

New Patient Questionnaire

NAME _____

AGE _____

DATE _____

WHAT BRINGS YOU TO CLINIC TODAY?

LIST ANY CHRONIC MEDICAL ISSUES YOU HAVE: (Diabetes, High blood pressure, Asthma, etc.)

Do you have a primary care physician or specialist you see regularly? If so list here: _____

MEDICATIONS: List OR Show Provider Medications brought with you.

Drug name	Dosage	Frequency	How Long Taken?

SURGICAL HISTORY

Year: _____ Procedure: _____ Year: _____ Procedure: _____

Year: _____ Procedure: _____ Year: _____ Procedure: _____

HOSPITALIZATIONS

Year: _____ Reason: _____ Year: _____ Reason: _____

Year: _____ Reason: _____ Year: _____ Reason: _____

FAMILY HISTORY of: DIABETES, HIGH BLOOD PRESSURE, HEART PROBLEMS, CANCER, BLOOD CLOTS for the following:

Mother _____ Maternal Grandmother _____

Father _____ Maternal Grandfather _____

Brother _____ Paternal Grandmother _____

Sister _____ Paternal Grandfather _____

Others _____

HEALTH MAINTENANCE: Please indicate if you have received the following tests, with most recent date and result:

COLONOSCOPY: _____

LABS/BLOODWORK: _____

MAMMOGRAM: _____

EYE EXAM: _____ DENTAL VISIT: _____

PAP SMEAR: _____

Smoking/Drugs/ETOH/Dep/ Dom Vio: _____

BONE DENSITY: _____

HPV Vaccine/Multi Partners(Risk)/Abs/Prot. _____



URBAN INTER-TRIBAL CENTER OF TEXAS

1261 Records Crossing Rd Dallas TX 75235

Phone: 214-941-1050 Fax: 214-941-6537

Parental Consent Form for Medical Treatment of a Minor Child

To avoid possible delay in providing medical/dental treatment in the event your child becomes ill, injured, needs routine medical/dental care or needs vaccines in your absence, the Urban Inter-Tribal Center of Texas Medical Clinic offers this form for medical/dental consent and history. It offers assurance that your minor child will receive prompt, personalized attention if you or a legal guardian are not immediately available.

Please note:

- You must complete a separate form for each child
- Please update the information at least every six months
- If all blanks are not filled out completely, the form may not be considered valid

Name of Minor: _____ Date of Birth : ____ / ____ / ____ (mm/dd/yyyy)

Home Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Parent's /Guardian's Name: _____ Contact Phone(s) _____

Parent's /Guardian's Name: _____ Contact Phone(s) _____

Home Address: _____
(Street or PO Box) (City) (State) (Zip Code)

INSTRUCTIONS TO PARENT(S) OR GUARDIAN(S): *At least one parent or legal guardian must sign this form below.*

Parent/Guardian: _____ / ____ / ____
(Printed Name) (Signature) (Date)

Parent/Guardian: _____ / ____ / ____
(Printed Name) (Signature) (Date)

ORIGINAL COPY: *Make initial copy of this consent form for the parent/guardian.*
Original Copy - Medical Record Copy - Patient



Urban Inter-Tribal Center of Texas

1261 Record Crossing Rd., Dallas, TX 75235

Phone: 214/941-1050 Fax: 214/946-4738



HEALTH SERVICES

NO SHOW POLICY

To better serve all community members, the Health Services Department has the following policy concerning appointments:

1. Any patient who fails to come in for an appointment, arrives more than 15 minutes late for an appointment, or cancels an appointment with less than 24 hours notice will be documented in the patient record as a **No Show**.
2. If a **No Show** for medical and dental appointments occurs 3 times in one year for a patient, that patient will be seen only on a same day appointment basis for medical and walk-in time for dental for a period of six months. At the end of this probationary period, the patient may be reinstated to receive designated appointments for medical and dental care.
3. In the event that this patient has an occurrence of a **No Show** again after the probationary period, the patient will be placed on six months probationary period once again.

Please call no later than 12:00 noon the day before your appointment is scheduled (or on Friday if your appointment is on Monday) to cancel or reschedule your appointment if you will not be able to keep your appointment.

I understand my responsibility to keep my appointments and agree to comply with Health Services Department No Show Policy.

Patient or Parent/Guardian Signature

Date



Urban Inter-Tribal Center of Texas

1283 Record Crossing, Dallas, TX. 75235 Mailing Address

1261 Record Crossing, Dallas, TX. 75235 Physical Address

Phone: 214/941-1050 Fax: 214/946-4738



HEALTH SERVICES

CLINIC MEDICATION POLICY

To better serve all community members, the Health Services Department has the following policy concerning medications:

1. Please keep all appointments to ensure that you do not run out of medication. We are set up so that when you have your appointment you also receive medications. (Usually every two months)
2. If you are unable to keep your regular scheduled appointment and need medication, please request in advance no later than 7-10 days before your medications are out. Allow a 48 hour processing time and possibly more time depending on patient status and situation.
3. Refill of medication does not qualify as grounds for a walk-in visit.
4. The Urban Inter-Tribal Center of Texas pharmacy does not by any means fill outside prescriptions.

Note: Requests called in on Friday will have a 48 hour processing time that begins on Monday or following business day.

I understand my responsibility to agree to comply with Health Services Department Clinic Medication Policy.

Patient or Parent/Guardian Signature

Date



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ELIGIBILITY

In order to receive Clinical Services at this facility, proper documentation is required. No one will be permitted to utilize our services, otherwise.

We will accept as official documentation:

1. **C.D.I.B card with driver's license or official state I.D. card for those over 18 years old.**
C.D.I.B. with copy of birth certificate, social security card and shot record for those under 18 years old with parents ID.
2. **Tribal/B.I.A. verification on official letterhead with appropriate signature with driver's license and birth certificate:**

Infants from 1 day - 6 months will be seen if either parent has proper documentation. After 6 months, child will be required to also have birth certificate along with parent(s) proper documentation. **Due to our contracting guidelines we are only able to provide direct care to Native Americans. Those seeking services are strongly encouraged to obtain proper documentation.**

I have been informed and am aware of documentation required to be able to use this facility.

Patient or Parent/Guardian Signature

Date



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CONTRACT CARE FUNDS

If one of our doctors, physician's assistant, nurses, or dentists refer you to another health facility, hospital, or clinic to obtain health care services that we cannot or do not provide here:

PLEASE BE ADVISED, YOU ARE RESPONSIBLE TO PAY FOR THE COST OF THIS CARE.

You will be billed by the referral health facility. If you have private or public health insurance coverage you may use this to pay the bill, if appropriate. You may of course, refuse to go to the referral facility, but please remember the purpose of the referral is to provide you with the opportunity to receive the appropriate health care needed for your well being. If you go to the referral facility, please make the necessary arrangements to pay the bill.

WE CANNOT PAY THE BILL FOR YOU.

1. I have read the above and understand my financial responsibilities should I be referred to another health facility.
2. Because our funding does not cover any tests which are done by outside labs, we ask all patients receiving laboratory tests to pay for them prior to the specimens being sent out.

Patient or Parent/Guardian Signature

Date

CONSENT TO TREAT

I hereby give consent to the attending physician, physician's assistant, dentist or nurse of the Urban Inter-Tribal Center of Texas to examine and treat my child and/or myself.

I hereby authorize payment under the medical insurance program to be made to the Urban Inter-Tribal Center of Texas for services furnished to me. I authorize the provider to release to the authorized insurance company. I authorize that my signature be kept on file at the Urban Inter-Tribal Center of Texas. I HAVE READ AND UNDERSTAND THE ABOVE AND GIVE MY CONSENT.

Patient or Parent/Guardian Signature

Date



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Medication Release

I _____
(Patient name print.)

(Circle one)

a.) Give permission to:

b.) Do not give permission to anyone.

1. _____
(Name and Relation.)

2. _____
(Name and Relation.)

3. _____
(Name and Relation.)

4. _____
(Name and Relation.)

5. _____
(Name and Relation.)

The persons named above have my permission to pick up my medications and supplies until further notice is given. This form is not a release of information form.

(Patient Signature)

(Date)



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Release of Information / Assignment of Benefits

Urban Inter-Tribal Center of Texas has my permission to release information as needed for insurance processing and for my insurance to release payment to UITCT.

I HEARBY AUTHORIZE TREATMENT

Signature of Patient or guardian _____

Printed Name _____ *Date* _____



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Acknowledgement of Receipt of Urban Inter-Tribal Center of Texas Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

UITCT is furnishing you with the attached notice, which provides information about how UITCT and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have a copy of UITCT's *Notice of Privacy Practices*.**

Signature of Patient or Legal Representative

Date

JF 08/04/14

Initials of Screener _____



Urban Inter-Tribal Center of Texas

Patient Rights and Responsibilities

As a patient, you have a right to:

- Respectful and Considerate care in a safe environment that supports your personal dignity
- Receive, upon registration, information about the UITCT's Patient Rights
- Be involved in decisions about your care, treatment, and services
- Give Informed Consent or to refuse care, treatment and services as allowed by law and regulations
- Be informed about outcomes of care, treatment, and services
- Effective communication and to receive information and all communications in a manner you understand
- Make a complaint or file a grievance concerning the quality of your care, or any other issue
- Confidentiality, privacy, and security
- Be free from mental, physical, sexual and verbal abuse, neglect and exploitation
- Participate in the consideration of ethical issues that arise during your care
- Access the information contained in your medical record
- Have these rights extended to your guardian, next of kin or legally authorized responsible person if you are unable to speak for yourself
- Be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orientation, and gender identity or expression

As a patient, you have a responsibility to:

- Provide accurate and complete information about your medical history and current condition
- Participate in and follow your treatment plan, and accept the consequences of refusing treatment or not following your treatment plan
- Ask questions if you don't understand something that you have been told regarding your care
- Respect and show consideration for the rights of others by complying with UITCT's policies regarding noise, smoking, and conduct of visitors

Complaint & Grievance Policy Statement

- **Urban Inter-Tribal Center of Texas provides for and welcomes the expression of complaints/grievances and suggestions at any time by the patient, patient's family and/or designated representatives. This feedback allows us to understand and improve the environment of care.**
- **Every patient has the right to file a complaint/grievance with any staff member or the facility's Administrative Director. In absence of the Administrative Director, an Executive Assistant will address the complaint/grievance. The grievance process begins with the facility's Administrative Director. If the patient is still not satisfied, the process is given to the CEO. In the event the problem is still not resolved, a complaint can be registered by phone or in writing to :**

**Texas Department of State Health and Services
Health Facility Licensing and Compliance Division
1100 West 49th St., Austin, TX 78756
Or call 1-888-973-0022**

- **A complainant may also contact the state directly, bypassing any internal process.**
- **A complainant may provide his/her name, address, and phone number or may register an anonymous complaint. All complaints are confidential.**

INDIAN HEALTH SERVICE
Notice of Privacy Practices

"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."

SUMMARY OF YOUR PRIVACY RIGHTS

- 1) Understand Your Medical Record/Information. Each time you visit an Indian Health Service (IHS) facility for services, a record of your visit is made. If you are referred by the IHS through the Purchased/Referred Care (PRC) program, the IHS also keeps a record of your PRC visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:
 - 1) Plan for your care and treatment.
 - 2) Communication source between health care professionals.
 - 3) Tool with which we can check results and continually work to improve the care we provide.
 - 4) Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
 - 5) Tool for education of health care professionals.
 - 6) Source of information for public health authorities charged with improving the health of the people.
 - 7) Source of data for medical research, facility planning, and marketing.
- 2) Legal document that describes the care you receive.
- 3) Understanding what is in your medical record and how the information is used helps you to:
 - 1) Ensure its accuracy.
 - 2) Better understand why others may review your health information.
 - 3) Make an informed decision when authorizing disclosures.
- 4) Your Medical Record/Information Rights. Your medical record is the physical property of the IHS, but the information belongs to you. You have the right to:
 - 1) Inspect and receive a paper or electronic copy of your health information.
 - 2) Receive notification of a breach of your unsecured protected health information.
 - 3) Request a restriction on certain uses and disclosures of your health information to your health plan. The IHS is not required to agree to the requested restriction except when the disclosure would be for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI relates solely to health care items or services for which the individual, next of kin or person other than the health plan on behalf of the individual, has paid or will pay for the health information.
 - 4) Request a correction or amendment to your health information. The IHS may amend your record or include your Statement of Disagreement with confidential communications about your health information.
 - 5) Request and obtain a listing of certain disclosures the IHS has made of your health information.
 - 6) Revoke your written authorization to use or disclose health information.
 - 7) Request and obtain a paper or electronic copy of the IHS Notice of Privacy Practices.
 - 8) Request and obtain a paper or electronic copy of the patient's medical record from the IHS Medical, Health and Billing Records, System Notice Number 09-17-0001.
- 5) Indian Health Service Responsibilities. The IHS understands that health information about you is personal and is committed to protecting your health information. The IHS is required by law to:
 - 1) Maintain the privacy of your health information.
 - 2) Inform you about our privacy practices regarding health information we collect and maintain about you.
 - 3) Notify you if we do not agree to a requested restriction.

- 4) Notify you of our decision regarding a request for correction or amendment.
- 5) Accommodate reasonable requests you may have to communicate health information by alternate means or to an alternate location.
- 6) Promptly notify you of a breach of unsecured protected health information (PHI).
- 7) Honor the terms of this Notice or any subsequent revisions of this Notice.

REVISED NOTICE OF PRIVACY PRACTICES

The Indian Health Service (IHS) reserves the right to change its privacy practices and to make the new provisions effective for all PHI it maintains. The IHS will post any revised Notice of Privacy Practices at public places within its facilities and on the IHS web site at: www.ihs.gov/AdministrativeResources/PHI/PHIIndex.cfm

- 1) How the IHS may use and disclose health information about you. The IHS will not use or disclose your health information without your permission, except as described in this Notice and as permitted by the IHS Privacy Act regulations, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, Genetic Information Nondiscrimination Act (GINA) of 2008, and the IHS Medical, Health, and Billing Records, System Notice 09 17 0001. The following categories describe how we may use and/or disclose your health information.
 - A. Treatment. We will use and/or disclose your health information to provide your treatment. For example:
 - 1) Your personal information will be recorded in your medical record and used to determine the course of treatment for you. Your health care provider will document in this record their instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your medical record so your health care provider will know how you are responding to treatment.
 - 2) If you are referred or transferred to another facility or provider for further care and treatment, the IHS may disclose information to that facility or provider to enable them to know the extent of treatment you have received and other information about your condition.
 - 3) Your health care provider(s) may give copies of your health information to others, including health care professionals or personal representatives, to assist in your treatment.
 - B. Payment Purposes. We will use and disclose your health information for payment purposes. For example:
 - 1) If you have private insurance, Medicare, or Medicaid, a bill will be sent to your health plan for payment. The information on an accompanying bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
 - 2) If you are referred to another health care provider under the Purchased/Referred Care (PRC) program, the IHS may disclose your health information to that provider for health care payment purposes.
 - C. Health Care Operations. We will use and disclose your health information for health care operations. For example:
 - 1) We may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide.
 - D. Health Information Exchange (HIE). The IHS HIE may make your health information available electronically through an information exchange network to other providers involved in your care who request your electronic health information. Participation in the national e-Health Exchange network is voluntary. If you want your health information to be accessible to authorized health care providers through the IHS HIE to the national e-Health Exchange, you must authorize this use and disclosure. More information is available at <http://www.ihs.gov/hie/> Personal Health Record. The Personal Health Record (PHR) is a secure web based application that provides patient access to their health care information. The PHR is accessible to any patient who

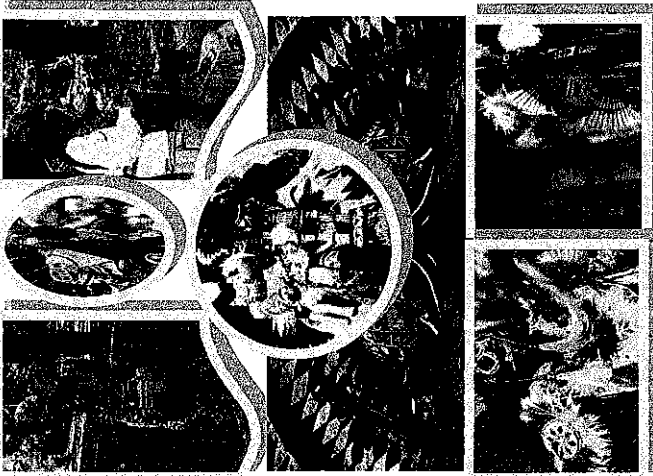
receives care at an IHS facility and requests a PHR account.
F. Direct. The IHS may share your health information between providers and between healthcare providers, patients and/or patients' authorized representatives, using the DIRECT secure, web-based messaging service.
G. Business Associates. The IHS provides some healthcare services and related functions through the use of contracts with business associates. For example, the IHS may have contracts for medical transcription. When these services are contracted, the IHS may disclose your health information to business associates so that they can perform their jobs. The IHS requires our business associates to protect and safeguard your health information in accordance with applicable Federal laws.

H. Directory. If you are admitted to an IHS inpatient facility, the IHS may use your name, general condition, and location within our facility for directory purposes, unless you notify us that you object to this information being listed. If an individual asks for you by name, the IHS may disclose your name, general condition, and location within our facility, unless you notify us that you object to this information being listed. The IHS may provide your religious affiliation only to members of the clergy.

I. Notification. The IHS may use or disclose your health information to notify or assist in the notification of a family member, personal representative, or other authorized person(s) responsible for your care, unless you notify us that you object.

J. Communication with Family. All IHS health providers may use or disclose your health information to others involved with and/or responsible for your care unless you object. For example, the IHS may provide your family members, other relatives, close personal friends, or any other person you identify, with health information that is relevant to that person's involvement with your care or payment for such care.

K. Adults and Emancipated Minors with Personal Representatives. The IHS may disclose health information to a personal representative of an individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction.



INDIAN HEALTH SERVICE
DIVISION OF REGULATORY AFFAIRS
NOTICE OF PRIVACY PRACTICES

HIPAA
Health Insurance Portability and Accountability Act
PRIVACY RULE

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.

SUMMARY OF YOUR PRIVACY RIGHTS

Rights under this Notice or to Request Information or Report a Problem
 To exercise your rights under this Notice, to ask for more information, or to report a problem contact the Service Unit Chief Executive Officer or the appropriate Privacy official at:

administrative proceedings if required or authorized by law.
 5) The IHS may disclose health information to report a crime committed on IHS health facility premises or when the IHS is providing emergency health care; and
 6) The IHS may use or disclose health information during a disaster and for disaster relief purposes.

2) To government authorities that are authorized by law to receive reports of child abuse or neglect, and
 3) To government authorities that are authorized by law to receive reports of other abuse, neglect or domestic violence, or as authorized by law if the IHS believes it is necessary to prevent serious harm. Where authorized by law, the IHS may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. In some situations or if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public, the IHS may disclose to your employer health information concerning a work related illness or injury or a workplace related medical surveillance. (for example, if you are employed by IHS or another component of the Department of Health and Human Services (HHS))

U. Correctional Institution. If you are an inmate of a correctional institution, the IHS may disclose to the institution, health information necessary for your health and the health and safety of other individuals such as officers, employees, or other inmates.
 V. Law Enforcement. The IHS may disclose your health information for law enforcement activities as authorized by law or in response to an order of a court of competent jurisdiction.
 W. Health Oversight Authorities. The IHS may disclose your health information to health oversight agencies for activities authorized by law. These oversight activities may include: investigations, audits, inspections, and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance. The IHS is required by law to disclose health information to the Secretary, HHS to investigate or determine compliance with the HIPAA privacy standards.
 X. Members of the Military. If you are a member of the military services, the IHS may disclose your health information if necessary to the appropriate military command authorities as authorized by law.
 Y. Compelling Circumstances. The IHS may disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances:
 1) The IHS may disclose limited health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
 2) If you are believed to be a victim of a crime and a law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency circumstances, we may disclose the requested information if we determine that such disclosure would be in your best interests;
 3) The IHS may use or disclose health information that we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person;
 4) The IHS may disclose health information in the course of judicial and

_____ Facility name

_____ Address

_____ Phone number

_____ Address

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If you believe your privacy rights have been violated, you may file a written complaint with the above individual or the Secretary, Department of Health and Human Services, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

Effective Date: April 05, 2014