three-month period. If the patient wants to be seen during this period, they must arrive and wait to see if an opening becomes available. Once seen, the patient will be removed from the no-show list.

Specialty Services- For specialty services, other restrictions may apply. These services may include Obstetrics, Endodontics, IV Sedation, and Orthodontics, but is not exclusive. Reference should be made to the applicable Department's process.

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PATIENT LATE/NO-SHOW POLICY ACKNOWLEDGEMENT- MEDICAL & DENTAL DEPARTMENT

At IHC, we strive to meet and exceed the expectations of all our patients, and we are dedicated to providing our patients with the best care and services possible. We also strive to meet our patients' needs by providing appointment times that best fit your schedule.

Time is specifically reserved for you on our schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give us enough time to contact another patient who could come to the clinic during your assigned time. This results in other patients not getting the care they need when they need it.

In order to be fair and consistent with all of our patients, we have implemented this Late/No-Show Policy. We understand that unanticipated events happen occasionally; emergency cancellations are handled on a case by case basis to be determined by the patient's provider. As a courtesy, Indian Health Council, Inc. will make an effort to confirm with you two days before your appointment; however, it ultimately remains the patient's responsibility to keep track of scheduled appointments.

Definitions:

Late- is a specified amount of time after the scheduled appointment time.

No-Show- is not showing up for an appointment with no notice or not canceling/rescheduling an appointment within 24 hours of the appointment. Showing up late for an appointment also qualifies as a no-show.

I have read and understand Indian Health Council's Late/No-Show Policy. I consent to these terms.

Patient Printed Name____

Patient Signature____

Date__________________________

Effective 5/30/2023

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ANNUAL FINANCIAL SCREENING FORM

CHART # ___________

Indian Health Council, Inc. is currently participating in the following programs: Medi-Cal, Covered California (all programs consistent). 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 Purchased Referred Care (PRC) benefits.

SIGNATURE: ____ **DATE:** ___________

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

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

☐ Medi-Cal ☐ Medicare (Part A,B,C,D) ☐ 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 FRONT DESK ALONG WITH YOUR CARD.

Patients will be notified of Sliding fee discount after form is completed.

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