Siletz Community Health Clinic

Dear Patient and family,

We are glad that you have shown interest in becoming a New Patient at the Siletz Community Health Clinic. Attached to this letter is the New Patient Registration Packet, which includes the **required forms** to let us enroll you in our practice and manage your healthcare needs.

Please completely fill out and return the following forms

- New Patient Registration Form
- General Patient Consent Form
- Payment Policy Form
- **WE ALSO NEED** proof of tribal affiliation or Alaska Native. This may be your tribal ID card/document, OR it could be the tribal ID of your parent or grandparent, along with the birth certificates linking you to the enrolled tribal member if you are a dependent/descendent. Please include photocopies of these documents with your enrollment packet
- **If non-tribal**, Driver's License or State issued ID
- **Anyone under 18**, must provide a birth certificate

Please ask for these additional forms if they are applicable to you

- Authorization to Discuss Medical Information with Family, Friends, & Caregivers (optional)
- Authorization For Use or Disclosure of Protected Health Information
  Please make sure to follow all instructions on this form, as well as initial and sign
  (16 & older can sign, under 16 yrs, parent or guardian can sign for patient.)

To submit your forms:
IN-PERSON: Drop the completed forms to the clinic at 200 Gwee Shut Rd., Siletz, OR 97380
EMAIL: Download and save all forms to your desktop. Email the completed forms to medicalrecords@ctsi.nsn.us. If you email your forms, remove the SSN and Date of Birth, we will call you for this information. – This is not a secured email address, if you choose to utilize this process, please know you are doing so at your own risk.
US MAIL: Complete all forms and mail to: SCHC, PO Box 320, Siletz, OR 97380.
FAX: Complete all forms and fax to 541.444.9695.
CALL: If you have any questions, please do not hesitate to call us for assistance at 541.444.1030 or 1.800.648.0449.

**If you are currently uninsured, SCHC can assist you with your application for the Oregon Health Plan. Visit https://www.oregon.gov/oha/hsd/ohp/Pages/Apply.aspx to find out more. Contact us to start the process prior to your first appointment.

OHP - Patient Benefits Coordinator
Danielle Stutheit
Contact #: 541.444.9611 or
danielles@ctsi.nsn.us

IMPORTANT – PLEASE READ

1. Registration Forms are received in clinic.
2. Insurance will be verified.
3. Chart will be created.
4. You will receive a call after Step 3 to set up a New Patient appointment.

Siletz Community Health Clinic

New Patient Registration Form

OFFICE USE ONLY	
Patient IHS Eligibility Status ❑ Direct Only ❑ Ineligible ❑ OOA Direct ❑ PRC Direct ❑ Siletz Direct ❑ Pending Verification	Chart #_____ Tribe_____ Roll #_____
Official Signature_____	Date_____

Demographics

Patient Legal Name_____
Last First Middle Preferred Name

Physical Address_____
Street City/State/ZIP

Mailing Address ❑ Same as above_____
Street/PO City/State/ZIP

SSN_____ Date of Birth_____ Drivers License: State____ DL#_____

Marital Status: ❑ Single ❑ Divorced ❑ Domestic Partner ❑ Married ❑ Widow(er) ❑ Other

Gender, assigned at birth *why we ask: Physical gender is needed for informed medical decision-making.*

❑ Male ❑ Female ❑ Undifferentiated

Gender Identity, if applicable:

❑ Female ❑ Female to Male (FTM) Transgender Male/Trans Man
❑ Male ❑ Male to Female (MTF) Transgender Female/Trans Woman ❑ Choose not to disclose
❑ Additional gender category or other, please specify:_____

Race/Ethnicity: *Why we ask: Race/ethnicity can be attributed to higher incidents of certain medical conditions. This data can assist your healthcare team in determining screening needs.*

❑ American Indian/Alaska Native Tribal affiliation:_____

Roll #_____ Are you a dependent/descendant of a Tribal member? ❑ No ❑ Yes

If yes, WHO is enrolled? _____ Which tribe?_____

❑ Asian ❑ Black or African American ❑ Caucasian/White ❑ Hispanic/Latino (all races)
❑ Native Hawaiian or Other Pacific Islander ❑ Decline to answer
❑ Other race_____

Are you a Veteran? ❑ No ❑ Yes **Are you a full-time College Student?** (provide verification) ❑ No ❑ Yes

Are you Homeless? ❑ No ❑ Yes If yes: ❑ Doubling up ❑ Other ❑ Shelter ❑ Street ❑Transitional ❑ unknown/unreported
Are you a Migrant Worker? ❑ No ❑ Yes If yes, which type? ❑ Migrant ❑ Seasonal

Contact Information

❑ I authorize SCHC to leave messages on my voicemail/answering machine.

Email_____ Cell #_____

Alternate#_____ Do you consent to receive text reminders from us? ❑ Yes ❑ No

If patient is under 18, with whom do they live? ❑ Mother & Father ❑ Mother ❑ Father
❑ Foster parent ❑ Legal guardian

Mother's Name_____ Mother's phone_____

Father's Name_____ Father's phone_____

Guardian Name_____ Guardian phone_____

Primary Address for child_____
Street City/State/ZIP

Emergency Contact

If married, Spouse/Partner Name_____ Phone #_____

Spouse/Partner Address if different from yours_____
Street City/State/ZIP

Other Emergency contacts not living in your home (preferred, one non-relative)

(1) Name_____ Relationship_____ Contact#_____

(2) Name_____ Relationship_____ Contact#_____

Preferred Pharmacy Information

❑ **Please check this box if you have a pharmacy you prefer to use for picking up your medications and provide the pharmacy information below.**

Primary Pharmacy Name_____ Pharmacy phone_____

Primary Pharmacy City_____

Secondary Pharmacy Name_____ Pharmacy phone_____

Secondary Pharmacy City_____

❑ Check here if you would like to use the Siletz Community Health Clinic Pharmacy, which has mail and pick-up options for most medications.

The SCHC Pharmacy is available to the below listed patient categories. Please select the one that applies to you:

- ❑ Siletz Tribal Member/Dependent with PRC
- ❑ Siletz Tribal Employee/Any Tribal Employee household members covered by CTSI insurance
- ❑ Native American or Alaska Native regardless of insurance

Employer

Name of Employer_____ Phone_____

Insurance and Billing Information

Responsible Party (Person Responsible for Payment) **OR** ❑ Same as Registering Patient

Name_____

Relationship to Patient_____ SSN_____ DOB_____

Home Address_____
Street City/State/ZIP

Phone Number_____ Email_____

Medical Insurance Information

Bring your insurance card(s) with you to your first appointment, and whenever your insurance changes.

IF insurance card is not provided, the following information MUST BE ENTERED before appointment is made.

PRIMARY INSURANCE: Type ❑ Medical ❑ Optometry ❑ Pharmacy ❑ Dental

Primary Insurance Carrier_____ Insurance Phone_____

Name of Policy Holder_____ Policy Holder DOB_____

Relationship to Policy Holder ❑ Self ❑ Spouse ❑ Parent ❑ Other

Insurance Billing Address_____

Policy Number_____ Group Policy Number_____

SECONDARY INSURANCE: Type ❑ Medical ❑ Optometry ❑ Pharmacy ❑ Dental

Secondary Insurance Carrier_____ Insurance Phone_____

Name of Policy Holder_____ Policy Holder DOB_____

Relationship to Policy Holder ❑ Self ❑ Spouse ❑ Parent ❑ Other

Insurance Billing Address_____

Policy Number_____ Group Policy Number_____

ADDITIONAL INSURANCE: Type ❑ Medical ❑ Optometry ❑ Pharmacy ❑ Dental

Insurance Carrier_____ Insurance Phone_____

Name of Policy Holder_____ Policy Holder DOB_____

Relationship to Policy Holder ❑ Self ❑ Spouse ❑ Parent ❑ Other

Insurance Billing Address_____

Policy Number_____ Group Policy Number_____

Official Use Only

Verified ❑ Yes ❑ No

Date:_____

Signature:_____

Siletz Community Health Clinic

General Patient Consent

Consent for Evaluation and Treatment

Initials

To the Patient: Welcome to the Siletz Community Health Clinic. At this point in your care, no specific treatment plan has been recommended. This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s). You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By initialing on the side, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. (3) you understand that you may be asked to sign a separate informed consent form for certain vaccines, lab tests, treatment(s) or procedures that require such. (4) you understand that consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Consent to Bill Insurance and Collect Payment

Initials

I have received a copy of the SCHC Payment Policy, attached to this form. I hereby authorize the SCHC to furnish information to insurance carriers concerning my conditions and treatments, and I hereby assign the healthcare provider(s) all payments for services rendered to my dependents or myself. I authorize SCHC to collect payments from third party payors such as Medicare/Medicaid and insurance companies. I have read and have had the opportunity to have my questions explained to me regarding my rights and responsibilities and payment policy under this agreement. My signature indicates that I consent to receiving services from the Clinic Staff at this time.

I acknowledge my responsibility to pay for care according to the fees established.

In the event that the patient is a minor, I am the parent and/or guardian of said patient and I agree that I am responsible for all services provided to the patient herein.

HIPAA Acknowledgement of Privacy Practices

Initials

I have received a copy of SCHC "Notice of Privacy Practices". This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Patient Rights & Responsibilities

Initials

I have received a copy of SCHC's "Patient Rights and Responsibilities". This Notice details my rights as a patient and expectations of me throughout the course of my care at SCHC.

Patient/Guardian signature:_____ Date:_____

Siletz Community Health Clinic

Payment Policy

Some services are based on eligibility status. Patient should verify eligibility prior to requesting an appointment.

A. All Patients
   1. All insurances (primary, secondary, and tertiary) will be billed electronically in the NextGen Practice Management system via Trizetto Clearinghouse and paper claims when electronic billing is not an option.
   2. Statements will be sent monthly to patients for charges not covered by insurance or Indian Health Service. Administrative action may occur if payment or payment arrangements have not been made within 90 days. The action may include sending the claim to collections or dismissal as a patient from the clinic.
   3. Payment to outside providers is the responsibility of the patient even when referred by an SCHC provider.
   4. Insurance coverage is an agreement between the patient and his or her insurance company to pay certain amounts for medical care. SCHC will not accept responsibility for collecting a patient's insurance claim or negotiating a settlement on a disputed claim.

B. Native Americans
   1. There are benefit limitations for dental and optometry services. Patients need to ask about benefits prior to scheduling services. Patients are responsible for any non-covered services and full payment is required before services are rendered. Unpaid balances may be subject to garnishment against paychecks and per capita payments. Non-covered services are as follows:
      a. Amounts over the optometry PRC benefit allowance
      b. Second replacement of removable dentures, partials (flippers) if sent to a laboratory
      c. Second replacement of mouth guards (night guard, sports guard) if sent to a laboratory
   2. All Native Americans who are eligible for insurance, Medicare, or Medicaid are required to enroll so that tribal resources can be conserved. To encourage this, Native Americans are not required to pay co-pays or deductibles for office visits. An Oregon Heath Program (OHP) outreach and eligibility expert will assist the patient in applying for Medicaid or proving over income status.
      a. IHS eligible patients are required to apply for OHP (annually) if they do not have another third-party resource. Patients that refuse to apply for OHP will be subject to lab costs billed by LabCorp.
   3. Any monies received from an insurance company for services provided are owed to SCHC. Occasionally, patients may receive a payment directly; if that happens, the patient should bring the check to the Business Office. The Business Office will contact the insurance company directly if no payment is received within 60 days. A letter will be sent to the insurance company.
   4. Tribal patients who are not Siletz Tribal members will be responsible for all dental lab fees and optometry hardware.
   5. Siletz Tribal member patients **who live out of the 11-county service area** should contact Purchased/Referred Care to check eligibility and current benefits. Siletz Tribal members who lives within the 11-county service area who has not completed a yearly update will need to do so prior to obtaining any service outside of the facility.

C. Non-Natives
   1. Patients should refer to their benefits manual or plan administrator for questions concerning covered services.
   2. Co-pay is required at the time of service. Payment or payment arrangements are required at the time of service if the required calendar year deductible is not met.
   3. **CTSI Employees Only:** A voluntary wage agreement will be initiated with the payroll department regarding outstanding account balances if payment arrangements have not been made. CTSI Employee patients should discuss payment arrangements with the Business Office prior to receiving services. If a service is provided but deemed un-payable by the insurance plan, Medicare, Workers' Compensation, or the Oregon Health Plan, the patient accepts full responsibility for the costs.
   4. Self-pay patients are required to pay in full at the time of service for all services rendered unless arrangements are made in advance.

Patient's Printed Name:_____ DOB:_____
Patient's Signature:_____
Or Parent/Patient Representative:_____ Today's Date:_____
Printed Name of
Parent/Patient Representative:_____ Date of Birth:_____

Nothing in this agreement waives the sovereign immunity of the SCHC or the Confederated Tribes of Siletz Indians

Siletz Community Health Clinic

Rights and Responsibilities of Patients

December 17, 2021

The rights and responsibilities of patients are distributed to new patients at registration, posted in the waiting area, distributed to new employees at the time of orientation and posted on the CTSI website.

Rights of Patients

1. You have the right to considerate, respectful and culturally sensitive care.
2. You have the right to be given complete information, to the degree known, from your health care provider concerning your health care and recommended treatments.
3. You have the right to know which health care provider is responsible for your care and to choose or change providers if such are available.
4. You have the right to know your health care provider's credentials and privileges and when he or she was granted Medical Staff privileges.
5. You have the right to participate in decisions about your treatment and to develop a mutually acceptable treatment plan in conjunction with your health care provider. You will be informed if your treatment is new, experimental, or unproven.
6. You have the right to give, withhold or withdraw your consent to have special procedures or treatments done to the extent permitted by law. You must be informed of the risks you are taking (although in emergency situations the health care provider may not be able to provide extensive information because of the loss of time, which could be dangerous for you).
7. You have the right to participate in decisions regarding the intensity and scope of care. Assistance to help you obtain a Living Will or Durable Power of Attorney will be made available at your request.
8. You have the right to privacy and dignity concerning your health care issues. Case discussion, examination and treatment shall be conducted in confidence. Medical and other health professional students will always be introduced to you as such. You have the right to refuse permission for their presence if so desired.
9. You have the right to know the SCHC privacy practices including how all the records and other information about your care will be used and disclosed, and how you can access this information.
10. You have the right to know how the SCHC is related to other health facilities (private, county, tribal, state or federal facilities).
11. You have the right to be informed of service limitations or payment policies concerning services prior to treatment.
12. You have the right to expect reasonable continuity of care such as to know: what appointment times are available to you; what services are available to you; where the services can be obtained.
13. You have the right to know what SCHC rules and regulations apply to your conduct.
14. You, or a person of your choice, have the right to present a grievance, complaint, and suggestion regarding health services to SCHC Administration, who will follow-up and respond in writing within ten (10) working days.
15. You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
16. You have the right to use a pharmacy that is not owned or operated by SCHC.

Responsibilities of Patients

1. You are responsible for your own behavior and are expected to treat the staff, other patients, clients, visitors and community members with respect and courtesy. Parents or guardians are responsible for their children.

a. Persons under the influence of drugs or alcohol may be excluded from CTSI property or tribal program activities.

b. Physical or verbal abuse, harassment, or the use of foul language or intimidation will not be tolerated in any form (in person, telephonic, writings). Bullying, harassment, and/or sexual harassment of staff, other patients, clients, visitors, or community members is prohibited.

2. Any person engaging in any of the above behaviors may be refused services and, when warranted, will be asked to leave the premises.
3. You are responsible for making and keeping appointments. If not able to keep an appointment, you must call SCHC to cancel or reschedule the appointment at least 24 hours prior to your scheduled appointment so that someone else can be given the opportunity to be seen.
4. Routine prescription refills should be requested two working days prior to time of pickup to allow the pharmacy time to contact your health care provider.
5. You are responsible for informing SCHC of insurance providers and any changes in your personal status, including changes in your address or phone number, legal name changes and changes in eligibility or health insurance coverage.
6. You are responsible for informing SCHC about any living will, medical power of attorney or other directive that could affect your care.
7. You are responsible for releasing all information related to past illnesses, treatment and medications (prescriptions, OTC and herbal supplements) to assist the staff in the provision of optimal health care.
8. The success of your care is related to your cooperation in following directions, treatment plans and other recommendations given you by the health care providers. If you desire to alter the course of recommended treatment (such as stopping a medication), please consult your provider first.
9. Parents/legal guardians or designated guardians are responsible for accompanying children to SCHC for appointments for routine healthcare and dental care if the child is under age 15. Parents/legal guardians or designated guardians are responsible for accompanying children to SCHC for sports physical or well child exam appointments until the child reaches the age 18. SCHC will not require parental permission or attendance for appointments for adolescents, age 12 and over, seeking diagnosis or treatment related to sexually transmitted disease, pregnancy, or contraception. Such care will be considered confidential, including from the adolescent's parent(s), although evidence of child abuse will be reported as mandated.
10. Depending on eligibility at the time of service, you may be responsible for costs for services rendered.
11. You are responsible for adherence to COVID related policies and procedures.

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Siletz Community Health Clinic
Confidential Health History

Date:_____ Have you executed an Advance Directive? ❑ Yes ❑ No

Name:_____ DOB:_____ Age:_____

Pharmacy: ❑ SCHC and/or ❑Other (please list): _____

Location:_____ Phone number:_____

MEDICATIONS: Including OTC (over the counter)

Name	Dosage	Frequency
EXAMPLE: Vitamin D3	4 / 2000 iu	1/day

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list:

MEDICAL HISTORY: Current health issues: Please check all that apply:

❑ Alzheimers/Memory issues
❑ Anemia
❑ Chest pain
❑ Arthritis/ type: _____
❑ Asthma
❑ Atrial fibrillation
❑ Benign prostatic hypertrophy
❑ Blood clots
❑ Cancer / type:_____
❑ Congestive heart failure
❑ COPD/Emphysema
❑ Coronary heart disease
❑ Crohn's disease
❑ Depression
❑ Diabetes/ type:_____
❑ Elevated cholesterol
❑ Gallbladder disease
❑ GERD/heartburn
❑ Headache/migraine
❑ Heart disease
❑ Heart valve disease
❑ Hepatitis/Liver disease/Fatty liver
❑ Hypertension/High blood pressure
❑ Irritable bowel disease
❑ Myocardial infarction/Heart attach
❑ Osteoporosis
❑ Renal disease/Kidney disease/stones
❑ Seizure disorder/Epilepsy
❑ Stroke
❑ Thyroid Disease
❑ Abdominal aortic aneurysm
❑ Carotid artery stenosis (blockage of neck arteries)
❑ Cardiac arrhythmia (ie: fibrillation, etc.)
❑ Celiac disease
❑ Colon polyps
❑ Pancreatitis
❑ Genital Herpes
❑ UTI's / chronic
❑ Degenerative joint disease (ie: knees, etc)
❑ Drug abuse
❑ Fibromyalgia
❑ Fracture/ list:_____
❑ Restless leg syndrome
❑ Sleep apnea
❑ Other:_____

SURGICAL HISTORY

❑ Appendectomy
❑ Arthroscopy/what joint:_____
❑ Back surgery
❑ Blood transfusion
❑ CABG
❑ Pacemaker
❑ Carpal tunnel release
❑ Cataract extraction
❑ Cholecystectomy/Gallbladder removal
❑ Colostomy
❑ Gastric bypass surgery
❑ Hernia repair
❑ Hip replacement
❑ Knee replacement
❑ Thyroidectomy
❑ Tonsillectomy
❑ Other_____

FAMILY HISTORY

- ❑ ADD/ADHD
- ❑ Alcoholism
- ❑ Alzheimers disease
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorder
- ❑ Cancer/ type:_____
- ❑ Heart disease
- ❑ Coronary artery disease
- ❑ Depression
- ❑ Diabetes/ type:_____
- ❑ Eczema
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Mental illness
- ❑ Migraines
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Kidney disease
- ❑ Seizure disease
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Other_____

SOCIAL HISTORY

TOBACCO: Have you ever used tobacco products? ❑ Yes ❑ No

- ❑ Cigarettes/# per day_____
- ❑ Cigars/# per day_____
- ❑ Pipe/# per day_____
- ❑ Chewing tobacco
- ❑ Smokeless
- ❑ Snuff

How many years have you smoked?_____

When did you start smoking?_____

Have you ever quit? ❑ Yes ❑ No

How did you quit?_____

ALCOHOL: Do you drink alcohol? ❑ Yes ❑ No

Type of alcohol_____ Frequency_____ Last drink_____

CAFFEINE: Do you drink caffeine? ❑ Yes ❑ No

Type of caffeine_____ Amount of caffeine_____

LIFESTYLE: Describe your daily activity:

❑ Sedentary ❑ Moderate ❑ Vigorous

Type of exercise: (ie: walking, etc.)_____

How often do you exercise:_____

DIET: Any specialized diet you follow? (ie: gluten free, vegan, etc.)_____

HOME SAFETY:

- ❑ Smoke detectors
- ❑ Carbon Monoxide Monitor
- ❑ Falls in the past year
- ❑ Firearms in your home
- ❑ Seat belt use

*CONFIDENTIAL INFORMATION CAN BE DISCUSSED IN PRIVATE.