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

Insurance Card(s)
Driver's License/Photo ID
Tribal Identification (If you are an enrolled member of a Federally recognized tribe)
Medications in original prescription bottles

☐ Lac Vieux Desert Health Center- (Monday-Friday 7:30 a.m.- 4:00 p.m.) N5241 State HWY 45
Watersmeet, MI 49969
(906) 358-4588

Pharmacy is open Monday-Friday 7:30 a.m. to 4:30 p.m.

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

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

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

Sincerely,

The Staff of the Lac Vieux Desert Health Center

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

Insurance Carrier:	
Subscriber Name:	Policy Number:
Group Name and Number:	Insurance Phone Number:
Insurance Address:	

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

Authorization to Share Medical Information

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

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

Name	Relationship	Date of Birth	Phone Number

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

Signature:____**Date:**________________

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

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

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

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

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

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

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

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

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

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

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

CONSENT FOR TREATMENT/HIPAA
AND
AUTHORIZATION TO BILL INSURANCE

Patient Name______________________________________**DOB** ____________________________

Parent's/Guardian's Name ____

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

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

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

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

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

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

______________________________________ ________________
Patient/Legal Guardian Signature **Date**

______________________________________ ________________
Witness Signature **Date**

New Patient History Questionnaire

Today's Date:_______________________________

PLEASE COMPLETE THIS FORM AND RETURN WITH YOUR REGISTRATION PACKET

Your Name:____Date of Birth:_______________________________

What type of complaint or disease is the reason for requesting this visit?______________________________________
____

Who is your current/most recent primary care provider? ____

TELL US ABOUT YOURSELF:
Home situation (circle, or add in writing):

Single______ Married _____ Divorced ______ Widowed ______

Domestic partnership______Children?_______Are they healthy?______________

Employment:

Status: full-time_____part-time_______retired______disabled______homemaker_______

Occupation/type of work/jobs: ____

Habits: Do you smoke? No______ Yes______If yes, how many packs per day?_________________________

If you have quit, how long ago?________________________

Do you use alcohol? No______Yes______If yes, how often do you drink?___________________________

If you have quit, how long ago?_________________________

Do family or friends worry about your alcohol **intake**? ____

Have you ever had problems with drug use?____

Past Medical History:

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

MEDICATIONS:

Prescription medications	Dose	How often taken

*List additional prescriptions on back of this sheet.

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction:

____

____

____

____

____

Family History:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives:

Illness/Condition	Family Member							
	grandparent	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

SYMPTOM REVIEW

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular

- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone

- ☐ swelling of ankles or legs

Pain, weakness, or numbness in

- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General

- ☐ weight gain/loss of 10+ lbs during last 6months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat

- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent or painful urination
- ☐ blood in urine

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only

- ☐ abnormal Pap smear
- ☐ bleeding between periods
- ☐ date of last mammogram___________

Anything else?

Are you experiencing an unusually stressful situation?

Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: if YES, give approximate year given:

COVID-19	No__________	Yes_____________
Pneumococcal	No__________	Yes_____________
Influenza	No__________	Yes_____________
Hepatitis B	No__________	Yes_____________
Tetanus	No__________	Yes_____________

List any other immunizations:

____

Do you have an **advanced directive**? No ______ Yes_______

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: ____

Physician's Address: ____

Physician's Phone: ___________________________ Physician's Fax: ____________________________

Reason for Disclosure of Records: ____

These Records Are to Be Sent To

Lac Vieux Desert Health Center
PO Box 9, Watersmeet, MI 49969
Attn: Medical Records Department
Fax: 906-523-3167 Phone: 906-358-4588

Secure email: medicalrecords@lvdhealthcenter.com

Patient's Name: _________________________________ Phone #: _________________________________

Address: ____

Social Security # (Last 4 Digits): ____________________ DOB: ___________________________________

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

____ Entire Medical Record (includes all Patient Information listed below) **(Most recent records, 3 CONSECUTIVE YEARS)**

____ X-ray films (Specify type/date)
____
____ Immunizations
____ Last Mammogram
____ Last Pap

____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Most recent labs
____ Psychological or psychiatric conditions
____ Last Bone Density Testing

____ ____
Patient or Patient Representative's Signature **Today's Date**

____ ____
Representative's Name (PRINT) **Relationship to Patient (PRINT)**

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

Lac Vieux Desert Health Center Patient Policies

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

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

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

Office Hours

Our clinic is open Monday through Friday. Appointments are scheduled from 8:00 a.m. to 12:00 p.m. and 1:00 to 4:00 p.m.

We are not an emergency room or an urgent care center. If you require such services, go to the nearest Emergency Department, or call 9-1-1.

We offer walk-in appointments for sick visits or sudden minor illness or injury. Patients will be seen based on the acuity of their symptoms; and thereafter, the time of arrival.

New Patient Policy

We are accepting new patients (insured and private). We request that you complete the new patient registration forms prior to scheduling your initial appointment.

We are contracted with multiple insurance plans. If your insurance company is unable to tell you if we are an accepted provider, please call our office for assistance.

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

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

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

1. **New Patient Registration Form**: Provides basic contact and insurance information that is necessary for administrative account set-up.
2. **HIPAA Agreement**: Provides information and acknowledgement of our privacy policy.

3. **Medical History Intake Form**: Provides your future physician with basic medical and surgical history information.

4. **Authorization to Receive Medical Records:** Provides our medical records department with the ability to request your past 3 years of medical records to be sent to our facility to ensure a smooth transition of care. Our medical records department can help coordinate your records request(s). The number is (906) 358-4588, ext. 122.

Dependent on your medical history and complexity, your first visit may be a consult with the provider. Be sure to arrive 20 minutes early so all the appropriate paperwork is complete prior to your scheduled appointment time. At this time, we will decide together how we can best manage your health care needs.

Preparation for Appointment

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

Late Appointment Arrival

We strive to see all patients on time for their scheduled appointment. If you are a returning patient, please arrive 10 minutes prior to your scheduled appointment to check in. If you are a new patient, please arrive at least 20 minutes prior to your appointment to complete any outstanding new patient paperwork and registration needs. If the schedule permits, we will do everything we can to accommodate patients who arrive late, however, we will not be willing to make other patients with appointments wait. Unfortunately, if you do not arrive timely, the scheduled appointment may not be long enough to provide the quality of care you deserve.

Missed Appointment/No-Show

A missed appointment is when you fail to show up, fail to cancel, or arrive after your scheduled appointment and there is not enough time remaining for you to be seen. A reminder call is made in advance of your appointment, so please reschedule if you are unable to attend your appointment. *Some departments require a confirmation, or your appointment slot will be rebooked, and you may need to wait to be seen.

Ideally, cancellations should be made at least 24 hours prior to the appointment.

By failing to cancel or reschedule your appointment 3 or more times, we will only allow you to schedule on stand-by should someone else cancel and an appointment becomes available.

Same Day Appointments/Walk In

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

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

Treatment of Minors
To comply with Michigan Law, Lac Vieux Desert Health Center (LVDHC) requires that a parent (not stepparent or foster parent) or legal guardian (court appointed legal guardian) must provide consent, through completion of the treatment of minor consent form, prior to the medical/dental/mental health appointment for their minor child (17 years of age or younger). Any appointment which does not require a parent or legal guardian's consent shall be provided without completion of the form. A parent, legal guardian, or designated adult must also accompany the minor child unless that child is at least 16 years of age.

Time Management
We know your schedule is busy and that your time is valuable. Please let our front desk staff know if you have been waiting for more than 15 minutes so we can determine the reason for the wait. Please be considerate if the office is running behind. Emergencies occur and each patient will be treated with the same time and care it takes to address their problem, including you. Our staff is committed to keeping you informed of delays and giving you options to manage your valuable time.

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

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

Controlled Substances
We are not a pain specialist clinic and do not manage chronic opioid use and/or dependency. Patients taking chronic narcotics or currently on a drug contract are encouraged to continue to be managed by that provider. After evaluation by our providers, we will refer you to a pain management center if this specialized care is needed.

Phone Messages
To provide the best possible care to our patients and allow our scheduled patients to be seen by our medical providers without multiple interruptions, messages will be taken by other medical staff working with each provider during office hours. If the nurse is unable to answer, a message may be left on the confidential voicemail. When leaving a voicemail message, please indicate your name, the patient's name, the reason for your call, and phone number where you can be reached. The medical staff will alert the provider of your message and will call you back with a response in a timely manner. We strive to return patient calls on the same day. Non urgent calls will be returned within 48 business hours. After two unsuccessful attempts, we will mail you a letter asking you to call our facility.

Laboratory Testing

To receive lab services, you must be an active patient at Lac Vieux Desert Health Center. To ensure accurate testing is completed, we require that an order for all lab tests has been sent to our laboratory staff prior to scheduling an appointment. Please call our facility to schedule an appointment for this service.

Health Forms and Records

We understand that there are forms that may need to be completed by one of our staff and/or medical providers. These forms include, but are not limited to, disability, Family Medical Leave, school forms, prior authorizations, insurance paperwork, etc. For our office to properly complete any forms on our patients' behalf, we require the patient to complete all patient portions of any form **prior** to sending it to our office. We ask that you provide any additional information we may need to complete the provider portion of the form. In some cases, an appointment is necessary to properly complete the forms. Please allow at least 6 business days for your provider to complete any paperwork.

To ensure accuracy and safety of your medical information, all our medical records are in digital format. Copies of your medical records are available to you with a signed medical release.

VA Choice

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

Patient Dismissal

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

Filing a Complaint

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

Phone Calls

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

Financial Policies

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

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

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

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

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

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

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

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

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

Patient Bill of Rights and Responsibilities

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

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

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

- Receive considerate, respectful, and compassionate health care regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disability or any other status protected by relevant law.
- Expect courteous and helpful attention and understanding from Clinic employees.
- Obtain complete and current information regarding our knowledge of your health status, your diagnosis, treatment, and prognosis.
- Make decisions about your care. You or your legally designated representative should expect to receive information needed to give informed consent, including proposed procedures and treatment options and their risks and benefits. You have the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
- Receive prompt treatment in emergency situations, regardless of economic status.
- Have privacy and confidentiality. Communications and records pertaining to your care will be treated in confidence.
- Prepare advanced directives and receive care that meets your wishes as permitted by law.
- Ask questions or voice concerns about care or service by talking with a staff member, including management staff

To help us provide you with quality care, you are responsible for:

- Providing, to the best of your knowledge, complete and accurate medical information, including the nature of your illnesses, medications, hospitalizations, and family history ofillness, advance directives, and other matters relating to present health.
- Asking questions if you do not understand your treatment plan and making informed decisions about your care.
- Following Clinic rules as they affect patient care and cooperating with Clinic staff.
- Behave respectfully toward all health care professionals and staff/ as well as other patients and visitors
- Following medical advice and instructions given for healthcare services, and to inform your provider if you have chosen not to follow that advice.
- Providing complete, accurate and timely information about telephone number or address changes and insurance or other sources of payment for the care provided and your ability to pay for services rendered.
- Fulfilling your financial obligations for your healthcare as arranged and as promptly as possible.
- Keeping scheduled appointments or canceling them at least 24 hours in advance.
- Provide a responsible adult to provide transportation home and to remain with minor or compromised patient as directed by the provider or as indicated on discharge instructions or have premeditated clinic transportation (if applicable).