Little Shell Healthcare Program
A "NEW" PATIENT APPOINTMENT

GENERAL ELIGIBILITY 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 FOR REGISTRATION.

b. **IF DESCENDENT of parent or grandparent, we will need their TRIBAL ID. BIRTH CERTIFICATE: ONLY REQUIRED FOR MINORS to show proof of descendancy.**

- **Example: Patient is descendent of Grandmother; we will need Grandmother's Tribal ID.**
- **Birth Certificate: Only Required for Minors.**

c. **ADDITIONAL DOCUMENTS we will also need:**

- **State ID Card or Driver's License (picture ID)**
- **Insurance Cards. (So proper ID/Group Name/Group # is entered for billing purposes).**

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 Little Shell Tribal Health Clinic forms at customer registration.**

f. **NEWBORN: We will need Mother's Tribal ID along with the Hospital Record and/or CRIB Card at first visit; mother's name will be on the Hospital Record of Birth/CRIB Card. Birth Certificate: Only Required for Minors.**

CUSTOMER REGISTRATION

Established Customer: _____ **New Customer:** _____ **(If Insured) SSN#:** _____ **HRN:** _____

Name: _____ **DOB:** _____ Male: _____ Female: _____
First Middle Last

Marital Status: Single _____ Married _____ Widow/Widower _____ Divorced _____ Separated _____

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

Physical Address: _____
(If Different from Above)

Home Phone: _____ **Cell #:** _____ **Work #:** _____ **Message #:** _____

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

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

Tribe Quantum: _____ Native Blood Quantum: _____ Enrollment #: _____

Employer Name: _____

Employer Address & Phone: _____

Spouse's Name: _____
(If applicable)

Emergency Contact (EC): _____

Relationship to Emergency Contact: _____

Emergency Contact's Phone Number: _____

Emergency Contact's Address: _____

Insurance Information (Check All that Apply):

Medicaid: _____ **Medicare:** _____ **Railroad:** _____

*****Please present Insurance Card & complete the reverse side of form*****

Private Insurance: _____ **Other:** _____ **None:** _____

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 Little Shell Tribal Health Clinic 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**

_____ _____

HEALTH INSURANCE (Please provide copies of all insurances cards)

MEDICAID INFORMATION

Case ID#: _____ **Primary Care Physician:** _____

MEDICARE INFORMATION

Part A □ Part B □ Part C □ Part D □

PRIVATE INSURANCE INFORMATION

Primary Insurance Co: _____
Name of Policy Holder: _____
Covered Members: _____
Primary Care Physician (if HMO): _____

Secondary Insurance Co: _____
Name of Policy Holder: _____
Covered Members: _____
Primary Care Physician (if HMO): _____

DENTAL INSURANCE

Insurance Co: _____
Name of Policy Holder: _____
Covered Members: _____
Primary Care Physician (if HMO): _____

VISION INSURANCE

Insurance Co: _____
Name of Policy Holder: _____
Covered Members: _____
Primary Care Physician (if HMO): _____

I hereby certify that the information I have given is correct to the best of my ability. I authorize the clinic or its agent to receive medical records information for the purposes of billing. I authorize the clinic or its agent to access information regarding availability of alternate resource coverage on my behalf. The clinic is authorized to bill my insurance for covered services provided to me as a patient of its clinic. I further authorize payments to be made directly to the clinic at (mailing address).

PATIENT SIGNATURE: _____

DATE: _____

Assignment of Benefits (AOB) and Release of Information (ROI)

- I hereby authorize and request that payment of benefits by my primary insurance company _____ and my secondary insurance (if any) _____ be made directly to the clinic for services furnished to me or my dependent.
- I authorize clinic to disclose any and all written information from the above-named insurance company and/or its designated representatives, at the determination of. Such disclosure shall be for reimbursement purposes for those services received.
- I hereby release clinic, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives.
- By signing this Assignment of Benefits and Release of Information, I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist the clinic or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. The clinic is acting in filing for insurance benefits assigned to and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by the clinic for billing and collection purposes may do billing.
7. Clinic is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Clinic shall be entitled to the full amount of its charges without offset. I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____ _____ _____

Signature of Patient or Personal Representative | Patient DOB | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship to Patient

_____ _____

Printed Name of Clinic Employee Witness | Employee Job Title

_____ _____

Signature of Clinic Employee Witness | Date

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
- ☐ HIV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ 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

List other past medical problems: _____

☐ Mental illness ☐ NONE of the Above

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 _____

☐ 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

FAMILY MEDICAL HISTORY

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

- ☐ 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: _____

Acknowledgement of Receipt of Notice of Privacy Practices (PP)

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge our Notice of Privacy Practices was provided.

I have received Little Shell Health's Privacy Notice. If I choose to not receive a paper copy, I understand the Notice of Privacy Practices is available for review at my request.

Signature of Patient or Personal Representative	Patient DOB	Date

Printed Name of Patient or Personal Representative	Relationship to Patient

Clinic staff should complete below if Acknowledgement Form is <u>not signed:</u>

Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

If you answered "No" above, please explain why the patient did not sign an acknowledgement form and 's efforts in trying to obtain the patient's signature (check all that apply):

[ ] Patient Unable to Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative not Available
[ ] Other: _____
[ ] Patient/Legal Representative Left before Signature Obtained
[ ] Emergency Admission/Patient Not Present for Registration
[ ] Patient bypassed Registration — Not Available

Completed by:

Employee Name & Title	Date

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this clinic. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____	_____
Signature of Patient or Personal Representative	**Patient DOB**	**Date**

_____	_____
Printed Name of Patient or Personal Representative	**Relationship to Patient**

_____	_____
Printed Name of Clinic Employee Witness	**Employee Job Title**

_____	_____
Signature of Clinic Employee Witness	**Date**

Approved March 12, 2026

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.

Approved March 12, 2026

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 usto correct healthinformation 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 complainifyou 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.

Approved March 12, 2026

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 lawto 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.

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

a. Non-Native woman pregnant with eligible Native'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-Native member of eligible Native's household-public health hazard only.
c. Non-Native:adopted, foster,step-child/children of eligible Native until age of 19 years of age. (PL100-713).NOTE:Non-Native patients who do not meet the above eligibility but present at Little Shell Tribal Health Clinic Emergency Room for emergency care (prevent immediate death, serious impairment to life, limb, senses) can be treated, stabilized and outed to a non-Little Shell Tribal Health Clinic facility with patient responsible for costs; they will need to follow up with their own provider.

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.

Patient Rights & Responsibilities

As a patient at the Little Shell Tribal 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 Little Shell Tribal Health Clinic is producing 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.
- 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.