PATIENT CONSENT FORM

Patient Name Printed _____ Date of Birth _____

(Please read and sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of procedures as may be deemed necessary or advisable in the treatment of this patient
- Health Wellness Treatment Plan and Chart Review by GLTHC Case Management Team (which includes Clinical, Behavioral Health, Domestic Violence, and Social Services)
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician and their assigned designees
- I fully understand that this consent is given in advance of any specific diagnosis or treatment
- I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force for one full year unless it is revoked in writing
- I understand the Gun Lake Tribal Health Center may include consent at other treatment locations: i.e. other property owned by the Gun Lake Tribe, for transportation services, and/or at my home when in-home services are needed
- I, the undersigned, acknowledge that the Gun Lake Tribal Health Center will use and disclose my personal health information for the purposes of treatment, payment and healthcare operations as described in the Gun Lake Tribal Health Center's Notice of Privacy Practices
- A photocopy of this consent shall be considered as valid as the original

MEDICARE PATIENTS

I authorize the Gun Lake Tribal Health Center to release information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services provided by the Gun Lake Tribal Health Center. I acknowledge that I have been given the Gun Lake Tribal Health Center's Notice of Privacy Practices. I understand that if I have any questions or complaints that I should contact the Privacy Official.

Patient's Initials _____

I certify that I have read and fully understand my rights and responsibilities as a patient.

Signature of Patient or Patients Representative _____ Date _____

Witness_____ Date _____

Health and Human Services
2880 Mission Drive, Shelbyville, MI 49344 | {p} 269.397.1760 | gunlaketribe-nsn.gov

Patient Health History Form

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Pronouns: ☐ **he/him** ☐ **she/her** ☐ **they/them**

Past Medical History *(Check all that apply)*

- ☐ Anemia
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Blood Clots
- ☐ Bleeding disorder
- ☐ Cancer: _____
- ☐ Chronic Lung Disease
- ☐ Chronic Infections
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Skin Problems
- ☐ Seizures
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Stomach/Bowel Problems
- ☐ Serious Accident/Injury
- ☐ Thyroid Disease
- ☐ Urinary Problems
- ☐ Vision Impairment
- ☐ Other: _____

Past Surgical History *(Check and date)*

- ☐ Tonsillectomy: Date_____
- ☐ Cardiac catheterization: Date_____
- ☐ Coronary Bypass: Date_____
- ☐ Pacemaker: Date_____
- ☐ Gallbladder: Date_____
- ☐ Colonoscopy: Date_____
- ☐ C-section: Date_____
- ☐ Hysterectomy: Date_____
- ☐ Appendectomy: Date_____
- ☐ Other: _____

Family History

RELATIONSHIP	STATUS Use "A" for alive Use "D" for deceased	CANCER	DIABETES	HEART FAILURE	HYPERTENSION	ASTHMA	HIGH CHOLESTEROL	ARTHRITIS-RHEUMATOID	ARTHRISTIS-OSTEO	STROKE	THRYROID DISEASE	SEIZURES	MIGRAINES	RASHES/ SKIN PROBLEMS
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sister		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Current Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: _____

Sexual History

Sex assigned at birth: ☐ Female ☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Non-binary
☐ Transgender ☐ Intersex ☐ I prefer not to say

Are you sexually active? ☐ Yes ☐ No

Are your partners ☐ Male ☐ Female ☐ Both ☐ Other

Females Only

Age of 1st period? ____ First Day of Last Menstrual cycle _____ I no longer have periods_____

Date of last PAP _____ Have you ever had an abnormal PAP smear? _____

Number of Pregnancies? _____ Live births_____

Are you currently using contraception? ☐ Yes ☐No If yes, what type are you using?

☐ Birth Control Pills/Patch ☐ Tubal Ligation (tubes tied) ☐ Diaphragm (Cup) ☐ abstinence ☐ Condoms
☐ Hysterectomy ☐ Partner with vasectomy ☐ IUD -year placed_____ ☐Implant Year placed_____
☐ Natural Planning ☐ Depo provera injection ☐ Other_____

Social History

Relationship status: ☐ married ☐ divorced ☐ widowed
☐ single ☐ other ☐ I prefer not to answer

Living situation: ☐ I live alone ☐ I live with others ☐ I prefer not to answer

Employment: ☐ currently employed ☐currently unemployed

Employer: _____

Hobbies:_____

Exercise: ☐ Never ☐Rarely ☐ 1-2 times weekly
☐ 3-4 times weekly ☐ 5-6 times weekly ☐ daily

Foods I choose to eat : ☐< 1 fruit/veggie daily ☐1-2 fruits/veggies daily
☐3-4 fruits and veggies daily ☐> 5 fruits and veggies daily

Caffeine: ☐None _____Number of Cups/Day

Tobacco Use: ☐ Non-Tobacco User ☐ Current Smoker, Amount/Day__ ____ # of Years: ____
☐ Previous Smoker, Year Quit___ _____ ☐ Smoker in Home ☐ Ceremonial Use Only

Alcohol Use: ☐ Do not drink Number of Drink/Day _____ Number of Drink/Week _____

Other Drug Use: ☐ None History of use but none currently

☐Current User ☐ Marijuana ☐ Heroin ☐ Methamphetamine ☐Cocaine ☐ Other: _____

Health Screening:

Last Mammogram: _____ N/A ☐ Last Colonoscopy: _____ N/A ☐

Last bone density: _____ N/A ☐ Last blood work: _____ N/A ☐

Last Physical Exam _____ N/A☐

I would like to update my immunizations if I am due for any: ☐ Yes ☐ No

Patient Name: _____

Signature of Patient or Patient Representative: _____ _____Date: _____

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NEW PATIENT REGISTRATION INFORMATION

Last Name _____ First Name _____ Middle Name _____

Address _____ City _____ State _____ Zipcode_____

Home Phone _____ Cellphone _____ Work Phone _____

Gender _____ Social Security Number _____ Email _____

Date of Birth _____ Marital Status _____

Primary Care Physician _____

TRIBAL INFORMATION (If affiliated please complete the section below.)

Tribal Affiliation _____ Enrollment Number _____

Descendant Designation _____

Are you a Veteran? ☐ Yes ☐ No Branch of Service _____ Last Entry Date _____

Separation Date _____ Claim Number _____

EMERGENCY CONTACTS

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

OTHER INFORMATION

☐ GLT Citizen ☐ GLT Citizen Household ☐ Other Tribe ☐ Other Tribe Household ☐ GLT Staff ☐ GLC Staff

☐ GLT Staff Household ☐ GLC Staff Household ☐ Medicaid Beneficiary ☐ Other _____

Ethnicity

☐ Non Hispanic or Latino

☐ Hispanic or Latino

☐ Decline to Answer

☐ Unknown

Race

☐ American Indian / Alaskan Native

☐ Caucasian

☐ African American

☐ Native Hawaiian

Do you have an Advanced Directive

☐ Yes ☐ No

EMPLOYER INFORMATION

Patient's Employer (if applicable) _____ ☐ Full-time ☐ Part-time

Employer Address _____

Spouse's Employer (if applicable) _____ ☐ Full-time ☐ Part-time

Employer Address _____

990286, 990352 & 990174

PRIMARY INSURANCE

Insurance Name: _____ Policy holder name: _____

Policy Number: _____ Policy Holder Date of Birth _____

Group Number: _____ Policy Holder Social Security Number _____

Effective Date _____

SECONDARY INSURANCE

Insurance Name: _____ Policy holder name: _____

Policy Number: _____ Policy Holder Date of Birth _____

Group Number: _____ Policy Holder Social Security Number _____

Effective Date _____

☐ Yes, I would like a copy of my Patient Rights and Responsibilities

☐ No, I do not want a copy of my Patient Rights and Responsibilities

Patient Initials _____
I authorize my insurance benefits to be paid directly to Gun Lake Tribal Health Center, GLT HHS. Realizing I am responsible to pay non-covered services and/or any co-pay/deductible.

Patient Initials_____
I acknowledge that my insurance will be billed by the lab that performs tests ordered by my provider. Any balance remaining is my responsibility.

Patient Initials _____
I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices and have been provided the opportunity to review it.

I certify that the information I have provided to the Gun Lake Tribe Health & Human Services staff is complete and accurate. I understand that if any information should change, it is my responsibility to provide Gun Lake Tribe Health & Human Services with all updated information (insurance card, verification of vision, dental and health coverage, name change, address changes).

I understand that if Gun Lake Tribe Health & Human Services makes unnecessary or improper payments on my behalf based on the information that I provided, I may be liable for such payments, and I may be ineligible for Gun Lake Tribe health services in the future.

I assign to Gun Lake Tribe Health & Human Services any medical, dental and/or behavioral health benefits that I am entitled to under the terms of my health care coverage, in whole or in part, for the services paid for, or provided by, the Gun Lake Tribe Health & Human Services.
I authorize the release of any medical information necessary to process my submitted claim.

Patient Name _____

Signature of Patient/Guardian _____ Date _____

Patient Initials _____

To utilize the services of Gun Lake Tribal Health Center, patients must meet one of the following qualifications:

- Native or Alaskan American
- Household member of a Native or Alaskan American
- Employee of Gun Lake Tribe, Gun Lake Casino or Gun Lake Investments.
- Household member of an employee of Gun Lake Tribe, Gun Lake Casino or Gun Lake Investments.
- Medicaid beneficiary

Failure to meet one of these qualifications will result in termination of services.

Patient Initials _____

By providing my wireless phone number to Gun Lake Tribal Health Center, I agree and acknowledge that Gun Lake Tribal Health Center may send text messages to my wireless phone number for any purpose, including marketing purposes.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Last Name _____ First Name _____ Middle Name _____
Date of Birth_____Phone _____ Email Address _____
Address _____ City _____ State _____ Zipcode_____

Your medical information is confidential. In order to discuss or answer questions about your health with anyone, such as your spouse/ significant other, adult child, etc., Gun Lake Tribe Health and Human Services needs your permission. If you choose you may indicate that you do not want us to discuss your medical information with anyone by writing "NONE" on one of the lines below and signing this form. Otherwise, please list the name(s) of the individuals you authorize Gun Lake Tribe Health and Human Services to release information to, as well as the type of information you are authorizing.

Note: This consent form allows personal and health information to be shared via telephone with the person(s) being authorized.
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Select the Protected Personal Health Information to be released or disclosed to the above listed individual(s):
Medical Care/Treatment ☐ Yes ☐ No Alcohol/Drug Abuse Treatment/Referral ☐ Yes ☐ No
Medications ☐ Yes ☐ No HIV/AIDS-related Treatment ☐ Yes ☐ No
Medical Billing Information ☐ Yes ☐ No Sexually Transmitted Disease ☐ Yes ☐ No
Mental Health (Other than Psychotherapy Notes) ☐ Yes ☐ No
Psychotherapy Notes ONLY (I am waiving any psychotherapist-patient privilege) ☐ Yes ☐ No
Is able to pick-up Personal Health Information (prescriptions, billing, etc.) ☐ Yes ☐ No
Other (please explain) _____

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

If there is any information in your medical record that you DO NOT want discussed with, or released to, the above name individuals please state what information you wish excluded from release to the above named individuals.

This authorization shall be in force and effect for one year from the date of signing, or until it is revoked in writing. I understand that I have the right to revoke this authorization in writing at any time by sending written notification to: Gun Lake Tribe Health and Human Services, 2880 Mission Drive, Shelbyville, MI 49344. I understand that Personal Health Information released under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Personal Health Information may no longer be protected by law.

I, _____ hereby request and authorize Gun Lake Tribe Health and Human Services to use or disclose my Protected Personal Health Information.

Patient Signature_____ Date_____
Guardian or Legal Representative Signature_____ Date_____
Relationship to Patient_____
Witness _____ Date_____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rule prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

NAME_____

DATE OF BIRTH_____

CONSENT TO PARTICIPATE IN A TELEHEALTH APPOINTMENT

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me.

2. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.

4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me telemedicine consultation.

6. In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the Doxy.me video conference connection.

7. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

8. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911 or visit my local hospital's Emergency Room department. They have trained staff available to ensure my wellbeing.

9. Though my provider and I may be in direct, virtual contact through the Telehealth Service, urgent mental health matters that cannot wait until the following business day, should be directed to emergency or urgent medical services.

10. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

BY SIGNING THIS FORM, I CERTIFY:

* That I have read or had this form read and/or had this form explained to me

* That I fully understand its contents including the risks and benefits of the procedure(s).

* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

PATIENT SIGNATURE_____ **DATE**_____

WITNESS SIGNATURE _____ **DATE**_____