American Indian Health & Services

4141 State Street Suite B11 Santa Barbara, CA 93110-2829 (805) 696-1002

Oral Health Department

Confidential Health History Form

Today's Date: _____

Patient Name _____ Date of Birth _____
Last First Initial

I. Circle appropriate answer

1. Is your general health good? Yes / No
If NO, explain
_____

2. Has there been a change in your health within the last year? Yes / No
If YES, explain
_____

3. Have you gone to the hospital or emergency room or had a serious illness in the last three years? Yes / No
If YES, explain
_____

4. Are you being treated by a physician now? Yes / No
If YES, explain
_____
Date of last medical exam? Reason for exam
_____

5. Have you had problems with prior dental treatment? Yes / No
If YES, explain
_____

6. Date of last dental exam. Name of last treating dentist
_____

7. Are you in pain now? Yes / No
If YES, explain
_____

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II. Have you experienced any of the following? *(Please check)*

Yes	No		Yes	No		Yes	No	
□	□	Chest pain (angina)	□	□	Blood in stool	□	□	Frequent vomiting
□	□	Fainting spells	□	□	Diarrhea or constipation	□	□	Jaundice
□	□	Recent significant weight loss	□	□	Frequent urination	□	□	Dry mouth
□	□	Fever				□	□	Difficulty urinating
□	□	Excessive thirst						
□	□	Night sweats	□	□	Ringing in ears	□	□	Difficulty swallowing
□	□	Persistent cough	□	□	Headaches	□	□	Swollen ankles
□	□	Coughing up blood	□	□	Dizziness	□	□	Joint pain or stiffness
□	□	Bleeding problems	□	□	Blurred vision	□	□	Shortness of breath
□	□	Blood in urine	□	□	Bruise easily	□	□	Sinus problems

III. Have you had or do you have any of the following? *(Please check)*

Yes	No		Yes	No		Yes	No	
□	□	Heart disease	□	□	High blood pressure	□	□	Hardening of arteries
□	□	Family history of heart disease	□	□	Seizures	□	□	Arthritis, rheumatism
□	□	Heart attack	□	□	Surgeries	□	□	Emphysema/ lung disease
□	□	Artificial joint	□	□	Hospitalizations	□	□	Kidney or bladder disease
□	□	Stomach problems or ulcers	□	□	Diabetes	□	□	Stroke
□	□	Heart defects	□	□	Family history of diabetes	□	□	Eating disorders
□	□	Heart murmurs	□	□	Tumors or cancer	□	□	Osteoporosis
□	□	Rheumatic fever	□	□	Chemotherapy	□	□	Thyroid disease
□	□	Skin disease	□	□	Radiation	□	□	Asthma
□	□	Hepatitis	□	□	Canker or cold sores	□	□	Eye disease
□	□	Sexual transmitted disease	□	□	Anemia	□	□	Transplants
□	□	Herpes	□	□	Liver disease	□	□	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes	No		Yes	No		Yes	No	
□	□	Treatment for emotional condition	□	□	AIDS/HIV			
□	□	Depression	□	□	Anxiety			

IV. Any allergies (I.e. medications, food)? *(Please list)*:

_____

V. Are you taking or have you taken any of the following in the last three months? *(Please check)*

Yes	No		Yes	No		Yes	No	
□	□	Recreational drugs	□	□	Cortico – Steroids	□	□	Tobacco (any form)
□	□	Alcohol	□	□	Bisphosphonate (Fosamax)	□	□	Antibiotics
□	□	Aspirin						

Please list all medications you are currently taking:

_____

_____

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VI. Women only *(Please check)*

Yes	No	
□	□	Are you or could you be pregnant? If YES, what month? _____
□	□	Are you nursing?
□	□	Are you taking birth control pills?

VII. All patients *(Please check)*

Yes	No	
□	□	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, explain: _____

Yes	No	
□	□	Have you ever been pre-medicated for dental treatment?

If YES, why: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

*Physician's Name*_____ *Phone Number* _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) _____ **Date** _____

Signature of Dentist _____ **Date** _____

American Indian Health and Services
4141 State Street, Suite C 2. (805) 696-1002

Dental Treatment Consent Form: Please read and initial the items below and sign at the bottom of form.

1. X-RAYS (Initials_____)

2. DRUGS AND MEDICATIONS I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

3. CHANGES IN TREATMENT PLAN I understand that during treatment it may be necessary to change or add procedures because of findings found on subsequent visits not discovered during examination. The most common being root canal therapy following routine restorative procedures. (Initials_____)

4. REMOVAL OF TEETH Alternatives to tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the affected teeth. I understand removing teeth does not always remove all the infection, if present further treatment may be necessary. I understand the risks involved in having teeth removed such as pain, swelling, spread of infection, dry socket, fractured jaw or loss of feeling of the teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) may be necessary. I understand further treatment may be needed by a specialist or even hospitalization if complications arise during or following treatment in whichthe cost of which is my responsibility.
(Initials_____)

5. CROWNS, BRIDGES AND CAPS I understand that sometimes it is not possible to exactly match the natural color of teeth. I further understand that temporary crowns when placed may come off easily. I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.
(Initials_____)

6. DENTURES COMPLETE OR PARTIAL I understand that full or partial dentures are artificial (constructed of plastic, metal, and/or porcelain). The problems of wearing these appliances have been explained to me, which I understand the final opportunity to make changes to my new dentures (such as shape, fit, size, placement, and color) include looseness, soreness, and possible breakage.
will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials_____)

7. ENDODONTIC TREATMENT (ROOT CANAL)
I understand there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
(Initials_____)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand that periodontal disease could lead loss of teeth. I have been informed of alternative treatments including maintenance therapy and extraction. I understand that if treatment is not rendered the risk may include tooth movement, loss of teeth, gum recession, halitosis, infection, and further progression of periodontal disease. Risk of therapy include pain, swelling, thermal sensitivity, recession, infection, tooth mobility, food impactions and other. I agree to follow home care prevention technique and treatment regimen as counseled by staff.

9. FILLINGS I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filing. (Initials_____)

10. DENTURES I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures may be painful. Immediate dentures may require considerable adjusting and several relines. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days.
(Initials_____)

I understand that a perfect result cannot be guaranteed. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Print Name: _____

Patient /Guardian Signature_____ Date_____

MRN:

PATIENT REGISTRATION FORM

How did you hear about us?

[ ] Insurance/CenCal [ ] Family/Friend [ ] Caretaker [ ] Self [ ] Skilled Nursing [ ] Hospital

[ ] Agency: _____ [ ] Referral: _____ [ ] Other: _____

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____FirstName:_____MI:_____

Social Security#:_____ Date of Birth: _____ Sex: [ ] M [ ] F

Address: _____City:_____State:_____Zip:_____

Email: _____ Employer: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed **Primary Care Physician Name**: _____

Preferred Language: _____ Do you need an Interpreter? [ ] Yes [ ] No **Religious Preference:** _____

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or other Pacific Islander [ ] White [ ] Unknown/Declined to answer

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Unknown/Declined to answer

Preferred Method of Communication: [ ] Phone [ ] Text Message [ ] Email [ ] Do Not Notify / Opt-Out

Day Phone: (____)_____Cell Phone: (____)_____Home Phone: (____)_____

Best number to reach you: [ ] Day Phone [ ] Cell Phone [ ] Home Phone OK to leave a message? _____

RESPONSIBLE PARTY: IF PATIENT IS UNDER AGE 18

Last Name: _____First Name: _____MI:_____

Relationship to Patient: _____ *(Present Photo ID so we may make a photocopy)*

Social Security Number: _____ Birthdate (mm/dd/yyyy):_____ Sex: [ ] Male [ ] Female

Address: _____City:_____State:_____Zip:_____

Home Phone :(_____)_____Cell Phone :(_____)_____Work Phone:(_____)_____

EMERGENCY CONTACTS

Emergency Contact Name: _____ Phone _____

Address: _____ Relationship: _____

Next of Kin Name: _____ Phone _____

Address: _____ Relationship: _____

MRN:

FAMILY INFORMATION

Family Size: _____ Income: _____ *Income cycle:* [ ] Weekly [ ] Monthly [ ] Annually

Mother's Last Name: _____ First Name: _____ Maiden Name: _____

As a Federally Qualified Health Center and to keep our services affordable, AIH&S receives grant funding. To qualify for these resources we must collect the following information on all our clients. Please support AIH&S by answering all questions.

INSURANCE INFORMATION

Present all current insurance cards so we may make a photocopy

Primary Insurance Coverage: _____

Secondary Insurance Coverage: _____

If you have Private Insurance and are a dependent on someone else's insurance we will need the following:

Policy Holder's Full Name: _____ Date of Birth: _____ Sex _____

Non-Insured Patients: There are programs available for patients whom are uninsured or underinsured. Please contact a front office staff member or call our clinic at (805) 681-7144 for more information.

Do you have an Advance Directive: [ ] Yes [ ] No *If yes, specify name of document*: _____

Are you currently Homeless: [ ] Yes [ ] No *If Yes, please indicate if you are:* [ ] Doubling Up [ ] Shelter

Are you a US Veteran: [ ] Yes [ ] No [ ] Street [ ] Transitional

Are you a Migrant Worker: [ ] Yes [ ] No *If Yes, please indicate if you are:* [ ] Seasonal [ ] Migrant

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a copy of your membership documentation. **Specify Name of Tribe(s):** _____

Release of Information / Assignment of Benefits: American Indian Health & Services has my permission to release information as needed for insurance processing and for my insurance to release payment to American Indian Health & services.

I HEREBY AUTHORIZE TREATMENT: I hereby grant authorization and consent for medical treatment for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for.

_____ _____

Signature of Patient or Guardian if patient a Minor Date

_____ _____

Print Patient/Guardian's Name from above Relationship to Patient

Office Use Only: [ ] Toolkit Provided [ ] Verified Patient Information [ ] Collected Photo ID/Insurance Card(s)

Reviewer's Initials: _____ Data Entry Completed by: _____ Date Scanned: _____

American Indian Health & Services

4141 State Street, Suite B-11, Santa Barbara, CA 93110 Phone: (805) 681-7356 I Fax: (805) 681-7358

MRN:_____

Reminder Calls

As a courtesy, American Indian Health & Services will call to remind you of your appointment. Reminder calls are made two business days before your scheduled appointment. You will receive an automated reminder call by phone. Please contact a front office staff member if you prefer to receive a text, email or opt-out.

No-Show Policy

Broken appointments are ill-advised. They may be unsafe for you and make it hard for us to care for you. If you are unable to keep an appointment, you must notify us at least 24 hours in advance so that we may make the time available for another patient in need of care. If you do not notify us at least 24 hours in advance we consider you to have no-showed for your appointment.

Our policy is to deny scheduled appointments for 30 days for patients who have no-showed 3 consecutive times. After the 30 days have passed you are able to schedule appointments again. If you need to see your care team during the 30 days you may contact us for the possibility of a same day visit. There is no guarantee a same day visit will be available.

Executive Director Signature:  _____

Patient Name (please print):_____Date of Birth:_____

Patient Signature: _____Date_____
(Parent/Guardian Signature if under age 18)

American Indian Health & Services

4141 State Street, Suite B-11, Santa Barbara, CA 93110 Phone: (805) 681-7356 I Fax: (805) 681-7358

MRN:_____

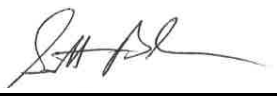
LAS LLAMADAS DE RECORDATORIO

Como cortesía, American Indian Health & Services le llamará para recordarle de su cita. Las llamadas de recordatorio se realizan dos días hábiles antes de su cita programada. Usted recibirá una llamada de recordatorio automática por teléfono. Si usted prefiere recibir un mensaje de texto, correo electrónico o no recibir la llamada, por favor, póngase en contacto con el personal de la oficina.

POLÍTICA EN CASO DE NO PRESENTARSE

Desaconsejamos faltar a su cita. Puede ser peligroso para usted y hacer que sea difícil para nosotros cuidar de usted. Si usted no puede asistir a una cita, debe notificarnos con al menos 24 horas de antelación para que podamos disponer del tiempo para otro paciente que necesite atención. Si no nos informa con al menos 24 horas de antelación, consideramos que ha faltado a su cita.

Nuestra política es negar la programación de citas durante 30 días a los pacientes que no se presentaron a su cita durante 3 veces consecutivas. Después de que los 30 días haya pasado podrá programar una cita de nuevo. Si necesita ver a su equipo de cuidados durante los 30 días puede ponerse en contacto con nosotros para evaluar la posibilidad de una visita el mismo día. No ofrecemos garantía de que habrá una hora disponible para una visita el mismo día.

Firma del director ejecutivo: 

Nombre del paciente (en letra de imprenta): _____ Fecha de Nacimiento: _____

Firma del paciente: _____Fecha: _____
(Firma del padre/tutor legal si es menor de 18 años)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

American Indian Health & Services ("AIHS") and its employees are dedicated to maintaining the privacy of your personal health information ("PHI"), as required by applicable federal and state laws. These laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning Protected Health Information, or PHI, which is information that identifies you and that relates to your physical or mental health condition. We are required to follow the privacy practices described below while this Notice in effect. This Notice applies to all of the records of your care generated or maintained by AIHS.

A. PERMITTED DISCLOSURES OF PHI. The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We may disclose your PHI for the following reasons:

1. **TREATMENT**. We may disclose your PHI to a physician or other health care provider providing treatment to you. For example, we may disclose medical information about you to physicians, mental health professionals, nurses, technicians or personnel who are involved with the administration of your care. Different departments of AIHS may share medical information about you in order to coordinate different items, such as prescriptions, lab work, nutrition and behavioral health counseling.

2. **PAYMENT**. We may disclose your PHI to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third party payer for the rendering of services by us. The bill may contain information that identifies you, your diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. **HEALTH CARE OPERATIONS**. We may disclose your PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, and other business operations. For example, we may use and disclose medical information to contact you as a reminder that you an appointment for treatment at AIHS. We may use your PHI to evaluate the

performance of the health care services you received. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us. We may also remove information that identifies you from a set of records so others may use it to study health care and health care delivery without learning the patient's identity.

4. **EMERGENCY TREATMENT**. We may disclose your PHI if you require emergency treatment or you are unable to communicate with us.

5. **FAMILY AND FRIENDS**. We may disclose your PHI to a family member, friend or any other person who you identify as being involved with your care or payment for care, unless you object in writing.

6. **REQUIRED BY LAW**. We may disclose your PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you or your representative if we disclose your PHI because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you or your representative would place you at risk.

7. **LAWSUITS AND DISPUTES**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include a written notice to you) or to obtain an order protecting the information requested.

8. **SERIOUS THREAT TO HEALTH OR SAFETY**. We may disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.

9. **PUBLIC HEALTH**. We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.

10. **HEALTH OVERSIGHT ACTIVITIES**. We may disclose your PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings; inspections; licensure or disciplinary action; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.

11. **FUNDRAISING ACTIVITIES**. We may use information about you, or disclose such information to a foundation related to AIHS, to contact you in an effort to raise money for AIHS and its operations. In such cases, we would only release contact information, such as your name, address, and phone number and the dates your

received treatment or services at AIHS. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out or you may do so in writing at the address provided at the end of this Notice.

12. **RESEARCH**. We may disclose your PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.

13. **WORKERS' COMPENSATION**. We may disclose your PHI to comply with laws relating to workers compensation or other similar programs.

14. **SPECIALIZED GOVERNMENT ACTIVITIES**. If you are active military or a veteran, we may disclose your PHI as required to disclose PHI to authorized federal officials for the conducting of intelligence or other national security activities.

15. **ORGAN DONATION**. If you are an organ donor, or have not indicated that you do not wish to be a donor, we may disclose your PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

16. **CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS**. We may disclose your PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.

17. **DISASTER RELIEF**. Unless you object, we may disclose your PHI to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

B. DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

1. **NOT OTHERWISE PERMITTED**. In any other situation not described in Section A above, we may not disclose your PHI without your written authorization.

2. **PSYCHOTHERAPY NOTES**. Psychotherapy notes means notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities. We may disclose your psychotherapy notes as required by law.

3. **MARKETING AND SALE OF PHI**. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. YOUR RIGHTS

1. **RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE**. You have the right to receive a paper copy of this Notice upon request.

2. **RIGHT TO ACCESS PHI**. You have the right to inspect and copy your PHI for as long as we maintain your medical record. This includes medical and billing records, but may not include psychotherapy notes. You must make a written request for access to the Privacy Officer at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record pursuant to the State of California. In certain circumstance we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.

3. **RIGHT TO REQUEST RESTRICTIONS**. You have the right to request a restriction on the use or disclosure of your PHI for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction and AIHS is not required to notify other healthcare providers of these restrictions.

4. **RIGHT TO RESTRICT DISCLOSURE FOR SERVICES PAID BY YOU IN FULL**. You have the right to restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.

5. **RIGHT TO REQUEST AMENDMENT**. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.

6. **RIGHT TO AN ACCOUNTING OF DISCLOSURES**. You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request for an accounting, specifying the time period for the accounting, to the Privacy Officer at the address listed at the end of this Notice.

7. **RIGHT TO CONFIDENTIAL COMMUNICATIONS**. You have the right to request that we communicate with you about your PHI by certain means or at certain locations.

For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Privacy Officer at the address listed at the end of this Notice.

8. **RIGHT TO NOTICE OF BREACH**. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

D. CHANGES TO THIS NOTICE. We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI, your rights or our duties, we will revise and distribute this Notice.

E. ACKNOWLEDGMENT OF RECEIPT OF NOTICE. We will ask you to sign an acknowledgement that you received this Notice.

F. QUESTIONS AND COMPLAINTS. If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to your PHI, you may complain to us by contacting the Privacy Officer at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will proved you with the address to file such a complaint upon request.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services. Please direct any of your questions or complaints to:

Privacy/Compliance Officer
American Indian Health & Services
4141 State Street, Suite B-11
Santa Barbara, CA 93110
(805) 681-7356

AMERICAN INDIAN HEALTH & SERVICES
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of American Indian Health & Services (AIHS). Our "Notice of Privacy Practices" tells you how we may use and disclose your protected health information (PHI). We encourage you to read it in full. The following is a summary of the reasons we may use or disclose your information:

We may use your health information to provide you with medical treatment, and to arrange and coordinate your health care; to obtain payment for our services; and to conduct our health care operations, including quality assurance, fundraising, and general management and administration. We may disclose your health information for a variety of purposes in the public interest, as required or permitted by law. We will obtain your written authorization to use or disclose your health information for other purposes. There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as when you receive services in a substance abuse treatment agency.

We may change our "Notice of Policy Practices." If we change our notice, you may obtain a copy of the revised notice by contacting us a (805) 681-7356. If you wish to file a complaint regarding the use, disclosure or access to your PHI, you may submit a written complaint to AIHS at 4141 State Street, Ste. B-11, Santa Barbara, CA 93110 or to the U.S. Department of Health and Human Services. Filing a complaint will not affect your patient status with or care at AIHS.

I acknowledge that I have received a copy of the American Indian Health & Services' "Notice of Privacy Practices."

Signature: _____ Date: _____ Time: _____
(*Patient / Legal Representative*)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(*Legal Representative*)

OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain the individual's Acknowledgment was not obtained.

Reasons why the Acknowledgment was not obtained:

_____ Patient refused to sign this Acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

_____ Other: _____

Date: _____ Time: _____ AIHS Rep: _____