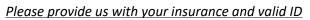


Santa Ynez Tribal Health Clinic PATIENT INTAKE





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Santa Ynez Tribal Health Clinic

Acknowledgement of Receipt Privacy Practices Notice and Advance Health Care Directives Information



I understand that the information provided by me and stored in my health record is necessary for the Santa Ynez Tribal Health Clinic (SYTHC) and staff, in conjunction with Indian Health Services (IHS), to provide services for my health and well-being. I understand that my health record information is securely stored either electronically or physically, and that my health record or any portion of my health record shall not be disclosed to another agency or person(s), unless specified as routine use, without my signed consent.

l,	_, acknowledge the following:				
I have been provided the HIPAA Privacy Act Notice to read.					
I have been provided the Patient Rights and Responsibilities Notice to read.					
I have been provided the Advance Health Care Directive Information to read.					
**At any time, I may request a copy of any of the above documents from the rec	eptionist if I so chose.				
The Santa Ynez Tribal Health Clinic (SYTHC) is considered a training facility, employed staff (student, interns, interested physicians, health care represental premises, Normally, these non-employed staff are allowed in patient care area assistant a provider. I understand that I have the option, at any time, to request that non-employother professionals) be excused while I am receiving direct patient care service.	tives, surveyors, etc.) on our as for observation and/or to yed staff (students, interns and/or				
Patient's Signature	- Date				
Signature of Parent or Patient's Representative	 Date				



Santa Ynez Tribal Health Clinic Cancellation/No Show Policy



The mission of the Santa Ynez Tribal Health Clinic is to provide the highest quality of health care, honoring cultural values and integrating best practices. When any of our scheduled appointments are cancelled by a patient with short notice, when a patient arrives late for their appointment, or when a patient "no shows", there is insufficient time for us to reappoint that time for another patient. Late cancellations/arrivals or "no shows" are a lost opportunity for patients to take advantage of our valued services.

The following guidelines outline our Cancellation/No-Show policy for the SYTHC Behavioral Health/Medical/Dental clinics, effective immediately:

- Cancellations of scheduled appointments should be received by the Front Office, **at least 24-hours prior** to the scheduled appointment time.
 - Exceptions will be considered in the event of an emergency or illness on a case-by-case basis.
 - Any late cancellation (not received 24 hours prior to the appointment time) will be considered a "no-show".
- When a patient arrives more than nine (9) minutes late for their scheduled appointment time, the appointment will be considered a "no-show".
- If a patient does not show up (w/o sufficient or zero notice) for their scheduled appointment, this will be considered a "no-show".
- If a patient has two (2) "no-shows" over a 6-month timeframe for any of our clinical departments, the patient may <u>not</u> be eligible to schedule an appointment in that clinical department for six (6) months, from the date of the second no-show.

Please sign this form, indicating your understanding of our cancellation/no-show policy. Your cooperation is vital to the clinic's ability to offer the highest quality health care to all of our patients.

Sincerely,		
Santa Ynez Tríbal Health Clínic Health Board		
Print Patient Name	Date	
Patient Signature		
Patient Signature		



Santa Ynez Tribal Health Clinic Absent Consent Form



In the event you are unable to accompany your child to his/her appointment at SYTHC, please list all persons over the age of 18 that you authorize to make decisions for your child's treatment.

PARENT/GUARDIAN NAME						
PATIENT NAME		PATIENT DATE OF BIRTH				
I hereby appoint,						
NAME	RELATIONSHIP		CONTACT NUMBER			
NAME	RELATIONSHIP		CONTACT NUMBER			
NAME	RELATIONSHIP		CONTACT NUMBER			
NAME	RELATIONSHIP		CONTACT NUMBER			
I hereby release the Santa Ynez	Tribal Health Clin	ic and it's staff fro	om all harm which may results			
from treatment. The consent and						
consent, or authorization is requi	•					
consideration of the services which are rendered to my child, we agree to pay for all services						
provided.						
Please note: if there is a custody dispute involving the child, please be advised that unless a court order is submitted to SYTHC, both parents will have rights to the child's healthcare records. ALL						
persons listed on this form must present a photo identification when accompanying the child to the						
appointment. This permission shall remain in effect until such time as I issue a written revocation.						
The state of the s						
PARENT SIGNATURE		DATE				
WITNESS SIGNATURE		DATE				