SUQUAMISH TRIBE HEALING HOUSE
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PATIENT NOTICES AND GENERAL CONSENT FOR CARE

NOTICE OF PRIVACY PRACTICES

A federal law commonly known as Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires we provide you with a Notice of Privacy Practices. The Notice describes how we may use and disclose protected health information to carry out treatment, payment or health care operations. This notice also describes rights regarding health information maintained about patients and a brief description of how patients may exercise these rights. If I wish to read the full Notice, I will ask the front desk for a copy. By signing this form, which will be retained in my medical records, I acknowledge that I received a copy of the Notice of Privacy Practices for the Suquamish Tribe Healing House (STHH).

HEALTH DATA SHARING FOR COORDINATION OF CARE

As patient, parent or guardian, I understand that the STHH, Wellness Clinic, and Community Health operate with an integrated electronic medical record system (EMR) which allows providers to access and exchange information between the departments for coordinated patient care. I understand providers must abide by HIPPA and other applicable laws when accessing any health records and will access records only to the extent necessary for patient care. I authorize STHH to access and share medical records on my behalf with all my current and future treating providers who use the same and/or interconnected Electronic Medical Records (EMR) systems, as well as other Electronic Medical Records for which STHH has authorized access. I authorize STHH to share medication history with pharmacies and immunization status with the Washington State Immunization Information System (WAIIS) (this is required to receive vaccinations by STHH).

I understand I have a right to receive a list of all such disclosures from the Health Information Exchange.

I understand that substance use disorder records are protected under federal law 42 CFR Part 2, HIPPA, and 45 CFR Part 160 and 164 and cannot be disclosed without written consent unless otherwise provided for by regulations. I understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically if I transfer my primary care to another provider or clinic.

CONSENT TO MEDICAL TREATMENT

I consent to evaluation and treatment by Health Care Professionals (HCPs), blood draws and laboratory tests (including Human Immunodeficiency Virus, HIV), and noninvasive procedures or other STHH service rendered under the general and special instructions of the physician caring for me.

I understand that the clinic, as part of its responsibilities and service to the community, may participate in educational programs involving medical, nursing, and allied health care occupations, wherein students obtain clinical training and experience in the care of patients. These students are under the instruction and supervision of qualified instructors and/or clinic personnel at all times while attending patients in the clinic. I understand that I may be attended and cared for by these students in the course of my care and treatment. I understand that photographs, videotapes, digital and other images may be recorded to document my medical and surgical care, diagnosis and treatment.

In the event a healthcare worker engaged in my treatment is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-borne infection, I consent to be tested for HIV, Hepatitis B, and Hepatitis C done at no cost to me, so the healthcare worker can be treated promptly. I authorize release of the information to the exposed healthcare worker, their healthcare provider, and clinic staff.

*Note only veterans may refuse a blood draw in the event of a needlestick.

TREATMENT AUTHORIZATION OF MINORS, IF APPLICABLE

I, the undersigned parent/guardian of _____(patient's full name), grant permission and authorize medical care and treatment for the above mentioned minor, if minor should present to STHH without a parent or guardian for the treatment of medical conditions which require parental consent.

ELECTRONIC RECORD PATIENT PORTAL & TEXT MESSAGES

I understand that if I sign up for the secure patient portal or text messaging that I will receive emails and/or texts regarding visit summaries, appointment reminders, health notifications. I understand that this portal is to be used for non-urgent issues only.

AUTHORIZATION TO BILL INSURANCE

I, the undersigned, give the **Suquamish Tribe Health Division authorization** to access my medical records, including any records for Mental Health and Substance Use Dependence, or those of my covered dependents (if a minor child) in order to facilitate the processing of claims & determine eligibility. I authorize STHH permission to bill insurance on my behalf. I understand the services offered are subject to the Plan's coverage provisions and that services may require preauthorization by the Suquamish Tribe. I also request payment of government benefits either to myself or to the party who accepts assignment on the claim. I hereby assign benefits otherwise payable to me, to the STHH. I also understand that I am financially responsible for any balance not covered by my insurance company. My signature indicates I am accepting financial responsibility.

PATIENT RIGHTS AND RESPONSIBILITIES Patient Rights

1. You have the right to safe, high quality medical care without discrimination that is compassionate and respects your personal dignity, values, and beliefs.
2. You have the right to participate and make decisions about your care and pain management including refusing care to the extent permitted by law. Your care clinician will explain to you the medical consequences of refusing recommended treatments.
3. You have the right to have your illness, treatment, pain, alternatives, and likely outcomes explained to you in a manner you can understand including provision of interpretation services if needed.
4. You have the right to know the name and title of your health care clinicians. At your request, you have the right to a second opinion.
5. You have the right to request that a family member, friend, or outside physician be notified that you are under the care of this facility.
6. You have the right to be informed if your care will be provided by another organization or facility, including an explanation of alternatives to a transfer.
7. You have the right to know about the policies used by the organization that may affect your care and treatment.
8. You have the right to participate in, or decline to participate in, research studies. You may decline participation without compromising your access to care, treatment, or services.
9. You have the right to private and confidential treatment, communications, and patient records as permitted by law.
10. You have the right to receive information concerning advance directives (living wills, power of attorney, and mental health advance directives) and these will be respected during treatment to the extent permitted by law.
11. You have the right to access your personal medical records within a reasonable timeframe to the extent permitted by law.
12. You have the right to be informed of charges and receive counseling on the availability of known financial resources for your health care.
13. You have the right to be free from abuse including accessing advocacy or protective service agencies.
14. You have the right to voice compliments, concerns, or complaints without compromising your access to care, treatment, or services. (For concerns/complaints/grievances please see the Patient Grievance Policy.)
15. You have the right to change clinicians if other qualified clinicians are available.
16. You have the right to refuse observation or treatment by students or other nonSTHH credentialed clinicians.

Patient Responsibilities

1. You are responsible for providing accurate and timely information about your health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities, and insurance benefits.
2. You are responsible for asking our health care clinician if you do not understand the medical terminology being used or instructions relating to your plan of care.
3. You are responsible for following your plan of care. If you are unable or unwilling to follow this plan, you are responsible for informing your health care clinician. The clinician will then explain the medical consequences of not following the recommended treatment and you are responsible for any outcomes related to not following your plan of care.

4. You are responsible for following the rules, regulations, and policies of the facility.
5. You are responsible for acting in a manner that is respectful to other patients, staff, and Tribal property.
6. You are responsible for meeting your financial obligations to the facility.
7. You are responsible for using standard, HIPPA compliant communications with the clinic which include contacting the clinic reception desk or using the electronic medical record patient portal. Standard email or organizational communication platform inquiries will be directed to the clinic staff.

PATIENT FINANCIAL RESPONSIBLITY

The medical services you are accessing imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Please ask if you have questions regarding your financial responsibility.

If someone besides the patient is financially responsible for the expenses (parent, spouse, domestic partner, etc), that person should have their signature included on this form.

By signing below and/or receiving medical services from the STHH, you understand and agree:

1. **Suquamish Tribal Members and their Enrolled Descendants 18 years old and younger (or still enrolled in high school) who are enrolled or are eligible for Health Benefits will not have any financial responsibility for their care.**
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or STHH Policies, which are not otherwise covered by your health insurance.
3. **It is your responsibility to know your own insurance benefits**, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any preauthorization requirements of your insurance company.
4. We accept cash, check, credit cards, and pre-approved insurance.
5. Proof of payment (insurance card) and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
6. We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible for services rendered.
7. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting **insurance card** for verification of current coverage, providing signatures, and paying any co-pays or other patient responsibility amount **at each visit**. Your card or other insurance verification must be on file for your insurance to be billed.

8. If we do not have your card on file, or are unable to verify your insurance eligibility, the clinic will expect payment in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other financial responsibility, STHH may re-schedule your visit.
9. **For patients without a billable resource**, the STHH staff will assist in determining eligibility for alternate coverage.
10. **For non-Indian Health Service beneficiaries**, if we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
11. **For non-Indian Health Service beneficiaries**, some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
12. **Unpaid Accounts** for patients who are not Indian Health Service Eligible Beneficiaries: Accounts owing $250 or more will require a payment plan to be established between the patient and the STHH. Non-compliance with the payment plan or a balance of $350 or more will result in 30 days' written notice of suspension of services to the patient until paid in full.
13. Any balance due greater than $350 after 180 days may be turned over to collections and the patient will be given 30 days' written notice that they no longer can be seen at the clinic due to unpaid accounts. The STHH will transfer records to physician/clinic where patient establishes care as per release of information protocols. If a payment plan has been established with the STHH then the patient can continue care so long as the payment plan is current. The payment plan must be completed and paid in full within 6 months.
14. **Authorization to bill insurance:** I authorize STHH to verify my insurance benefits and submit my claim to my insurance carrier or other plan provider. I agree to facilitate payment of claims by contacting my insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, I assign to STHH, for application onto my bill for services, all of my rights and claims for the medical benefits to which I, or my dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I authorize Suquamish Tribe Healing House and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to my treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in my care.
15. Any payment for services that insurance sends directly to patients must be signed over to the STHH as payment for services rendered.

16. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

LATE AND NO-SHOW POLICY

We know that there are times when circumstances may arise beyond the control of our patients which may prevent them from arriving on time or cancelling appointments with advanced notice. We are sensitive to those situations and simply ask that you call our clinic as soon as possible so that our staff can work with you to reschedule your appointment.

The Suquamish Tribe Healing House is committed to providing our patients with the best and timely care possible. No-Show appointments and late cancellations (same day) reduce appointment availability for other patients. For this reason, we have implemented a No-Show Policy.

A NO-SHOW includes any of the following:

- Arriving more than ten (10) minutes after your scheduled check in time: in this case, your appointment will need to be rescheduled.
- Failing to show up to your appointment.
- Same Day cancellation: cancelling an appointment less than four (4) hours prior to your scheduled appointment time.

After two (2) No-Shows, our clinic will contact you to discuss the impact of not respecting and adhering to our policy. If you accrue three (3) No-Shows in a rolling twelve (12) month calendar period, it will be at the clinic leadership's discretion to discharge you from our clinic.

I have read the policies contained above, and my signature below acknowledges a clear understanding of my responsibilities.

SIGNATURE

Patient/Parent/Guardian/Representative _____ Date:_____

This acknowledgment is signed by a parent/guardian/personal representative on behalf of the patient.

Parent/Guardian/Representative Name PRINT:_____

Relationship:_____