SOUTHERN INDIAN HEALTH COUNCIL, INC.
4058 Willows Road Alpine, CA 91901
phone (619) 445-1188 fax (619) 659-3144
www.SIHC.org

Welcome to Southern Indian Health Council, Inc. (SIHC) and thank you for allowing us this opportunity to provide quality integrated wellness services. We look forward to developing a healthy and positive relationship with you and your family.

Southern Indian Health Council, Inc. always has exciting opportunities - programs offered onsite, activities held on various reservations, and larger events held each year. All of these programs and events are designed with SIHC patients and the community in mind.

Southern Indian Health Council, Inc. is here to be a partner in your wellness journey. For tough decisions you may be facing SIHC is honored to be by your side to provide education, support, and guidance through the highest quality service delivery that is timely and respectful.

We encourage you to take a moment and familiarize yourself with SIHC's many resources such as: SIHC's website, Patient Handbook, Program Services and Eligibility Information booklet, and think about how SIHC can fit into your wellness journey. It is beneficial to understand all aspects of wellness from behavioral health, community health, dental, and medical focusing on a patient center model. With that comes **patient rights and responsibilities** to be sure that everyone feels welcome, respected, and safe while at SIHC.

Preparing for a successful first appointment:

Please complete as much of the new patient packet prior to your appointment. This saves time and allows us to spend more time getting you acquainted with SIHC. Please **remember to bring**:

- ❑**Medication bottles**
- ❑**Picture identification**
- ❑**Dental/medical insurance and pharmacy benefits cards**
- ❑**Tribal identification, letter, or (if minor) birth certificate**

Please plan on the first appointment to take about an hour. To help support quality care delivery and access to care please ensure cancelations are done 24 hours before your appointment time. If you arrive 15 minutes (Dental and Kumeyaay Family Services) or 10 minutes (Medical) after your scheduled appointment time you may be asked to reschedule your appointment to ensure best practices in care delivery.

Oh behalf of SIHC's Board of Directors and all employees, SIHC is honored that you have chosen us to be your care provider. We are always open to feedback and suggestions.

Thank you and I look forward to seeing you at one of our locations,

Laura Caswell,
Chief Executive Officer

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Patient Registration – Demographic Information Form

Date Completed: ___/___/___

Patient's Legal Name: _____
Last First Middle Initial/Maiden Name

Date of Birth: ___/___/___ ❑Male ❑Female ❑Nonbinary ❑Single ❑Married

U.S. Veteran: ❑Yes ❑No If married, spouse's name: _____

Mailing Address: _____
Street City State Zip

Home Address: _____
if different than mailing Street City State Zip

Cell Phone #: (____)____-_____ Home Phone #: (____)____-_____ Work Phone #: (____)____-_____

Primary Language: _____ Email Address: _____

Race: ❑American Indian ❑African American ❑Asian ❑Caucasian ❑Hispanic
❑Pacific Islander ❑Other Non-Caucasian

If American Indian: Tribal Affiliation: _____ Tribal Roll #: _____

If you are not American Indian, are you a member of an Indian household? ❑Yes ❑No

In Case of Emergency Contact: _____ Phone #: (____)____-_____
Name Relationship

Minor Patients – Parent Guardian Information

Parent 1/Legal Representative Name: _____
Last First Middle

Date of Birth: _____/___/_____

Tribal Affiliation: _____ Tribal Roll #: _____

Cell Phone #: (____)____-_____ Home Phone #: (____)____-_____ Work Phone #: (____)____-_____

Mailing Address: _____
Street City State Zip

Home Address: _____
if different than mailing Street City State Zip

Does the minor live with you?: ❑Yes ❑No **If there is a custody situation, please provide court papers.*

Parent 2/Legal Representative Name: _____
Last First Middle

Date of Birth: _____/___/_____

Tribal Affiliation: _____ Tribal Roll #: _____

Cell Phone #: (____)____-_____ Home Phone #: (____)____-_____ Work Phone #: (____)____-_____

Mailing Address: _____
Street City State Zip

Home Address: _____
if different than mailing Street City State Zip

Does the minor live with you?: ❑Yes ❑No **If there is a custody situation, please provide court papers.*

Southern Indian Health Council, Inc. Front Office Use Only:

Chart: _____ Registration Date: ____/____/_____

Eligibility P D I Eligibility Determination Made By: _____

Approval Date:04/26/2019
Revision Date: 02/26/2021
Creation Date: 2013
Department Origin: Quality Management

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General Consent for Diagnosis and Treatment

Patient Name:_____ Date of Birth:____/____/_____

All Patients

1. **Consent to Behavioral Health, Dental, Medical, Nursing Procedures**
The undersigned consents for the above named patient to receive behavioral health, dental, medical, and nursing, which may include anesthesia, emergency services, examinations, laboratory procedures, routine immunizations, x-rays, and other procedures as instructed by the patient's Southern Indian Health Council, Inc. (SIHC) healthcare provider(s) in their professional judgment, as deemed necessary or beneficial. Additional and specific consents will be required for complex treatments and procedures.
2. **Consent to Being Offered**

a.	Notice of Privacy Practices	*I am*	❑*refusing*	❑*requesting and have received a copy.*
b.	Advance Health Care Directive	*I am*	❑*refusing*	❑*requesting and have received a copy.*
c.	Dental Materials Fact Sheet	*I am*	❑*refusing*	❑*requesting and have received a copy.*

Minor/Dependent Adult Patients

3. **Consent to Treatment of a Minor Child/Dependent Adult Unaccompanied by Parent/Legal Representative**

I,_____ authorize the following individual(s):
Parent/Legal Guardian Name

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

to accompany and consent to routine healthcare and/or services for the above named patient, which may include sharing protected health information related to the appointment. Routine healthcare services and/or treatment includes, but is not limited to, those listed in Section 1 with the exception of behavioral health. This consent/authorization does not permit the individual(s) listed above to request and/or receive health records from SIHC for the above name patient as outlined in the Notice of Privacy Practices.

Limitations: identify any specific limitations on the kinds of services for which this authorization is given. (If none, write "none"): _____

I understand that in the event of a major illness or injury, an attempt will be made to contact the parent(s)/legal representative.

By signing below I acknowledge I have read, understand, and give my consent as stipulated above. I understand this General Consent shall go into effect upon signature date and remain in effect as long as the above named patient utilizes SIHC services unless revoked in writing and submitted to SIHC. Please note, a New Patient Packet will be required for any patients that have three years of patient inactivity, or as determined by a specific department/program. I further understand that this General Consent includes the right to use minimal necessary protected health information for the purpose of treatment, payment, or operations.

_____ _____ ____/____/_____

❑Patient/❑Legal Representative (signature) if Legal Representative, print name Date
(check one)

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Department Origin: Quality Management

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Financial Responsibilities and Agreement

Patient Name:_____ Date of Birth:____/____/_____

Patients coming to Southern Indian Health Council, Inc. (SIHC) must provide proof of dental/medical insurance(s) (Medi-Cal, Medicare, VA, private insurance plan). SIHC bills for services rendered consistent with applicable laws, terms of patient's insurance or other applicable plan coverage:

- Native Americans must provide tribal verification (tribal ID, letter of enrollment from affiliated tribe, or letter from the Bureau of Indian Affairs).
  - Native Americans without tribal verification proof will only be seen one time under Native American eligibility. There are times patients will incur charges for services rendered.
- Fees for services and responsibility for payment are based on the patient's eligibility (PRC, Direct, non-Native) for care.

Patient's Financial Responsibilities

- Provide current insurance information to allow SIHC to bill for services rendered.
  - Update insurance (subscriber, change in insurance) and contact information.
  - Verification of insurance coverage and limitations by SIHC is based on information provided.
- Payment for services rendered
  - co-payment, deductible, co-insurance
  - non-covered services
- Delinquent Balance
  - The responsible party will receive a statement from SIHC indicating any balance due. Payment for any balance is due upon receipt. Please discuss any questions or special payment circumstances with Billing.

Behavioral Health: To ensure proper insurance coverage, insurance/financial responsibilities will be covered during the initial intake.

Dental: During treatment it may be necessary to change or add procedures due to conditions found while working on the patient's teeth.

- Insurance portion is an estimate and not a guarantee of coverage.
  - Patient's portion is due at the time of service.
- If insurance pays less than anticipated amount, you will be responsible for unpaid balance.

Medical: To ensure proper insurance coverage verify SIHC is assigned as the primary care provider.

Certification Statement: By singing below I acknowledge I have read and understand the Financial Responsibilities and Agreement. I certify that information provided to SIHC in applying for payment by third parties is correct. I hereby assign benefits on my behalf for services rendered and authorize SIHC to release all information necessary to secure payment for such services. A copy of this Agreement is to be considered as valid as an original and will remain in effect until revoked by me in writing.

_____ _____ ____/____/_____

❑Patient/❑Legal Representative (signature) (check one) if Legal Representative, print name Date

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Department Origin: Fiscal/Billing

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Patient Rights

Southern Indian Health Council, Inc. desires to serve all patients in a manner appropriate to each individual's integrity and healthcare needs. SIHC is committed to providing integrated quality care. SIHC partners with its patients on this journey. To benefit the most from your experience and get the most from your care, SIHC is committed to working with you as a team. As an SIHC patient you have the following rights when receiving care:

- to be informed of Patient Rights and Responsibilities
- to receive considerate and respectful care in a safe and secure environment with respect and regard for your privacy, individuality, personal beliefs and cultural traditions
- to be treated with courtesy, dignity, and respect at all times and to receive information and care in a non-abusive manner
- to receive appropriate, timely and qualified care in a setting appropriate to your healthcare needs
- to understand and agree to the care you will receive
- to know the name and qualifications of all individuals providing services and how to contact SIHC, including accessibility to advice after-hours
- to expect reasonable continuity of care between services and providers
- to accessible services and timely referrals to staff and services consistent with quality professional practices
- to refuse treatment, except where prohibited by law, and to be fully informed of the possible consequences of such refusal, without reprisal
- to be informed of the reasons for tests and treatments and to receive the results in a timely manner
- to participate in decisions affecting your care and treatment according to your own desires, needs, and understanding, including the choice to have family or friends participate in this process
- to receive information about your condition, the course of treatment, and the prospects for good health in terms that you can understand, including any ethical issues that impact your care
- to change providers if other qualified providers are available
- to know SIHC policy for accessing and disclosing information in your health record and reviewing, requesting and receiving a copy of your health record
- to know, in advance of service, the cost of service and any applicable payment policies
- to express your complaints and satisfaction regarding the services received and to comment and make suggestions for improvement of the quality of care and services
- to file a complaint and to receive a response, in a timely manner, to your complaint without fear of discrimination or reprisal
- to refuse to sign consent forms until you understand what you are signing
- to appoint a legal representative to make decisions regarding your healthcare, who will have all the above rights apply to them on your behalf
- to expect that your personal privacy will be respected by all employees
- to expect that your health records will be kept confidential and information released according to SIHC policy and Notice of Privacy Practices (HIPAA)
- to identify a person whom you would like to make decisions for you when you are unable to do so, using the Advance Care Directives

If you have a compliment, concern, complaint, or suggestion please contact Quality Management at x360.
You may also ask any employee for an Experience Feedback Form.

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Patient Responsibilities

Southern Indian Health Council, Inc.'s journey to be patient centered involves the patient to be at the center of all decisions and care provided. You and your provider are in a partnership together to provide the best possible care at the right time with the highest quality of care. As a participant and key player in your care, you have responsibilities:

- to discuss your care problems, concerns, and personal needs with your provider(s) in an honest manner and to inform the provider of any changes occurring in your health
- to actively participate in decisions regarding your care and to follow your provider's care instructions and advice
- to provide a complete and accurate health history, including a list of current medications (including over-the-counter and dietary supplements), and inform your provider of information related to past conditions (including allergies or sensitivities), treatments, and medications
- to bring all discharge papers from emergency room and urgent care visits and ensure any specialist sends SIHC your visit notes
- to ask questions when in need of further instructions or better understanding
- to let your provider know if you cannot or will not follow a certain treatment plan
- to make healthy decisions about your daily habits and lifestyle
- to make, keep, and arrive on time for all scheduled appointments
- to cancel any appointment a minimum of 24-hours prior to the appointment
- to pay for service at the time service is provided
- to provide accurate, complete, and current information for insurance coverage, home address, telephone number, social security number, and Indian verification
- to advise your provider(s) of all changes in any decisions concerning Advance Directives and/or persons designated by you to make healthcare decisions for you
- to cooperate with the various providers involved in your care and to conduct yourself in a polite and respectful manner
- to treat all persons with courtesy, dignity, and respect at all times and to exchange information in a non-abusive, either physically or verbally, manner while receiving care
- to respect the rights and property of all employees and other patients
- to call SIHC first with all problems, unless it is a medical emergency
- to inform SIHC of any requirements or accommodations needed to meet your cultural and/or language needs

By signing below I acknowledge I have read and understand my responsibilities of being an SIHC patient.

_____ ____/____/_____

❑Patient/❑Legal Representative (signature) Date

(check one)

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