STUDENT/ PEDIATRIC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HASKELL INDIAN HEALTH CENTER * 2415 MASSACHUSETTS, LAWRENCE, KS 66046 (785)-843-3750

# Welcome to Haskell Indian Health Center

## ***Required*** **documents for Patient Registration:**

- ☐ Social Security Card
- ☐ State Driver's License/ID
  - (IF under 18 years of age, Parents ID may be used)
- ☐ Insurance Cards
- ☐ Certificate Degree of Indian Blood (CDIB) or Tribal Enrollment Card
  - (IF under 18 years of age, Parents CDIB may be used)
- ☐ Birth Certificate
  - (IF under 18 years of age or upon request)
- ☐ If FIRST or LAST Names have been changed (IF Applicable) –
  - Marriage License
  - Divorce Decree
  - Court Affidavit

Any questions please contact:

Haskell Indian Health Center
Patient Registration
785-843-3750 Main
785-832-4887 FAX

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HASKELL INDIAN HEALTH CENTER * 2415 MASSACHUSETTS, LAWRENCE, KS 66046 (785)-843-3750

## PATIENT BILL OF RIGHTS

When you are seen at the Haskell Indian Health Center you have the right:

- To be treated with consideration, respect, and equality.
- To have the confidentiality of your medical information protected; and to have your "Privacy Act" regulations enforced.
- To be informed and to refuse services from a student, trainee or volunteer involved in your health care.
- To have privacy during case discussion, counseling, examination and treatment.
- To review your medical record, if you request it.
- To have your pain assessed by a healthcare provider.
- To know the name and qualifications of staff members providing you with care.
- To know your diagnosis, health problems, test results and the potential advantages and risks of treatment and procedures in language you can understand.
- To have a second medical option, if you request it.
- To except no treatment procedure or transfer will take place without your informed consent—except in emergencies.
- To refuse participation in any investigational or research activities.
- To participate in treatment, discharge, or referral planning.
- To have access to patient complaint procedures.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences.

## PATIENT BILL OF RESPONSIBIITIES

When you are seen at the Haskell Indian Health Center you have the responsibility:

- To treat staff with consideration, respect and equality.
- To understand that your lifestyle affects your health.
- To take an active part in your healthcare.
- To follow the treatment plan to which you agree and if for some reason you cannot, to inform your doctor.
- To observe the facility rules that are for safety and consideration of all patients and staff.
- To respect the property as if it were your own.

**INDIAN HEALTH SERVICE**
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."

SUMMARY OF YOUR PRIVACY RIGHTS

**A.** Understand Your Medical Record/Information. Each time you visit an Indian Health Service (IHS) facility for services, a record of your visit is made. If you are referred by the IHS through the Purchased/Referred Care (PRC) program, the IHS also keeps a record of your PRC visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

1) Plan for your care and treatment.
2) Communication source between health care professionals.
3) Tool with which we can check results and continually work to improve the care we provide.
4) Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
5) Tool for education of health care professionals.
6) Source of information for public health authorities charged with improving the health of the people.
7) Source of data for medical research, facility planning, and marketing.
8) Legal document that describes the care you receive.

**B.** Understanding what is in your medical record and how the information is used helps you to:

1) Ensure its accuracy.
2) Better understand why others may review your health information.
3) Make an informed decision when authorizing disclosures.

**C.** Your Medical Record/Information Rights. Your medical record is the physical property of the IHS, but the information belongs to you. You have the right to:

1) Inspect and receive a paper or electronic copy of your health information.
2) Receive notification of a breach of your unsecured protected health information.
3) Request a restriction on certain uses and disclosures of your health information to include certain disclosures of protected health information to your health plan. The IHS is not required to agree to the requested restriction except when the disclosure would be for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI relates solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.
4) Request a correction or amendment to your health information. The IHS may amend your record or include your Statement of Disagreement.
5) Request confidential communications about your health information.
6) Request and obtain a listing of certain disclosures the IHS has made of your health information.
7) Revoke your written authorization to use or disclose health information.
8) Request and obtain a paper or electronic copy of the IHS Notice of Privacy Practices
9) Request and obtain a paper or electronic copy of the patient's medical record from the IHS Medical, Health and Billing Records, System Notice Number 09-17-0001.

**D.** Indian Health Service Responsibilities. The IHS understands that health information about you is personal and is committed to protecting your health information. The IHS is required by law to:

1) Maintain the privacy of your health information.
2) Inform you about our privacy practices regarding health information we collect and maintain about you.
3) Notify you if we do not agree to a requested restriction.
4) Notify you of our decision regarding a request for correction or amendment.
5) Accommodate reasonable requests you may have to communicate health information by alternate means or to an alternate location.
6) Promptly notify you of a breach of unsecured protected health information (PHI).
7) Honor the terms of this Notice or any subsequent revisions of this Notice.

REVISED NOTICE OF PRIVACY PRACTICES

The Indian Health Service (IHS) reserves the right to change its privacy practices and to make the new provisions effective for all PHI it maintains. The IHS will post any revised Notice of Privacy Practices at public places within its facilities and on the IHS web site at:: http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm

1) How the IHS may use and disclose health information about you. The IHS will not use or disclose your health information without your permission, except as described in this Notice and as permitted by the HHS Privacy Act regulations, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, Genetic Information Nondiscrimination Act (GINA) of 2008, and the IHS Medical, Health, and Billing Records, System Notice 09 17 0001. The following categories describe how we may use and/or disclose your health information.

**A.** Treatment. We will use and/or disclose your health information to provide your treatment. For example:

1) Your personal information will be recorded in your medical record and used to determine the course of treatment for you. Your health care provider will document in your medical record their instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your medical record so your health care provider will know how you are responding to treatment.
2) If you are referred or transferred to another facility or provider for further care and treatment, the IHS may disclose information to that facility or provider to enable them to know the extent of treatment you have received and other information about your condition.
3) Your health care provider(s) may give copies of your health information to others, including health care professionals or personal representatives, to assist in your treatment.

**B.** Payment Purposes. We will use and disclose your health information for payment purposes. For example:

1) If you have private insurance, Medicare, or Medicaid, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
2) If you are referred to another health care provider under the Purchased/Referred Care (PRC) program, the IHS may disclose your health information to that provider for health care payment purposes.

**C.** Health Care Operations. We will use and disclose your health information for health care operations. For example:

1) We may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide.

**D.** Health Information Exchange (HIE). The IHS HIE may make your health information available electronically through an information exchange network to other providers involved in your care who request your electronic health information. Participation in the national eHealth Exchange network is voluntary. If you want your health information to be accessible to authorized health care providers through the IHS HIE to the national eHealth Exchange, you must authorize this use and disclosure. More information is available at http://www.ihs.gov/hie/

**E.** Personal Health Record. The Personal Health Record (PHR) is a secure web based application that provides patient access to their health care information. The PHR is accessible to any patient who receives care at an IHS facility and requests a PHR account.

**F.** Direct. The IHS may share your health information between providers and between healthcare providers, patients and/or patients' authorized representatives, using the DIRECT secure, web-based messaging service.

**G.** Business Associates. The IHS provides some healthcare services and related functions through the use of contracts with business associates. For example, the IHS may have contracts for medical transcription. When these services are contracted, the IHS may disclose your health information to business associates so that they can perform their jobs. The IHS requires our business associates to protect and safeguard your health information in accordance with applicable Federal laws.

**H.** Directory. If you are admitted to an IHS inpatient facility, the IHS may use your name, general condition, and location within our facility, for facility directory purposes, unless you notify us that you object to this information being listed. If an individual asks for you by name, the IHS may disclose your name, general condition, and location within our facility, unless you notify us that you object to this information being listed. The IHS may provide your religious affiliation only to members of the clergy.

**I.** Notification. The IHS may use or disclose your health information to notify or assist in the notification of a family member, personal representative, or other authorized person(s) responsible for your care, unless you notify us that you object.

**J.** Communication with Family. All IHS health providers may use or disclose your health information to others involved with and/or responsible for your care unless you object. For example, the IHS may provide your family members, other relatives, close personal friends, or any other person you identify, with health information that is relevant to that person's involvement with your care or payment for such care.

**K.** Adults and Emancipated Minors with Personal Representatives. The IHS may disclose health information to a personal representative of an individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction.

HIPAA
Health Insurance Portability and Accountability Act
PRIVACY RULE

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.

STUDENT/ PEDIATRIC

# STUDENT OR PEDIATRICS

## HASKELL Indian Health Center -- PATIENT REGISTRATION FORM

**FULL LEGAL NAME** (Last, First, Middle): _____ **DOB:** _____

**SSN**: _____-_____-_____ **BIRTH SEX:** MALE ☐ FEMALE ☐ **City /State of Birth**: _____

**PRIMARY LANGUAGE**: _____ **PREFERRED LANGUAGE**: _____

**HOME ADDRESS:** _____ **CITY:** _____ **STATE:** _____

**ZIP:** _____ **PHONE NUMBER** (____) _____-_____ ( ) HOME ( ) CELL ( ) WORK ( ) MESSAGE

**UNIVERSITY STUDENTS/NAME OF UNIVERISITY:** _____ NAME OF DORM: _____

ROOM#: _____ PO BOX: _____ CITY: _____ ZIP CODE: _____ DORM PHONE: (____) _____-_____

**PARENT 1 EMPLOYER**: _____ (Circle One) **FULL TIME / PART TIME / RETIRED**

**PARENT 2 EMPLOYER**: _____ (Circle One) **FULL TIME / PART TIME / RETIRED**

**MARTIAL STATUS**: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

IF MARRIED, SPOUSE'S FULL NAME: _____ SSN: _____-_____-_____

SPOUSE'S EMPLOYMENT: _____ CITY/STATE: _____

**Tribe:** _____ **CDIB#** _____ **TRIBAL BLOOD Quantum**: _____

**TOTAL Blood Quantum**: _____ **RACE**: _____ **Circle one**: HISPANIC / NON-HISPANIC

**MIGRANT WORKER:** YES / NO **HOMELESS:** YES / NO

EMAIL ADDRESS: _____ **Preferred Method of Contact:** _____

**INTERNET ACCESS:** YES / NO -From (Phone, Home, Etc.): _____

**FATHER'S NAME:** _____ **BIRTH PLACE** (CITY/STATE): _____

**MOTHER'S FULL MAIDEN NAME:** _____ **BIRTH PLACE** (CITY/STATE): _____

PARENT MAILING ADDRESS: _____ CITY: _____ STATE _____
PHONE NUMBER (_____) _____-_____ ( ) HOME ( ) CELL ( ) WORK ( ) MESSAGE ZIP CODE: _____

**EMERGENCY CONTACT NAME:** _____ RELATIONSHIP: _____

MAILING ADDRESS: _____ CITY: _____ STATE _____
PHONE NUMBER (_____) _____-_____ ( ) HOME ( ) CELL ( ) WORK ( ) MESSAGE ZIP CODE: _____
**NEXT OF KIN NAME:** _____ RELATIONSHIP: _____
MAILING ADDRESS: _____ CITY: _____ STATE _____
PHONE NUMBER (_____) _____-_____ ( ) HOME ( ) CELL ( ) WORK ( ) MESSAGE ZIP CODE: _____

**Do you have an Advance Directive, living will in place, or Power of Attorney? Yes** ☐ **No** ☐ **N/A** ☐

Served in the Military, please complete: SERVICE BRANCH: _____ VIETNAM SERVICE: YES / NO
SERVICE ENTRY DATE: _____ SERVICE SEPERATION DATE: _____ VA DISABILITY: YES / NO

*Office Only*

DATE: _____ Haskell Chart/DOB:_____ New Patient ☐ Reactivate: ☐

*Received By:* *Entered By:* *PCP Assigned:*

STUDENT/ PEDIATRIC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

# ACKNOWLEDGEMENT OF RECEIPT OF IHS NOTICE OF PRIVACY PRACTICES

Form Approved:
OMB No. 0917-0030
Expiration Date:
December 31, 2026
*See OMB Statement Below*

By signing this form, you acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by logging onto https://www.ihs.gov/sites/hipaa/themes/responsive2017/display_objects/documents/NoticePrivacyPracticePamphlet.pdf or by contacting the IHS Privacy Officer at (240) 479-8521.

If you have any questions about our Notice of Privacy Practices, please contact the IHS Privacy Officer at (240) 479-8521.

NAME OF PATIENT

| SIGNATURE OF PATIENT | DATE *(mm/dd/yyyy)* |
|---|---|

**IF PATIENT IS UNABLE TO SIGN:**

NAME OF LEGAL REPRESENTATIVE AND STATE RELATIONSHIP TO PATIENT (PARENT/ LEGAL GAURDIAN/ POA)

| SIGNATURE OF PATIENT REPRESENTATIVE | DATE *(mm/dd/yyyy)* |
|---|---|
| SIGNATURE AND TITLE OF IHS STAFF | DATE *(mm/dd/yyyy)* |

**STAFF ONLY: FOR PATIENTS UNABLE TO ACKNOWLEDGE RECEIPT**

I hereby certify that the patient was unable to acknowledge receipt of the IHS Notice of Practices because:

| SIGNATURE OF IHS STAFF | DATE *(mm/dd/yyyy)* |
|---|---|

**IHS STAFF USE ONLY:**

| HEALTH RECORD NUMBER | D.O.B. *(mm/dd/yyyy)* |
|---|---|

**OMB STATEMENT**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

STUDENT/ PEDIATRIC

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
HASKELL INDIAN HEALTH CENTER * 2415 MASSACHUSETTS, LAWRENCE, KS 66046 (785)-843-3750

# Assignment of Benefits (AOB) & Authorization to Bill

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to United States Public Health Service - Indian Health Services for any covered services furnished by Haskell Indian Health Center.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, CHAMPUS/TRICARE, Veterans Affairs and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I acknowledge having received 1) a copy of Indian Health Services' Notice of Privacy Practices Pamphlet, dated April 9, 2014, 2) Haskell Indian Health Center Patient Handbook which includes: Welcome Letter, Mission Statement, Bill of Rights, Patient Bill of Responsibilities and clinic directory. 3) Acknowledgement of Receipt of Indian Health Service Notice of Privacy Practices.

I further certify that the information provided by me is true, accurate and complete. Unless revoked, this authorization to furnish information and assignment of benefits is valid for all administrative and judicial reviews under the health care reform legislation, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

*I, of competent mind, attest to having read and understand this agreement as witnessed by my signature below.*

***HRN:_____***

☐ Insurance information has NOT changed, CURRENT insurance: _____

☐ Have Dependents on your insurance

| _____ | _____ | _____ |
|---|---|---|
| PRINT Patient Name | Representative Name | Relationship |
| _____ | _____ | |
| Patient/Representative Signature | Date | |
| _____ | _____ | |
| Insurance Company | Policy Number | |

STUDENT/ PEDIATRIC

**THIRD PARTY COVERAGE INFORMATION**

Patient Name: _____ DOB: _____ SSN:_____

**DEPENDENT INFORMATION (SPOUSE/CHILDREN UNDER AGE 26):**

1. _____ DOB: _____ HRN: _____
2. _____ DOB: _____ HRN: _____
3. _____ DOB: _____ HRN: _____
4. _____ DOB: _____ HRN: _____

**EMPLOYMENT INFORMATION:**

☐ *Policy Holder*
Name (Mother):_____
SSN (if available)_____
DOB: _____
Employer: _____
Address: _____
City/State/Zip: _____
Telephone #: _____

☐ *Policy Holder*
Name (Father): _____
SSN (if available)_____
DOB: _____
Employer: _____
Address: _____
City/State/Zip: _____
Telephone #: _____

Received By: _____ Date: _____

********** DO NOT WRITE BELOW THIS LINE***FOR OFFICE USE ONLY **********

| **MEDICAL** | **DENTAL** | **BEHAVIORAL HEALTH** | **PHARMACY** |
|---|---|---|---|
| Insurance Company | Insurance Company | Insurance Company | Insurance Company |
| Claims Address | Claims Address | Claims Address | Claims Address |
| City/State/Zip | City/State/Zip | City/State/Zip | City/State/Zip |
| Telephone# | Telephone# | Telephone# | Telephone# |
| Group Name/Number | Group Name/Number | Group Name/Number | Group Name/Number |
| ID # | ID # | ID # | ID # |
| Effective/Term Date | Effective/Term Date | Effective/Term Date | Effective/Term Date |
| | | | PCN# and BIN |

STUDENT/ PEDIATRIC

## HASKELL INDIAN HEALTH CENTER MEDICAL HEALTH HISTORY

***If you need assistance completing the form or are unsure of how to answer any of the items below, Please ask the nursing staff for help***

**FULL LEGAL NAME:** _____ **DOB:** _____

| SELF MEDICAL HISTORY | | | SELF MEDICAL HISTORY | | | FAMILY HISTORY | | |
|---|---|---|---|---|---|---|---|---|
| Diabetes: | YES | NO | Blood Clots | YES | NO | Diabetes: | YES | NO |
| if yes specify type: | | | Blood Defects | YES | NO | If yes specify type: | | |
| | | | Obesity | YES | NO | | | |
| High Cholesterol | YES | NO | Ulcers | YES | NO | | | |
| Heart Disease | YES | NO | Heart Murmur | YES | NO | | | |
| High Blood Pressure | YES | NO | Heart Attack | YES | NO | High Blood Pressure | YES | NO |
| Glaucoma | YES | NO | Heart Valve or Pacemaker | YES | NO | Asthma | YES | NO |
| TB or Lung Disease | YES | NO | Artificial Joint | YES | NO | High Cholesterol | YES | NO |
| Rheumatic Fever | YES | NO | Stroke | YES | NO | Heart Disease | YES | NO |
| Liver Disease | YES | NO | History of Hospitalization | YES | NO | Rheumatoid Arthritis | YES | NO |
| Kidney Disease | YES | NO | Asthma | YES | NO | Glaucoma | YES | NO |
| Seizures or Epilepsy | YES | NO | Hepatitis | YES | NO | Tuberculosis | YES | NO |
| Birth Defects | YES | NO | ADHD | YES | NO | Obesity | YES | NO |
| Sexually Transmitted Disease | YES | NO | Do you have a **history** of abuse? | YES | NO | Ulcers | YES | NO |
| Drug Abuse | YES | NO | Are you **currently** being threatened? | YES | NO | Seizures | YES | NO |
| Alcohol Abuse | YES | NO | Are you **currently** being abused? | YES | NO | Cancer | YES | NO |
| Hearing Impaired | YES | NO | Is your child **currently** being abused? | YES | NO | Mental Illness | YES | NO |
| Paralysis | YES | NO | Date of last Physical: | | | Specify: | | |
| Vision Impaired | YES | NO | | | | | | |
| Blood Transfusions | YES | NO | Mental Illness | YES | NO | | | |
| Sinus Trouble | YES | NO | Specify: | | | | | |
| AIDS or HIV | YES | NO | | | | | | |
| Arthritis | YES | NO | | | | | | |
| Cancer | YES | NO | | | | | | |

**WOMEN ONLY:**

| | | |
|---|---|---|
| Are you currently pregnant? | YES | NO |
| Currently breast feeding? | YES | NO |
| Do you use birth control? | YES | NO |

| | |
|---|---|
| What was the date of your Last Pap Smear? Month/Year | Normal / Abnormal |
| What was the date of your Last Mammogram? Month/Year | Normal / Abnormal |
| If you use birth control, what type do you use? | |

**INFANTS ONLY:**

Infant Feeding Choices:

| | | |
|---|---|---|
| Breastfeeding Only | YES | NO |
| Mostly Breastfeeding | YES | NO |
| 1/2 Breastfeeding & 1/2 Formula | YES | NO |
| Mostly Formula | YES | NO |
| Formula Only | YES | NO |

Drug & Food Allergies: (List & include reaction or check box) ☐ None

| Drug | Food | Reaction |
|---|---|---|
| | | |
| | | |
| | | |

Medications: (List dosage/quantity or check box) ☐ None

_____

_____

_____

_____

*PLEASE COMPLETE BACK PAGE*

STUDENT/ PEDIATRIC

**ADDITIONAL QUESTIONS:**

**DEPRESSION SCREENING**: (In the past 2 weeks check how often have you been bothered by the following problems)

| Little Interest or Pleasure in Doing Things | (Check One) | Feeling Down, Depressed or Hopeless | (Check One) |
|---|---|---|---|
| Not at All | | Not at All | |
| Several Days | | Several Days | |
| More than Half Days | | More than Half Days | |
| Nearly Everyday | | Nearly Everyday | |

**ALCOHOL USE (CIRCLE RESPONSE BELOW QUESTION)**

| | | |
|---|---|---|
| How often do you have a drink containing alcohol? | | |
| Never Monthly or Less 2-4 x Month 2-3 x Week 4 or Greater x Week | | |
| How many standard drinks containing alcohol do you have on a typical day? | | |
| 1 or 2 3 or 4 5 or 6 7 to 9 10 or more | | |
| How often do you have six or more drinks on one occasion? | | |
| Never Less than Monthly Monthly Weekly Daily or Almost Daily | | |

**TOBACCO USE:**

| | | |
|---|---|---|
| Smoker in the home? | YES | NO |
| Do you smoke tobacco? | YES | NO |
| Smokeless tobacco use? | YES | NO |
| Previous tobacco user? | YES | NO |
| Ceremonial use only | YES | NO |
| Year quit: | | |

List your total # PHYSICAL ACTIVITY minutes per week (for ie: 30min/3days per wk):

_____

_____

_____

| Surgeries | Year | Where |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Other: _____

_____

_____

_____

Patient Signature: _____ Date: _____

HRCN: _____