Santa Ynez Tribal Health Clinic

PATIENT INTAKE

Please provide us with your insurance and valid ID

PATIENT'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	NICKNAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MOTHER'S MAIDEN NAME

PHYSICAL ADDRESS	BILLING ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

HOME PHONE #	CELL PHONE #	E-MAIL ADDRESS	PREFERRED PRONOUNS

PREFERRED METHOD FOR NOTIFICATIONS (check all that apply) ○ Phone ○ Text ○ E-mail ○ Voice reminders

MARITAL STATUS
○ Annulled ○ Divorced ○ Domestic Partner ○ Legally Separated ○ Life Partner ○ Married ○ Polygamous
○ Single ○ Unknown ○ Widowed

RACE
○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino (all races)
○ Native Hawaiian or Other Pacific Islander ○ White ○ Other Race ○ Declined to specify

ETHNICITY
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Other ○ Unknown ○ Declined to Specify

PREFERRED LANGUAGE
○ English ○ Spanish ○ Other:_____

VETERAN
○ YES ○ NO

NATIVE AMERICAN (Tribal Patients Only)
Do you have verification of Tribal Membership? ○ Yes ○ No Name of Tribe: _____

EMERGENCY CONTACT

NAME	RELATIONSHIP	CONTACT PHONE NUMBER

INSURANCE

Do you have health insurance and/or Medi-Cal?
○ Yes ○ No

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

CONSENT FOR TREATMENT

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process the claim for treatment, payment, or operations. I authorize payment of medical benefits to Santa Ynez Tribal Health Clinic (SYTHC), provider or suppliers for services. I hereby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. We will bill your insurance as a courtesy. I authorize SYTHC to contact me by mobile phone text or email. (Standard rates may apply.)

Patient Signature _____ Date _____

Responsible Party's Signature _____ Date _____

Witness _____ Date _____

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.

I, _____, 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 receptionist if I so chose.***

The Santa Ynez Tribal Health Clinic (SYTHC) is considered a training facility, and has, from time to time, non-employed staff (student, interns, interested physicians, health care representatives, surveyors, etc.) on our premises, Normally, these non-employed staff are allowed in patient care areas for observation and/or to assistant a provider.

☐ I understand that I have the option, at any time, to request that non-employed staff (students, interns and/or other professionals) be excused while I am receiving direct patient care services.

_____ _____

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 Tribal Health Clinic Health Board

_____ _____

Print Patient Name Date

_____

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 Clinic and it's staff from all harm which may results from treatment. The consent and authorization shall include and extend to all matters for which consent, or authorization is required under the policies of Santa Ynez Tribal Health Clinic. In 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.

PARENT SIGNATURE	DATE
WITNESS SIGNATURE	DATE