LVDHC
Lac Vieux Desert Health Center

Welcome to the Lac Vieux Desert Health Center. We appreciate the trust and confidence you have placed in our practice. We are committed to providing you with the best dental care possible. Enclosed is our **Patient Registration Packet** and **Authorization to Receive Medical Records Form**. Please complete all forms and return them prior to your scheduled appointment. Please bring the following to your appointment:

Insurance Card(s)
Drivers License/Photo ID
Tribal Identification (If you are an enrolled member of a Federally recognized tribe)

We recognize that your time is valuable, and we make every effort to see you at the appointed time. We appreciate your patience if there is any delay due to unexpected circumstances. If you are going to be late for your appointment, please call us before you come, we may need to reschedule your appointment. If you must cancel or reschedule your appointment, please notify us at least 24 hours prior, so we may offer your appointment to another patient.

Thank you for choosing Lac Vieux Desert Health Center for your care. Please feel free to call us anytime with your questions or concerns.

We look forward to a long, healthy relationship with you.

Sincerely,

The Dental Staff of the Lac Vieux Desert Health Center

LVDHC
Lac Vieux Desert Health Center

Full Name (First, MI, Last):		
Address (Street AND Mailing)	City:	State & Zip
Date of Birth (Mo/Day/Year): (/ /)	Marital Status (circle one): Married Single Widow	Sex (circle one): Male or Female
Race:	Preferred Phone Number:	Email:
Preferred contact Method: TEXT EMAIL VOICE	Social Security #:	Tribal Affiliation and #:
Veteran Status (circle one): Active Discharged Retired Spouse/Child of a Veteran NOT a Veteran		
Employer Name:	Address:	City, State, Zip:

Insurance Carrier:	Date of Birth:
Subscriber Name:	Policy Number:
Group Name and Number:	Insurance Phone Number:

In Case of an Emergency -
Contact Information

Full Name (First, MI, Last):	Date of Birth:
Relationship:	Phone Number:
Consent to share Medical Information with emergency contact: Yes or No	

Authorization to Share Medical Information

☐ **I authorize Lac Vieux Desert Health Center to share medical information.**

I hereby request that the following person(s) be allowed to participate in my care and/or payment- decision process. I understand that these persons(s) may be given health or payment information about me. Lac Vieux Desert Health Center will act on this information for **1 year** or until I revoke or amend this authorization in writing.

Name	Relationship	Date of Birth	Phone Number

☐ **I do not authorize Lac Vieux Desert Health Center to share medical information**

Signature:_____ **Date:**_____

Patient Name: _____Date of Birth: _____Date:_____

Do you have a primary doctor? ◯ Yes ◯ No If yes, who? _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please list below:

Are you taking any medication, pills, or drugs? ◯ Yes ◯ No If yes, please list below:

Have you previously taken or currently take a premedication prior to your dental appointment? ◯ Yes ◯ No
If yes what medication? _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No
Do you currently use controlled substances? ◯ Yes ◯ No If yes, please list _____

Women are you…… ◯ Pregnant? ◯ Nursing? ◯ Taking oral contraceptives? ◯ Trying to get pregnant?

Are you allergic to any of the following: ◯ Aspirin ◯Penicillin ◯ Codeine ◯ Acrylic
◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics
Other allergies not listed ◯ Yes ◯ No If yes please list _____

Do you have, or have you had any of the following? Please mark Yes on any that apply.

AIDS/HIV Positive	◯ Yes	Cortisone Medicine	◯ Yes	Hemophilia	◯ Yes	Radiation Treatments	◯ Yes
Alzheimer's Disease	◯ Yes	Diabetes	◯ Yes	Recent weight loss	◯ Yes	Anaphylaxis	◯ Yes
Drug Addiction	◯ Yes	Hepatitis B or C	◯ Yes	Anemia	◯ Yes	Herpes	◯ Yes
Rheumatic Fever	◯ Yes	High Blood Pressure	◯ Yes	Rheumatism	◯ Yes	Arthritis/Gout	◯ Yes
Epilepsy or Seizures	◯ Yes	Scarlet Fever	◯ Yes	Artificial Heart Valve	◯ Yes	Excessive Bleeding	◯ Yes
Hives or Rash	◯ Yes	Shingles	◯ Yes	Artificial Joint	◯ Yes	Hypoglycemia	◯ Yes
Asthma	◯ Yes	Fainting/Dizziness	◯ Yes	Sinus Trouble	◯ Yes	Blood Disease	◯ Yes
Frequent Cough	◯ Yes	Kidney Problems	◯ Yes	Leukemia	◯ Yes	Breathing Problems	◯ Yes
Frequent Headaches	◯ Yes	Liver Disease	◯ Yes	Stroke	◯ Yes	Genital Herpes	◯ Yes
Low Blood Pressure	◯ Yes	Cancer	◯ Yes	Glaucoma	◯ Yes	Lung Disease	◯ Yes
Thyroid Disease	◯ Yes	Chemotherapy	◯ Yes	Mitral Valve Prolapse	◯ Yes	Tonsilitis	◯ Yes
Angina/Chest Pains	◯ Yes	Heart Attack/Failure	◯ Yes	Osteoporosis	◯ Yes	Tuberculosis	◯ Yes
Cold sores/Fever Blister	◯ Yes	Heart Murmur	◯ Yes	Pain in Jaw Joints	◯ Yes	Tumors/Growths	◯ Yes
Congenital HeartDisorder	◯ Yes	Heart Pacemaker	◯ Yes	Parathyroid Disease	◯ Yes	Ulcers	◯ Yes
Heart Trouble/Disease	◯ Yes	Psychiatric Care	◯ Yes	Tobacco Use	◯ Yes		

Have you ever had any serious illness/medical concerns not listed above? If yes, please list below:

LVDHC
Lac Vieux Desert Health Center

CONSENT FOR TREATMENT/HIPAA
AND
AUTHORIZATION TO BILL INSURANCE

Patient Name_____**DOB** _____

Parent's/Guardian's Name _____

****Please read and initial each item below, then sign at the bottom.**

_____I certify that I have been advised and have received a copy of my rights to confidentiality. I understand that these rights will be respected and upheld. I understand that disclosure of information suggesting harm or threat of harm to myself or any other person --by myself or my child--requires notification of the appropriate authorities and/or agencies as mandated by law.

_____I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to Lac Vieux Desert Health Center for any services provided to me. I authorize any holder to release to my insurance company medical information about me needed to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.

_____I understand that Lac Vieux Desert Health Center will submit my insurance claims and that I will be responsible for any deductible, co-payments, co-insurance or client fees at the time of services are rendered. I understand that Lac Vieux Desert Health Center cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account.

_____This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

_____ I certify that I have been provided with a copy of the LVDHC Patient Policies. I further certify that I have read, understand, and agree to abide by the LVD Patient Policies. I further understand that my failure to abide by the LVD Patient Policies may result in my dismissal as a patient from the LVDHC.

_____ _____

Patient Signature **OR** Parent/Guardian — Date

_____ _____

Witness Signature — Date

LVDHC
Lac Vieux Desert Health Center

Dental Confirmation Policy

Patient Name: _____ Date of Birth: _____

**** PLEASE READ AND SIGN AT THE BOTTOM**

It is our desire to provide every patient with the treatment they need. When patient's no-show or break their appointment, it has a very negative affect on the dental team's ability to comprehensively treat them in a timely manner. Please make sure you have provided us with the phone number(s) where we can best reach you during daytime hours.

As a courtesy to our patients, you will receive a text message 30 days, 8 days and same day reminders for your scheduled appointment. Our dental staff will attempt to call 8 days prior to your appointment to confirm. If the patient is unable to be reached, we will try to leave a message for you to contact our office. You will have 24 hours to confirm your dental appointment. It remains the patient's responsibility to confirm the scheduled appointment. If you do not confirm 7 days prior to your appointment, your appointment will be considered unconfirmed, and your appointment will be canceled and taken off the schedule.

If you are unable to reach us during business hours, please leave a voicemail with your name, date of appointment and your confirmation. We ask that you contact us as soon as possible if you are unable to keep a scheduled appointment.

If we do not receive a confirmation 7 days prior to your appointment, it is considered an unconfirmed appointment, and your appointment will be canceled and taken off the schedule.

Patients with 3 or more no-call/no-showed appointments on their account will no longer be able to schedule appointments in advance. We will only allow you to schedule on a stand-by basis should someone else cancel and an appointment becomes available. For access to these appointments, you can call any business day for same-day cancellations.

_____ _____

Patient Signature **OR** Parent/Guardian Date

_____ _____

Witness Signature Date

LVDHC
Lac Vieux Desert Health Center

N5241 US Hwy 45 – PO Box 9, Watersmeet, MI. 49969

AUTHORIZATION TO RECEIVE DENTAL RECORDS/INFORMATION

I authorize the release of my dental records by the organization or dentist listed below:

Dentist's Name: _____

Dentist's Address: _____

Dentist Phone #: _____ Dentist Fax #: _____

Reason for Disclosure of Records: _____

These records are to be sent to the Lac Vieux Desert Health Center - PO Box 9, Watersmeet, MI. 49969.
Attention: Dental Records Department
Fax: 906-358-0302 Phone: 906-358-4931
dentist@lvdhealthcenter.com

Patient's Name_____ Phone #: _____

Address: _____

Social Security # (Last 4 Digits): _____ DOB: _____

The type and amount of information to be disclosed is initialed as follow: (specify dates where appropriate)

___ Entire Dental Record (includes all Patient Information listed below)
___ X-Ray films (Specify type/date) ___ Treatment Plan

_____ _____
Patient or Patient Representative's Signature Today's Date

_____ _____
Representative's Name (PRINT) Relationship to Patient (PRINT)

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that treatment, payment, enrollment, or eligibility of benefits will not be conditioned in obtaining your authorization for release of records. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules

LVDHC
Lac Vieux Desert Health Center

Patient Rights regarding Medical Records and Responsibilities as required by the Health Insurance Portability and Accountability Act (HIPAA)

All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms, which will be provided upon request. All changes to preferred forms of communication must also be made in writing.

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and or supplies and services associated with your request. *We may deny your request to inspect and copy in certain, and very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.*

Right to Amend: If you believe that the health information, we have about you is incorrect or incomplete, you may ask us to amend the information. *We may deny your request for an amendment if it is not in writing or does not include a reason for the following: The health information was not created by us, unless the person or entity that created the information is no longer available to make the amendment and is not part of the health information kept by or for our practice and is not part of the information that you would be permitted to inspect and the coy is accurate and complete. Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.*

Right to an Accounting Disclosure: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care, we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy please request it from any staff member.

Changes to This Notice: We reserve the right to change this notice and apply it to any part present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy at any time.

If you believe your Privacy Rights have been violated, you may file a complaint with us or with the Secretary of Department of Health and Human Services. **Other uses and disclosures of health information** *not covered by this notice or the laws that apply to us will be made only with your written permission.* **YOU** *have the right to revoke this permission for any health information that has not yet been shared.*

Lac Vieux Desert Health Center Patient Policies

Welcome to Lac Vieux Desert Health Center. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all our patients in a timely, respectful, and efficient manner. EVERYONE at LVDHC strives to provide our patients with the highest level of customer service. We appreciate and welcome your feedback to improve services or address any personal concerns or compliments regarding your care or office experience. In an effort to makeyour transition to our practice as smooth as possible, please read and familiarize yourself with the following outline of policies and sign as indicated.

Vision: To be the area's leading multidisciplinary health center by providing excellence in healthcare, inspiring a culture of wellness, and to provide the highest level of satisfaction and convenience to our patients.

Mission: To provide excellence in healthcare and to inspire a culture of wellness.

Office Hours
Our clinic is open Monday through Friday. Appointments are scheduled from 8:00 a.m. to 12:00 p.m. and 1:00 to 4:00 p.m.
We are not an emergency room or an urgent care center. If you require such services, go to the nearest Emergency Department, or call 9-1-1.
We offer walk-in appointments for sick visits or sudden minor illness or injury. Patients will be seen based on the acuity of their symptoms; and thereafter, the time of arrival.

New Patient Policy
We are accepting new patients (insured and private). We request that you complete the new patient registration forms and have the past three years of your medical records forwarded to us for review. Our Clinical Manager will review your medical history and, along with the providers, will determine an appropriate provider team so your care is consistently managed by those familiar to your needs.
We are contracted with multiple insurance plans. If your insurance company is unable to tell you if we are an accepted provider, please call our office for assistance.

It is expected that patients are well aware of their benefits as per the contract with their insurance provider. If you are unsure if your insurance covers a particular visit, procedure, or medication our benefits coordinator, patient service representatives, or pharmacy staff may assist you in finding the information you need.

All copays and outstanding balances are due at the time of service unless a prior agreement has been made with our billing department.

Prior to your first appointment, we require that you have completed several forms.

1. New Patient Registration Form- Provides basic contact and insurance information necessary for administrative account set-up.
2. HIPAA Agreement- You are asked to acknowledge the essentials of our privacy policy.

3. Medical History Intake Form-Provides your future physician with basic medical and surgical history. Attach additional sheets if you feel this will be helpful.
4. We request you contact your current/previous provider and have them send your recent (past 3 years) medical records to us, so we have a comprehensive picture of your health care history and needs at your first appointment. Our medical records department can help coordinate your records request(s). The number is (906) 358-4588, ext. 6122.
5. Dependent on your medical history and complexity, your first visit may be a consult with the provider. Be sure to arrive 20 minutes early so all the appropriate paperwork is completed before your time scheduled with the provider. We will go over your health history, management, and needs. At this time, we will decide together how we can best manage your health care needs.

Preparation for Appointment

All patients will need to bring their current driver's license, Tribal ID or photo ID and a current insurance card to each appointment. We depend on accurate information to file your insurance claim. Incorrect information can result in denial of your claim. To protect your privacy, employees are requested to seek secondary identification from all patients in person and over the phone, and we ask for your cooperation in this verification process. We also ask that you bring all of your prescription and over the counter medications with you to your visit.

Late Appointment Arrival

We strive to see all patients on time for their scheduled appointment. If you are a returning patient, please arrive 20 minutes prior to your scheduled appointment to check in so the nurse may have you ready at the time of your appointment. New patients please arrive at least 20 minutes prior to your appointment to complete any outstanding new patient paperwork and registration needs. If the schedule permits, we will do everything we can to accommodate patients who arrive late, however, we will not be willing to make other patients with appointments wait.
Unfortunately, if you do not arrive timely, the scheduled appointment may not be long enough to provide the quality of care you deserve.

Missed Appointment/No-Show

A missed appointment is when you fail to show up without a phone call, fail to cancel, or arrive after your scheduled appointment and there is not enough time remaining for you to be seen. A reminder call is made in advance of your appointment, so you can reschedule if you are unable to attend your appointment. Some departments require a confirmation, or your appointment slot will be rebooked, and you may need to wait to be seen.
If you miss your appointments, you compromise the care that we can provide you and other patients that may have needed an appointment.
Ideally, cancellations should be made at least 24 hours prior to the appointment.
By failing to cancel or reschedule your appointment 3 or more times, we will only allow you to schedule on stand-by should someone else cancel and an appointment becomes available.

Same Day Appointments/Walk In

We accept walk in patients Monday through Friday from 8:00 a.m. to 12:00 noon and 1:00 p.m. to 4 p.m. There is a provider assigned to do walk in visits throughout the day. Walk in visits are screened by nursing staff and issued an available appointment time. We strive to see each patient as they come in but are unable to anticipate illness, injuries, or complications; so, you may be asked to wait or return at a later time. Walk in visits are triaged, and patients are seen as determined by their medical condition. Walk in/ same day visits are not for addressing routine medication refills and follow up exams, well child exams, annual physicals, or hospital and emergency room follow up visits. We are happy to see established and new patients for same day appointments. We will be sure to give you an appointment time before you leave for any other concerns or needs.

Annual Wellness Exams
LVDHC will schedule all new patients for their annual wellness exam, if due, after the initial exam has been completed. Many insurance companies encourage such visits and will waive your deductible or co-pay. Most insurance companies dictate that if any problems are discussed, or prescriptions are generated from this wellness exam, your co-pay and deductible will then become due. Wellness exams are to focus on health promotion activities, update screenings, and recommend vaccines.
Please discuss your wellness benefits with your insurance and notify us if such benefits are not available to you. Knowing the terms of your insurance is the patient's responsibility, and our office will make every attempt to answer any questions when possible.

Treatment of minors
To receive routine medical care any minor less than 16 years old must be accompanied by a parent or an adult designated as legal guardian. An adult acting in legal capacity of a parent needs a written consent from the parent. Minors may be seen without the presence or consent of a parent or guardian in some cases as defined by law.

Running on Time
We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 15 minutes so we can double check to see if you have been properly checked in. Please be considerate if the office is running behind, emergencies occur and each patient will be treated with the same time and care it takes to address their problem, including you. Our staff is committed to keeping you informed of delays and giving you options to manage your valuable time.

Medication Refill
Providing the highest quality of professional care to our patients is very important to us. Our providers will typically prescribe enough medication to last until you are due for a follow up visit for that condition. When you notice your medication has "0 refills", we ask that you call and schedule your follow up office visit to be evaluated and have your medications adjusted or refilled. Ifyou think you should have a refill on a medication and you do not have a scheduled appointment, the best method for obtaining medication refills is to make the request directly through the pharmacy. The pharmacy will then route the request into our system.

Please allow 24-48 hours for your request to be filled. If we require additional information or an office visit, we will contact you.

Controlled Substances
None of our providers are pain specialists and as a general rule do not manage chronic opioid use and/or dependency. Those patients taking chronic narcotics or currently on a drug contract are encouraged to continue to be managed by their pain specialist. We will refer you to a pain management center if you need this specialized form of care after evaluation by our provider.

Phone Messages
To provide the best possible care to our patients and allow our scheduled patients to be seen by our medical providers without multiple interruptions, messages will be taken by other medical staff working with each provider during office hours. If the nurse is unable to answer, a message may be left on the confidential voicemail. When leaving a voicemail message, please indicate your name, the patient's name, the reason for your call, and phone number where you can be reached. The medical staff will alert the provider of your message and will call the patient back with a response in a timely manner. We strive to return patient calls on the same day. Non urgent calls will be returned within 48 business hours. After two unsuccessful attempts return calls may not be made.

Laboratory Testing
Please call in advance to schedule an appointment for any lab tests ordered by a medical provider. In order to ensure accurate laboratory testing is done, a patient must be an active patient at Lac VieuxDesert, have an order for lab tests from one of our medical providers in their chart, a written orderfrom another medical provider's office, or obtain approval for requested lab work from a medical provider in the office prior to scheduling an appointment.

Health Forms and Records
We understand that there are forms that may need to be completed by one of our staff and/or medical providers. We will be happy to fill these out for a $25 fee. These forms include, but are not limited to, disability, Family Medical Leave, school forms, prior authorizations, insurance paperwork, etc. For our office to properly complete any forms on our patients' behalf we require the patient to complete all patient portions of any form and provide any information needed to assist theprovider in completing the form prior to submitting the form to our office. In some cases, an appointment is necessary to properly complete the forms. Please allow at least 6 business days for ouroffice to complete any forms.

To ensure accuracy and safety of your medical information, all of our medical records are in digital format. Copies of your medical records are available to you with a signed medical release. We do not charge for doctor to doctor medical record fax transfers, however, to cover costs we do charge $.25 per page for personal copies of records, or any documents that are printed.

VA Choice
We participate with the Veteran's Choice Program. If you are enrolled in VA healthcare, you may be able to receive care here instead of waiting for a VA appointment or traveling to a VA facility. For more information you can call 866-606-8198 or go to www.va.gov/opa/choiceact

Patient Dismissal
We sincerely hope that we never have to part ways with a patient. However, extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail. You will have thirty (30) days to find another provider during which we will continue to offer acute care services only.

Filing a Grievance
To file a complaint or grievance, please ask the one of the Patient Service Representatives (PSR) for a grievance form. The form will be sent to administration for review and consideration.

Phone Calls
By providing contact information, I authorize LVDHC, its assignees, and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre/ recorded /artificial/voice messages and /or auto-dialing devices in connection with any communication to me.

Financial Policies

Payment: Payment is expected at the time of service. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $35 charge for returned checks. If not paid within 60 days, LVDHC will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

Self-Payment (private/cash payment): If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

Managed Care: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non-covered or not authorized by the plan. Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers, or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service

Medicare: LVDHC providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

Children of Divorced Parents: Responsibility for payment for treatment of minor children, whose parentsare divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of LVDHC.

Secondary Insurance: Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes, or deletions in primary or secondary insurance coverage.

We will send a statement to the billing address you provide notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact the number on your statement within 30 days after receipt of the initial statement.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Having read the above, I agree to abide by the policies set by the LVDHC. I realize that all charges incurred by me and my dependents are my financial responsibility and all court fees, attorney fees, or other fees necessary to collect any past due balances are my responsibility. Failure to follow these policies could result in my dismissal as a patient. I confirm that the information that I have provided is true and correct.

Patient Bill of Rights and Responsibilities

At Lac Vieux Desert Health Center, we seek to provide quality care that is fair, responsive, and accountable to the needs of each patient and family. We are committed to ensuring that each patient is treated with respect and as an equal partner in care. You can help us make your healthcare experience safe by being an active and informed partner with your healthcare team.

As our patient, we want to make sure you understand your rights and responsibilities.

As a patient, you have the right to...

- Receive considerate, respectful, and compassionate health care, regardless of your age, gender, race, national origin, sexual orientation, gender identity, disability or any other status protected by relevant law.
- Expect courteous and helpful attention and understanding from clinic employees.
- Expect communications and records pertaining to your care to be kept confidential.
- A safe and secure health care facility.
- Be free from abuse and neglect.
- Know what services can be obtained at our clinics.
- Receive prompt treatment in emergent situations, regardless of economic status.
- Have access to your own health information, including the right to review it and receive a copy.
- Obtain complete and current information regarding our knowledge of your health status, your diagnosis, treatment, and prognosis needed to make an informed decision, including all treatment options and their risks and benefits.
- Participate in decisions about your care.
- To ask another healthcare provider, other than your own, for an opinion about your medical care. Known as a "second opinion," this may result in additional costs to you.
- Change your provider if another qualified provider is available.
- To use a pharmacy of your choice.
- Have access to clinic policies, procedures, rules, and regulations that are applicable to your care, upon request.
- Receive information in a manner that is easy to understand.
- Use an interpreter as needed or designate a family member or another representative you choose to communicate on your behalf.
- If you choose, have others (family/friends) included in discussions about your health.
- To have communications and records related to your care be kept confidential and be given the opportunity to approve or refuse their release except when disclosures are permitted or required by law.
- To be notified of a breach following the discovery of unauthorized release of your protected health information.
- To personal privacy related to your care, consultation, examination, and treatment.
- Know the names and qualifications of personnel providing care or services.
- Be advised why any individual is present during your care or service.
- If services will be discontinued, you will be given sufficient opportunity to make alternative arrangements.
- Providers will be aware of and abide by patients' Advanced Directives.
- Be advised of fee amounts and payment policies prior to receipt of care or services.
- To examine your bill and receive an explanation of the fees for services and payment policies, regardless of the source of payment for your care, and to meet with knowledgeable staff to access additional resources for payment.
- Refuse care or services, referral, or transfer to the extent permitted by law, and be informed of the consequences of this action.
- Voice concerns or complaints about care or services by talking to any staff member, including management staff and to have those concerns or complaints reviewed and resolved to the extent practicable, without fear of retaliation or penalty to yourself. You have a right to receive a response to your complaint.
- Provide feedback through patient satisfaction surveys either written or electronic.
- Know provisions for after-hour care and emergency care.

Patient Responsibilities:

- Show mutual consideration and respect for those who are providing medical care or services, as well as other patients and visitors.
- Respect clinic property and equipment and observe all clinic regulations, including infection control policies and procedures designed for comfort and safety of all other patients, visitors, and health care personnel.
- To follow clinic rules and regulations, including not using commercial tobacco products within the tobacco-free campus of LVDHC (except for ceremonial purposes).
- Have pre-arranged or provided a responsible adult to arrange transportation home and to remain with minor or compromised patient when directed by the provider.
- Keep appointments for the date and time scheduled or contact the appropriate clinic 24 hours in advance if unable to keep the appointment.
- Inform our clinics of care received elsewhere.
- Provide, to the best of your knowledge, accurate and complete information about current medical issues; past illnesses; hospitalizations; medications (including traditional medicine or over the counter products and herbal/dietary supplements); any allergies or sensitivities to medications or other substances; and other matters relating to your health.
- Ask questions about your health conditions or treatment plan, if not yet understood.
- Share with us any medical Power of Attorney and/or Health Care Advanced Directives
- Assure you understand each document you are asked to sign.-
- Follow the agreed upon care or treatment plan and inform your provider if you do not intend to or have chosen not to follow that advice.
    - Fulfill fiscal responsibility as arranged for any fees/charges not otherwise covered as promptly as able.
    - Provide complete, accurate, and timely information about changes in telephone number, address, insurance, or other sources of payment for the care provided and your ability to pay for services rendered.
    - Assume the responsibility for refusal of offered care or services, referral, or transfer.
    - Refrain from bringing illegal drugs or weapons of any kind into LVDHC Clinic and know that if you are under the influence of illegal drugs and/or alcohol while seeking care, it may impact your plan of care.

Pediatric patients have the following additional rights:

a. To have their parents or legal guardians serve as their advocate.
b. To receive medical treatment with prior consent from a parent or legal guardian. An exception is in an emergency when treatment would begin immediately.
c. To have the right to privacy and confidentiality for reproductive healthcare without consent from a parent or legal guardian.