Crooked Tree Wellness Clinic

CROOKED TREE WELLNESS CLINIC

Little Traverse Bay Bands of Odawa Indians

2390 Mitchell Park Drive,Unit D

Petoskey, MI 49770

P: 231-242-1760

CHILD PATIENT REGISTRATION

For the Little Traverse Bay Bands of Odawa Indians (LTBB) to provide efficient health services while following federal regulations, you must complete this form and return it to our Central Registration. If completed, the information provided will assist the Crooked Tree Wellness Clinic 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? ☐ MELESS 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: _____ RELACTIONSHIP: _____

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#: _____

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 Crooked Tree Wellness Clinic
(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 Crooked Tree Wellness Clinic.

Authorization:

Parent/Legal Guardian Name: _____

Phone: _____

Address: _____

_____

This authorization shall be effective until:_____or until revoked.

_____ _____
Signature of Parent/Guardian Date:

Patient Name_____ DOB_____ HRN_____

Crooked Tree Wellness Clinic

Insurance Attestation

I, _____, confirm that I have Michigan
(Print Name)
Medicaid (or managed care plan with Michigan Medicaid) as my only, or primary, form of insurance.

- I understand that Crooked Tree Wellness Clinic is only able to provide medical care and services as long as Medicaid is my primary insurance provider. If I obtain other insurance, I will no longer be eligible for services at this office.

- I will notify Crooked Tree Wellness Clinic immediately of any changes in my insurance coverage status, or if I obtain insurance coverage from another source or carrier.

- If it is found that I have I received care or services at Crooked Tree Wellness Clinic while covered by insurance other than Medicaid, I will be financially responsible for associated charges.

_____ _____
Patient/Responsible Party Signature Date

_____
Relationship to Patient

Patient Name	Patient DOB	HRN

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Phone: 231-242-1760
Fax: 978-367-5563

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

Address: _____ City:_____ State:_____ Zip:_____

I authorize CTWC to: □ Disclose to □ Receive from □ Both Disclose to and receive from

Name: _____ Phone/Fax #:_____

Address: _____

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

PLEASE CHECK REQUESTED ITEM(S):

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

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

□ Other_____

By signing this authorization form, I understand that:

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

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date of Signature

FOR OFFICE USE ONLY	
Staff Person Releasing Information:	
Date Information Released:	Record #:

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

INSTRUCTIONS FOR COMPLETING FORM

1. Section II: print the name, address, and phone/fax number of the facility releasing the information. The information for the LTBB Health Clinic has already been provided.
2. Section III: state the reason why the information is needed (disability claim, continuing medical care, legal, research related projects, etc.)
3. Section IV, check the appropriate box as applicable.
    a. **ENTIRE RECORD** – the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)

    b. **PSYCHOTHERAPY NOTES ONLY** – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.

    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

    Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

    c. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL AND DRUG ABUSE TREATMENT/REFERRAL, SEXUALLY TRANSMITTED DISEASES, HIV/AIDS RELATED TREATMENT, AND MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX MUST BE CHECKED BY THE PATIENT.**

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PATIENT CONSENT FORM

Crooked Tree Wellness Clinic is committed to providing highly qualified services and ensuring a holistic approach for all Anishinaabe by respecting and intertwining both modern and traditional healing.

We want you to understand your right and responsibilities while receiving care within our organization. If you have any questions about this form, please ask prior to signing. If you are a parent/legal guardian of a child, please read this agreement with the understanding that "I" and "me" means the child.

AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREAT:

I consent to outpatient care from Crooked Tree Wellness Clinic 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 Crooked Tree Wellness Clinic may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a remote site at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Possible Risks: Just like any other medical procedure, there are potential risk associated with the use of telemedicine. These risks include but may not be limited to:

- Information being transmitted may have poor sound or image quality to allow for appropriate medical decision making by the provider
- Delays in medical evaluation and treatment could occur due to equipment failure
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;
- In very rare instances, there could be a security breach causing your PHI information to be leaked

AUTHORIZATION TO RELEASE INFORMATION: Based on the Privacy Act of 1974, P.L. 93-579, I hereby authorize the release of my personal health information (PHI) for referral to health care providers outside of Crooked Tree Wellness Clinic 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: As part of the Little Traverse Bay Bands Health Department, Crooked Tree Wellness Clinic endorses, supports, and participates in Health Information Exchange (HIE) as a patient-centered care approach to improve the overall well-being of our patients. HIE allows us to efficiently share clinical information among the other providers within the LTBB Health Department (which includes Behavioral Health, Dental, and Community Health programs) to be able to treat the mind, body, and soul of our patients.
This model helps foster communication and shared decision-making among your care team about treatment options that will best address your healthcare needs. I understand that I can submit a written request for restrictions with the Privacy Officer or Health Information Management (HIM) staff at any time.

NOTIFICATION OF PRIVACY: I have read and acknowledge receipt of the Notice of Privacy Practice.

PATIENT RIGHTS AND RESPONSIBILITIES: I have read and acknowledge receipt of the Patient Rights and Responsibilities

CONSENT TO TREAT: I have read and understand the information provided above regarding my care here at the Crooked Tree Wellness Clinic, and all of my questions have been answered to my satisfaction.

Signature:_____Date:_____ Time:_____AM/PM
Patient or Patient Representative

If Not the patient: Relationship to Patient

_____

FOR OFFICE USE ONLY

☐Patient Rec'd Copy of NPP

☐Patient Rec'd Copy of

PRR CHART_____

Crooked Tree Wellness Clinic

LITTLE TRAVERSE BAY BANDS HEALTH DEPARTMENT
Crooked Tree Wellness Clinic

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:_____

CTWC HRN _____

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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.

Crooked Tree Wellness Clinic is required by law to maintain the privacy of every patient's health information, as required by the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

This notice describes how medical information about you may be used and how you can get access to this information. We are required by law to maintain the privacy and security of your protected health information (PHI). This notice applies to the PHI in our possession including the medical records generated by us.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **PAYMENT** means such activities as obtaining reimbursement for our services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, and utilization review. An example of this would be an internal assessment review.

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

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

Although your health records are the physical property of Crooked Tree Wellness Clinic, the information belongs to you.

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

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

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

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI.

This notice is effective as of June 25, 2020, and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all PHI that we maintain. If we have made any change to the Notice of Privacy Practices, you will be notified during your next visit or by mail. It is required that you also sign a copy of the Notice of Privacy Practices on an annual basis.

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

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

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Patient Rights and Responsibilities

As a patient of Crooked Tree Wellness Clinic, you have the right to:

- Receive complete and current information about your diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand
- Participate actively in determining a course of treatment for yourself
- Receive information that you need in order to give informed consent for any proposed procedure or treatment, including information about the risk, benefits and alternative to the proposed procedure or treatment
- Refuse treatment and be told what affect this may have on your health, and to be informed of the other potential consequences of refusal
- Request a second opinion from another physician
- Receive considerate and respectful care in a clean and safe environment
- Know by name the physicians, nurse and other staff members responsible for your care
- Refuse to take part in any research or educational projects
- Have privacy while in the Clinic, and confidentiality of all information and records regarding your care
- Designate an individual to represent you in making decisions regarding your treatment and health care
- Be provided with complete information about the Clinic's policies regarding patient rights, patient complaints and advance directives

Your Responsibilities

Rules and regulations regarding conduct are necessary to ensure that all patients are treated fairly and feel secure while being seen at the Clinic. Your cooperation in these responsibilities will help us provide quality care and service. Please....

- Provide accurate and updated information for your file.
- Follow the plan of care you, your physician, and your health care team have agreed upon
- Ask questions of your caregivers and communicate any concerns or wishes you may have.
- Respect the privacy and confidentiality of the other Clinic patients.
- Respect the staff of Crooked Tree Wellness Clinic by using considerate communication and behavior at all times. Yelling, cursing, and inappropriate language/behavior will not be tolerated.

If you have any questions about your rights, please contact the

LTBB Health Director, Jody Werner at 231-242-1612.

HEALTH HISTORY
(Confidential)

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of last physical examination: _____

Reason for Today's Visit: _____

Symptoms: check (√) symptoms you currently have or have had in the past year

	General
	Chills
	Depression
	Fainting
	Fever
	Forgetfulness
	Headache
	Difficulty sleeping
	Weight loss
	Nervousness
	Numbness
	Sweats

	MUSCLE/JOINT/BONE
	Pain/Weakness/ Numbness in:
	Arms
	Back
	Feet
	Hands
	Hips
	Legs
	Neck
	Shoulders

	GASTROINTESTINAL
	Poor Appetite
	Bloating
	Bowel Changes
	Constipation
	Diarrhea
	Excessive hunger
	Excessive thirst
	Gas
	Hemorrhoids
	Indigestion
	Nausea
	Rectal bleeding
	Stomach pain
	Vomiting
	Vomiting Blood

	SKIN
	Bruise Easily
	Hives
	Itching
	Change in moles
	Rash
	Scars
	Sore that won't heal

	EYE, EAR, NOSE, THROAT
	Bleeding gums
	Blurred vision
	Crossed eyes
	Difficulty swallowing
	Double vision
	Earaches
	Ear Discharge
	Hay fever
	Hoarseness
	Hearing loss
	Nosebleeds
	Persistent Cough
	Ringing in ears
	Sinus problems
	Vision—Flashes
	Vision—Halos

	GENITO-URINARY
	Blood in Urine
	Frequent urination
	Lack of bladder control
	Painful Urination

	Reproductive Health
	Breast Lump
	Erection difficulties
	Lump in testicles
	Penis discharge
	Sore on penis

	CARDIOPULMONARY
	Chest Pain
	High Blood Pressure
	Irregular heart beat
	Low Blood Pressure
	Poor circulation
	Rapid Heart Beat
	Selling of ankles
	Varicose Veins
	Shortness of breath

	Reproductive Health
	Abnormal Pap
	Bleeding between periods
	Breast Lump
	Extreme menstrual pain
	Hot Flashes
	Nipple discharge
	Painful intercourse
	Vaginal discharge
	Date of last menstrual period?
	Date of last Pap Smear?
	Have you had a mammogram?
	Are you pregnant?

Last Colonoscopy/Cologuard	
Results:	

Conditions: check (√) conditions you have or have had in the past

	HIV/AIDS		Cancer		Glaucoma		Kidney Disease		Pneumonia		Tonsillitis
	Anemia		Cataracts		Goiter		Liver Disease		Polio		Tuberculosis
	Anxiety		Chicken Pox		Gout		Measles		Prostate Problem		Ulcers
	Arrhythmia (irregular heartbeat)		Chemical dependency		Heart Disease		Migraine Head-aches		Prenatal substance exposure		Vaginal Infections
	Arthritis		Depression		Heart Murmur		Miscarriage		Sexually transmitted		Other:
	Asthma		Diabetes		Hepatitis		Mononucleosis		Shortness of breath		Other:
	Bleeding Disorders		Eating Disorder		Hernia		Multiple Sclerosis		Stroke		Other:
	Breast Lump		Emphysema		Herpes		Mumps		Suicide Attempt		Other:
	Bronchitis		Epilepsy		High Cholesterol		Pacemaker		Thyroid Problems		Other:

HEALTH HISTORY
(Confidential)

Name: _____ Today's Date: _____

Medication (s)	Dose (e.g. mg/pill)	How many times per day?

Allergy	Reaction or Side Affect

Family History: Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status: L=Living, D= Deceased, U=Unknown

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer (Type)	Colon Polyps	Depression	Other
Mother		☐	☐	☐	☐	☐		☐	☐	
Father		☐	☐	☐	☐	☐		☐	☐	
Siblings		☐	☐	☐	☐	☐		☐	☐	
Maternal Grandmother		☐	☐	☐	☐	☐		☐	☐	
Maternal Grandfather		☐	☐	☐	☐	☐		☐	☐	
Paternal Grandmother		☐	☐	☐	☐	☐		☐	☐	
Paternal Grandfather		☐	☐	☐	☐	☐		☐	☐	

Other Family Members Information (please write in)

HEALTH HISTORY

(Confidential)

Hospitalizations		
Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion □ Yes □ No

If yes, please give approximate dates:

Serious Illness/Injuries	Date	Outcome

Women's Health			
	Number of pregnancies		Number of abortions
	Number of Delivers		Number of Miscarriages

Social History:				
	Caffeine	□ Energy Drinks □ Coffee □ Pop/Soda □ Other		Marijuana □ Medical or □Recreational
	Tobacco	□ Never □ Current □ Former : quit: If current # of packs/day # of years		Drugs If yes, please describe:
	Other Tobacco	□ Pipe □ Cigar □ Snuff □ Chew Are you interested in quitting? □ Yes □no		Exercise: Do you exercise regularly:
	Alcohol	If yes, # of drinks per week		

Occupational Concerns check (√) if your work exposes you to the following:		
	Stress	
	Hazardous Substances	
	Heavy Lifting	
	Other	
Your Occupation:		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed by Date

Crooked Tree
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231.242-1760 (p)
978.367.5563 (f)

Cancellations, No Shows, and Late Arrivals

- CTWC requires a 24-hour notice for appointment cancellation. If this is not possible, you must notify CTWC of the need to cancel as soon as possible.

- Cancellations made within 24 hours of a scheduled appointment will be considered a late cancellation.

- Arriving 10 (or more) minutes past the given arrival time is considered a no-show. You will be asked to reschedule the appointment to another day.

- Repetitive no-shows and cancellation may result in termination of the patient-provider relationship.