Little Shell Healthcare Program
A "NEW" PATIENT APPOINTMENT

GENERAL ELIGIBLITY REQUIREMENTS: MUST BE an enrolled member or Descendent of an enrolled member of a Federally Recognized Tribe.

INFORM PATIENT TO CHECK IN AT LEAST 1 HOUR PRIOR TO APPOINTMENT IN ORDER TO ESTABLISH CHART WITH ALL DOCUMENTS

a. PROOF of being a member or descendent of Tribal member. **MUST BRING YOUR TRIBAL ID/CIB to your <u>1st appointment to establish eligibility</u>.**

b. IF DESCENDENT of parent, grandparent, we will need their TRIBAL ID & STATE BIRTH CERTIFICATES for ALL FAMILY MEMBERS WHICH links the patient to the Tribal Member to show proof of Decendency.

- **Example**: Patient is descendant of Grandmother; we will need Grandmothers Tribal ID, Parent State Birth Certificate and Patient's State BC; all birth certificates showing names or lineage "link" back to Grandmother.

c. ADDITIONAL DOCUMENTS we will also need:

- **Social Security Card** - our system is linked to Social Security Administration and once we put in the RPMS/GUI system it takes time for SSA to verify. That is why you see on page 2 in RPMS (Verified by SSA OR Not Verified by SSA).
- **State ID Card or Driver's License** (picture ID)
- **Insurance Cards**. (So proper ID/Group Name/Group # is entered for billing purposes).
- **Military DD-214** for those that served in the U.S. Military. Veterans maybe eligible for Veterans Medical Beneficiary.

d. CUSTODY/GUARDIAN PAPERWORK for Minors.

e. PARENTAL PRE-AUTHORIZATIONS signed by parent/legal guardian if you want another person to bring your child or children to a doctor's appointment. You can fill out the proper I.H.S. forms at patient registration.

f. NEWBORN: We will need Mothers Tribal ID along with the Hospital Record and/or CRIB Card at first visit; mothers name will be on the Hospital Record of Birth/CRIB Card. **WE WILL NEED STATE BIRTH CERTIFICATE ONCE PARENT RECEIVES IT WITH IN 60 DAYS OR patient will be considered ineligible.**

Eligibility will be extended to NON-INDIAN in only three (3) situations:

a. Non-Indian woman pregnant with eligible Indian's child for duration of pregnancy through six (6) weeks post-partum for pregnancy related care only. WE WILL NEED PROOF OF PREGNANCY FROM OUTSIDE FACILITY BEFORE APPOINTMENT.

b. Non-Indian member of eligible Indian's household-public health hazard only.

c. Non-Indian: adopted, foster, step-child/children of eligible Indian until age of 19 years of age. (PL100-713). **NOTE:** Non-Indian patients who do not meet the above eligibility **but present at I.H.S. Emergency Room** for emergency care (prevent immediate death, serious impairment to life, limb, senses) can be treated, stabilized and outed to a NON-I.H.S. facility with patient responsible for costs; they will need to follow up with their own provider.

PATIENT REGISTRATION

HRN:______________

Name:____ DOB:________________
First Middle Last

Birthplace:__________________________ SS#:__________________ Male:___ Female:___
City/State

Marital Status: Single____ Married_____ Widow/Widower____ Divorced____ Separated_____

Mailing Address:____
Street Address/P.O. Box City State Zip

Location of Home:____
If Different from Above

Home Phone:__________ Cell #:__________ Work #:__________ Message #:__________

E-mail Address:______________________________ Religious Preference:______________

TRIBAL INFORMATION: You Must Provide Proof of Enrollment/Descendancy to a Federally Recognized Tribe.

Tribe of Membership:______________________________ Enrolled/Descendant (circle one)

Tribe Quantum:________ Indian Blood Quantum:________ Enrollment #:______________

Father's Name:__________________________________ Birthplace:__________________
First Last City/State

Mother's Maiden Name:____________________________ Birthplace:__________________
First Last City/State

Father's Phone #:______________________ Mother's Phone #:______________________

Father's Employer:_____________________ Mother's Employer:_____________________

Father's E-mail Address:________________ Mother's E-mail Address:________________

Employer Name:____

Employer Address & Phone:____

Spouse's Employer Name:____

Spouse's Employer Address:______________________________ Employer Phone:__________

Emergency Contact:__________________________________ EC Phone:______________

Emergency Contact Address:__________________________ Relationship to EC:__________
City/State/Zip

Next of Kin:____ NOK Phone:______________

NOK Address:____ Relationship to NOK:__________
City/State/Zip

Insurance Information (Check All that Apply): **Medicaid:_____ Medicare:_____ Railroad:_____**
*****Please present Insurance Card & complete the reverse side of form***** **Private Insurance:_____ Other:_____ None:_____**

Are You a Veteran? Yes___ No___ If you answered Yes, what Branch?_________________

Entry Date:__________ Separation Date:__________ Vietnam Service Indicated? Yes___ No___

Service Connected? Yes___ No___ Valid VA Card? Yes___ No___

Description of VA Disability:____

Please Read the Following Before Signing Below:

Privacy Act of 1974, Public Law 93-579: I understand that the Information given by me and/or collected is necessary for the Indian Health Service to provide services for my health care and well being. Furthermore, I have been informed that my record shall not be disclosed to any other agency or person without my signed consent. I certify the above information is correct to the best of my knowledge.

____ ________________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN (if patient is a minor) **DATE**

Ethnicity: *Are you Hispanic or Latino?* Yes_____ No_____

Primary Language Spoken:______________________________

Other Language Spoken:____________________ Preferred Language:____________________

Are You a Migrant Worker? Yes_____ No____ Are You Homeless? Yes_____ No_____

Complete the following if you have Private Insurance, Workman's Comp, or Motor Vehicle Accident Insurance

Name of Insurance Company:______________________________

Address of Insurance Company:______________________________

Phone # of Insurance Company:____________________ Policy/Claim #:____________________

Policy Effective Date:____________________ Policy Term Date:____________________

Name of Policy Holder:______________________________

Policy Holder Date of Birth:____________________ SS#:____________________

Policy Holder Employer Name:______________________________

Employer Address:____________________ Phone #:____________________

Other Policy Members	Relationship to Policyholder	Date of Birth

MEDICARE ONLY: Please present your card and complete the following:

Name:______________________________ Medicare #:____________________
(As Shown on Card)

Part A: Yes___ No___ Effective Date:__________ Part B: Yes___ No___ Effective Date:__________

Medicare D (Prescription Drug Coverage): Yes___ No___ Plan Name:____________________

If you have Insurance:

The Indian Health Service may disclose information from my medical record to the Insurance Corporation, which is or may be liable for all or part of the medical services and supplies provided by the Indian Health Service. I hereby assign the Indian Health Service such insurance benefits that I may have pertaining to payment for medical services and supplies furnished by Indian Health Service. I authorize such benefits directly to the Indian Health Service.

STATE OF PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER:

I request that the payment of authorized Medicare benefits be made on my behalf to Indian Health Service Clinic/Hospital for any services furnished to me by this facility and attending physicians. I have also authorized any holder of needed medical information, pertaining to me, be released to the Montana Medical Foundation for Medical Care and its agents, to determine these benefits or the benefits payable to related services. This authorization shall cover inpatient and outpatient visits, clinic, and/or hospital.

______________________________ ____________________

POLICY HOLDER'S SIGNATURE DATE

Little Shell Health Clinic
425 Smelter Ave NE
Great Falls, MT 59404

PATIENT: ______________________________________ CHART: __________

BASIS FOR ENTITLEMENT TO MEDICARE: ___ AGE ___DISABILITY
___ END STAGE RENAL DISEASE

ARE YOU CURRENTLY EMPLOYED? ____ YES ____ NO

IS THIS ILLNESS/INJURY DUE TO AN ACCIDENT (AUTO)? ____ YES ____ NO

IS THE VISIT PAYABLE TO WORKERS COMPENSATION INSURANCE? ____YES ____ NO

DO YOU HAVE A VA FEE SERVICE CARD? ____YES ____NO

DO YOU HAVE BLACK LUNG DISEASE? ____YES ____NO

PATIENT SIGNATURE: ______________________________ DATE: __________

PATIENT UNABLE TO SIGN (REASON): ______________________________

____

(EXAMPLES: NURSING HOME PATIENT, MEDICAL CONDITION, OR INJURY)

EMPLOYEES SIGNATURE: ______________________________ DATE: __________

Summary Notice of Privacy Practices

425 Smelter Ave NE, Great Falls, MT 59404 • P: 406.760.2055 • F: 406.403.0276

Little Shell Commitment to Health Information Privacy
Little Shell Health provides care that preserves customer-owner dignity, privacy, safety, and security. Care provided honors cultural, spiritual, and personal beliefs, values, and preferences. We are committed to protecting customer-owner privacy. *This notice describes how medical information about you may be used and disclosed and how you can get access to this information.* ***Please review it carefully.***

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can choose to how we use and share information as we tell family and friends about your condition and provide mental health care.

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our Clinic
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

If you believe that your privacy rights have not been maintained, you can file a complaint with the Director of Operations, Skye McGinty, at s.mcginty@lstclinic.org or 406.760.2055.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never share your information unless you give us written permission for most psychotherapy notes.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Summary Notice of Privacy Practices

425 Smelter Ave NE, Great Falls, MT 59404 • P: 406.760.2055 • F: 406.403.0276

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Please list any person(s) you would like involved in your care or payment for your care.

Name: ______________________________

Name: ______________________________

Name: ______________________________

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Customer-Owner (Printed Name): ______________________________

Signature: ______________________________

Date: ______________________________

Customer-Owner Declines to Sign

LST Staff: ______________________________

Date: ______________________________

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Indian Health Service

FORM APPROVED: OMB NO. 0917-0040
Expiration Date: 06/30/2025
See OMB Statement on Page 3

PURCHASED / REFERRED CARE PROOF OF RESIDENCY

The Indian Health Service (IHS) provides services through Purchased/Referred Care (PRC) to American Indian/Alaska Native people who live within the designated geographic area known as a PRC delivery area. The PRC program is authorized to pay for medical care provided to IHS beneficiaries by non-IHS or Tribal, public or private health care providers, depending on the availability of funds.

Federal law generally requires residency within the PRC delivery area in order to receive services through PRC. If you are requesting PRC authorization of payment by the IHS for medical services/treatment from a non-IHS provider, you must prove that you reside within the PRC delivery area.

Please print when completing this form. If you need help in completing the sections, you may ask for assistance and instructions from the IHS PRC Office.

Section A: Your Information (Required)

Last Name	First Name	Middle Initial	Date of Birth
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?		
Home street address:	Post Office Box:	Home phone number:	
City:	State:	Zip Code:	Cell phone number:
Physical location: *(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)*			
Have you lived at this location for more than six months? ☐ Yes ☐ No	If not, provide your old address.		
Are you homeless? ☐ Yes ☐ No	Contact phone number:		

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to beneficiaries of the IHS who live in the PRC delivery area.

____________________________ Applicant Signature

______________ Date

Provide one of the following to show that you live within the PRC delivery area.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing address and withholding taxes.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
Valid college ID with a photo	Property Deed	Marriage License
Other Tribal government issued documents		

If you do not have any of these documents, you can prove that you live in the PRC delivery area by completing Section B or Section C.

PSC Publishing Services (301) 443-6740 EF

Another resident of the PRC delivery area, who knows where you live, can verify your residency by filling out Section B. If you do not know anyone who is willing or able to verify where you live, a local non-profit social services provider can verify your residency by completing Section C.

Section B: Individual Verifier's Information

This section must be filled out by a resident who knows where you, the applicant, live – someone you live with is best. If you do not know anyone who is willing or able to verify where you live, a local non-profit organization that provides you with services may complete Section C for you. *(You do not need to fill in Section C if this section is completed.)*

Last Name:	First Name:	Middle Initial

Home address:	Post Office Box:	Home phone number:

City:	State:	Zip Code:	Cell phone number:

Physical location: *(For Post Office Box addresses, provide house location with street or road and the nearest intersection.)*

How do you know the applicant?

Verification Statement

By signing this form, under perjury of law, I verify that the information provided is true and factual to the best of my knowledge. I know that if I knowingly and willfully give any false information, that a false statement on any part of this declaration or attached documents may be grounds for punishment by a fine or imprisonment. (18 U.S.C. § 1001)

I know that IHS PRC will check this information and I agree to cooperate with their information requests. I understand that the IHS PRC is only available to people who live in the PRC delivery area.

By signing below, I verify that, to the best of my knowledge, the applicant listed in Section A on page 1 lives at the location stated in Section A.

Verifier's Signature ______________________ Date ____________

The individual verifier must sign Section B and provide a copy of at least one (1) of the following documents showing the **verifier's** name and address.

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing name and address.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
Valid U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
	Property Deed	

Name *(Last, First, M.I.)*:______________________________________ ☐ M ☐ F **DOB:**____/______. _______

HEALTH HISTORY QUESTIONNAIRE

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

Marital status: Circle the answer. Single Partnered Married Separated Divorced Widowed

Number of children: _____ **How many live with you?** _____ **Occupation is/was:** ______________________________

Previous or referring doctor:__________________________ **Date of last physical exam:** _________________________

HEALTH HISTORY

Tests/Screenings and Dates: ☐ Eye Exam________ ☐ Colonoscopy_______ ☐ Dexa Scan_______

Hospitalizations /or Surgeries

Year_________ Reason______________________________ Hospital ______________________________

Year_________ Reason______________________________ Hospital _________________ ____________

Year_________ Reason______________________________ Hospital ______________________________

Year________ Reason___________________________ __ Hospital ______________________________

☐ I have had no surgeries ☐ I have never been hospitalized

Have you ever had a blood transfusion? ☐ Y ☐ N

Please list other physicians you have seen in the last 12 months, and for what reason.

____

____

Name (Last, First, M.I.):____ DOB ____/____/______

YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pain/Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ H IV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease, Cancer, or Significant Medical Illness
- ☐ NONE of the Above

List other past medical problems:____

List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers

Med______________________________ Dose/Frequency__________________________

Med______________________________ Dose/Frequency__________________________

Med______________________________ Dose/Frequency__________________________

Med______________________________ Dose/Frequency__________________________

Med______________________________ Dose/Frequency__________________________

Med______________________________ Dose/Frequency__________________________

☐ List additional drugs on back of questionnaire

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Allergies

Name______________________________ Reaction you had __________________________

Name______________________________ Reaction you had __________________________

Name______________________________ Reaction you had __________________________

Name______________________________ Reaction you had __________________________

☐ I have no known **drug** allergies

Name (Last, First, M.I.):______________________________ DOB ____/____/______

FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: *(**ONLY** include parents, grandparents, siblings, and children)*

☐ I am adopted and do not know biological family history ☐ Family History Unknown

☐ Mother, Grandmother, or Sister developed heart disease before the age of 65

☐ Father, Grandfather, or Brother developed heart disease before the age of 55

Disease/Conditions	**Relationship to you** (mom, grandparents, siblings, and children)
☐ Seizures/Convulsions	______________
☐ Colon Cancer	______________
☐ Migraines	______________
☐ Osteoporosis	______________
☐ Alcohol Abuse	______________
☐ Depression	______________
☐ Lung/Respiratory Disease	______________
☐ Anemia	______________
☐ Diabetes	______________
☐ Breast Cancer	______________
☐ Anesthetic Complication	______________
☐ Heart Disease	______________
☐ Rectal Cancer	______________
☐ Arthritis	______________
☐ Asthma	______________
☐ High Cholesterol	______________
☐ High Blood Pressure	______________
☐ Other Cancer -- Specify	______________
☐ Bladder Cancer	______________
☐ Kidney Disease	______________
☐ Stroke/CVA of the Brain	______________
☐ Bleeding Disease	______________
☐ Leukemia	______________
☐ Thyroid Disorder	______________
☐ Other -- Specify	______________

Patient's Signature:______________________________ Date:______________

Reviewed By: ______________________________ Date:______________

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Montana Provider Orders for Life-Sustaining Treatment (POLST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- Completing a POLST is **ALWAYS VOLUNTARY**.

Legal Last Name
Legal First Name/Middle Name
Date of Birth

In preparing these orders, inquire if the patient has a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed.

A (Check one box only)

CARDIOPULMONARY RESUSCITATION (CPR) ***Person has NO pulse and is not breathing.***

◯ **YES CPR:** Attempt Resuscitation ◯ **NO CPR:** Do Not Attempt Resuscitation(DNAR)/ Allow Natural Death (AND)

NOTE: Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B. When not in cardiopulmonary arrest, follow orders in Section B.

B (Check one box only)

MEDICAL INTERVENTIONS ***Person HAS a pulse and is breathing.***

◯ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatments described below in "Selective Treatment" and "Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion, as indicated. Transfer to hospital, if indicated. Includes intensive care.

◯ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described below in "Comfort-focused Treatment," use IV antibiotics and IV fluids, as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

◯ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route, as needed; use oxygen, suctioning, and manual treatment of airway obstruction, if indicated. Do not use treatments listed in "Full Treatment" and "Selective Treatment" above, unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

C (Check one box only)

ARTIFICIALLY ADMINISTERED NUTRITION ***If feasible, always offer food & water by mouth.***

◯ Artificial nutrition by tube --long term/permanent if needed.
◯ Artificial nutrition by tube --short term/temporary only.
◯ No artificial nutrition by tube. ◯ No decision has been made

D

DISCUSSED WITH (check all that apply):

☐ Patient
☐ Medical Power of Attorney
☐ Legal guardian
☐ Other (Name & Relationship):____________________

SIGNATURES OF PROVIDER AND PATIENT, Surrogate, Medical Power of Attorney, and Legal GUARDIAN (*MANDATORY*)

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.
Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Power of Attorney, CPR order, Living Will, or other Advance Directive (attach if available).

Patient/Legal Decision Maker Signature *(Mandatory)*	*Name (Print)*	*Relationship/ Decision maker status (Write "self" if patient)*	*Date Signed (Mandatory)*

SIGNATURE OF PROVIDER: My signature below indicates to the best of my knowledge that these orders are consistent with the patient preferences.

Name of Person Preparing Form	*Phone number of Preparer*	*Date Performed*
Physician / APRN / PA Signature *(Mandatory)*	***Print Physician / APRN / PA Name***	*Date Signed (Mandatory)*

Directions for Health Care Professionals

Completing POLST

- Completed by a health care professional based on patient preferences and medical indications.
- Provider signature must be a Montana licensed physician, advanced practice registered nurse or physician assistant.
- Patient (or legal decision-maker, if patient unable to make medical decisions), **must sign** to be valid.
- Verbal orders are acceptable with follow-up signature by provider in accordance with organization/ community policy.
- Documentation of conversations regarding POLST completion should be in the medical record.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid. The patient should retain the original on "Terra" Green colored paper.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- **No** defibrillator (including automated external defibrillators) should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi- level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-focused Treatment," should be transferred to a setting able to provide comfort (i.e. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort-focused Treatment."

Section C:

- Certain medical conditions may prevent intake of food and water, as it can worsen symptoms.
- If this applies, further discussion with and documentation by a healthcare provider is required.

Reviewing POLST

- Previously completed advance directives should not conflict with these Montana Provider Orders for Life-Sustaining Treatment (POLST) unless significant discussion and documentation between the patient, legal decision maker and healthcare provider occurs and is documented.
- POLST review is recommended when:
  - The patient is transferred from one care setting or care level to another.
  - There is substantial change in the patient's health care status including previous wishes that conflict with medical recommendations.
  - The patient has a change in treatment preference.

Modifying and Voiding POLST

- At any time a patient or legal decision-maker can void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or completing a new POLST.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date.
- The most recently dated POLST is considered the valid POLST and supersede all prior POLST directives.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATA, AND SIGN

I. I, ____, hereby voluntarily authorize the disclosure of information from my health record.

The information is to be disclosed by:	And is to be provided to
NAME OF PERSON/ORGANIZATION/FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY **Little Shell Health Clinic**
ADDRESS	ADDRESS ****FAX TO +1-406-403-0276****
CITY/STATE	CITY/STATE **425 Smelter Ave NE, Great Falls, MT 59404**

II. The purpose or need for this disclosure is: (check all that apply)

☐ Treatment, Payment, or other Healthcare Operations ☐ Research ☐ Insurance ☐ School
☐ Attorney ☐ Disability ☐ Personal Use ☐ Other (specify) ______________________

III. The information to be disclosed from my health record (check all that apply)

☐ Entire Record Lab Results ☐ Immunization Records ☐ Billing/Insurance Records
☐ Other (specify) ____________________

IV. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (other than Psychotherapy notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Director of Operations, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

____

(Specify new date or expiration event)

I understand that Little Shell Health Clinic (LSHC) will not condition treatment or eligibility for care on my providing this authorization.

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

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Information Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (*State relationship to patient*)	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly willfully requests or obtains any record concerning any individual under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

Patient Identification

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATA, AND SIGN

I. I, ____, hereby voluntarily authorize the disclosure of information from my health record.

The information is to be disclosed by:	And is to be provided to
NAME OF PERSON/ORGANIZATION/FACILITY **Little Shell Health Clinic**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS ****FAX TO +1-406-403-0333****	ADDRESS
CITY/STATE **425 Smelter Ave NE, Great Falls, MT 59404**	CITY/STATE

II. The purpose or need for this disclosure is: (check all that apply)
- ☐ Treatment, Payment, or other Healthcare Operations ☐ Research ☐ Insurance ☐ School
- ☐ Attorney ☐ Disability ☐ Personal Use ☐ Other (specify) ____________________

III. The information to be disclosed from my health record (check all that apply)
- ☐ Entire Record Lab Results ☐ Immunization Records ☐ Billing/Insurance Records
- ☐ Other (specify) ________________

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Patient Identification

Patient Rights and Responsibilities

As a patient at **Little Shell Health Clinic**, you have a right to:

- Considerate and respectful care.
- Know the name of your health care provider(s).
- Appropriate assessment, education and management of pain.
- All information about your health status and treatment.
- Participate in all decisions about your care.
- Informed consent. You must give permission for tests, treatment and medicines.
- Refuse treatment. You may choose not to be treated. The provider will tell you how it might affect your health.
- A safe environment.
- Acceptance for treatment. If you want treatment at this clinic, you should not be refused care or sent to another facility without good reason.
- Give permission if LSHC is producing the recordings, films, or other images of you.
- Give permission to students to be involved in your care.
- Privacy. You must give permission before anyone not directly involved in your care is given information about you.
- Confidentiality. Messages between you and your provider, health charts, test results and medications must be kept private.
- Choose to participate in research projects.
- Know about clinic rules and regulations.
- Information about continuing care.
- Voice complaints regarding your care and have them addressed without fear of it affecting your care.
- Practice your religious, cultural, and spiritual beliefs.

Patient Rights and Responsibilities

As a patient at **Little Shell Health Clinic**, you have a responsibility to:

- Give full information about your health including all medications and any herbal supplements you may be taking.
- Let staff know if you do not understand what you are told or what is happening to you.
- Respect and be considerate of the rights and property of others, including patients, clinic staff, and clinic property and equipment.
- Request a translator if needed.
- Express any concerns about your care or your safety to your healthcare team.
- Follow your provider's instructions and be responsible for what happens if you refuse the planned treatment.
- Keep all appointments or tell us if you can't keep them.
- Report any changes in your health.