LASSEN
INDIAN HEALTH CENTER

2026 Patient Update Checklist

Thank you for entrusting us with your healthcare and dental needs. Below you will find a checklist to help you update your personal information so that we can effectively coordinate treatment and continue your care. *Please ensure that all information is either typed or written in blue or black ink and that signatures are completed by hand, as no electronic signatures can be accepted.*

Forms to Complete

- ☐ Patient Update
- ☐ Patient Update Consent
- ☐ Coordinating Care Consent
- ☐ Consent for the Treatment of a Minor
- ☐ Office Policy Reminder for Patients

LASSEN INDIAN HEALTH CENTER

2026 Patient Information Update

Each year your information needs to be updated so that we can effectively coordinate treatment and communication.

1. Patient Information

Last Name _____ First Name _____ MI _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Mailing Address same as above ☐ *Mailing* Address _____ City _____ State _____ Zip _____

2. Employment Status

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Active Military

Occupation _____ Employer Name _____ Employer Phone Number _____

3. Spouse's Employment

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Active Military

Spouse's Name (If not married, check box: ☐) _____ Employer Name _____ Employer Phone Number _____

4. **Medical** Insurance Information

a. Primary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

b. Secondary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

**Please present insurance card to receptionist*

5. **Dental** Insurance Information

a. Primary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

b. Secondary Insurance

Subscriber Name _____ Subscriber ID# _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Insurance Phone # _____

Group Name _____ Group # _____

Employer _____ Relationship to Subscriber _____

**Please present insurance card to receptionist*

6. Emergency Contact

First Name _____ Last Name _____ Phone _____ Relationship _____

Address _____ City _____ State _____ Zip _____

7. Additional Details

(A) How many members are in your household? _____

(B) What is your total yearly household income? _____

(C) Are you a Migrant Worker? ☐ No ☐ Migrant Agricultural Worker ☐ Seasonal Agricultural Worker

(D) If homeless, where do you live? ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other_____

(E) How do you access internet? ☐ No Access ☐ Mobile Device ☐ Home ☐ Work ☐ School/Library

LASSEN INDIAN HEALTH CENTER

Patient Update Consent

This agreement is entered into by and between Lassen Indian Health Center and the patient in order to be able to bill available sources for services rendered and to allow for the release of information from the patient's records to the insurance companies and/or others who may be involved in caring for the patient in the future.

1. Patient Information

Last Name	First Name	Middle	Date of Birth
_____	_____	_____	_____

2. Patient Consent

- ✓ **The Agreement Authorization:** The patient or responsible party authorizes the providers at Lassen Indian Health Center to render treatment according to the treatment plan created for the patient.
- ✓ **Authorization to Pay:** The patient authorizes Lassen Indian Health Center to receive direct payment for services rendered from the appropriate payment sources. Charges will not exceed that which is reasonable and customary.
- ✓ **Release of Information:** The patient gives permission to Lassen Indian Health Center to release information to the insurer or other agencies for the purpose of billing as well as to other individuals who may provide additional healthcare, dental care, or social services to the patient.

3. Acknowledgment & Agreement

Please place a checkmark next to the following statements to indicate that you agree and then sign below.

- ☐ I give permission to LIHC to release my information for billing purposes.
- ☐ For the purposes of collection of third-party billing, I assign my benefits to LIHC.
- ☐ I understand that I can request copies of the above information from Lassen Indian Health Center.

I authorize the release of any medical information necessary to process bills to my insurance company, and request payment of benefits to Lassen Indian Health Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Name of Patient (or Guardian) *(print)*	Signature	Date
_____	_____	_____

LASSEN INDIAN HEALTH CENTER

Coordinating Care Consent

Please list any family members or others who may be involved in coordinating care or payment for care. Please indicate what type of information may be shared.

1. Patient Information

Last Name	First Name	Middle	Date of Birth
_____	_____	_____	_____

2. Family Members or Others Involved in Care

		Indicate the Type of Information to be Shared			
Name	Relationship to Patient	Medical	Dental	Scheduling & Appointments	Billing & Insurance
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

Specific instructions or limitations: _____

3. Validation Code

Please provide a validation code to any individual who may be involved in coordinating care or payment. You will be asked for this code before information can be released over the phone.

Validation Code: _____

4. Review & Consent

We will continue to use the information on this form when communicating with family members or others involved in your care unless you make changes. Promptly notify our office staff if you wish to alter any of the above designations. To revoke this authorization, please send written notice to 795 Joaquin Street, Susanville CA 96130.

Signature of patient/parent/guardian	Relationship to Patient	Date
_____	_____	_____

LASSEN INDIAN HEALTH CENTER

Consent for Treatment of Minor

The treatment of a minor requires the unified efforts of the healthcare provider and parent or legal guardian of the child. The role of the provider is to ensure that the parent or guardian is aware of and agrees with the treatment plan.

1. Patient Information

Last Name	First Name	Middle	Date of Birth
_____	_____	_____	_____

2. Authorization & Consent for the Treatment of a Minor

The parent or legal guardian authorizes consent for Lassen Indian Health Center to arrange for or provide the following services:

1. **Healthcare** including medical examinations, routine laboratory studies, x-ray procedures and skin tests
2. **Dental** care including dental examinations, preventative use of fluorides, and necessary emergency care
3. **Mental Health** and Substance Use Disorder (S.U.D.) services including evaluation and treatment as necessary
4. **Transportation** of the child to and from another Health Facility for these services

Exceptions or special instructions: _____

_____

3. Acknowledgment & Agreement

I hereby give consent for all of the above services. This authorization shall remain effective for one year from the date signed, unless revoked sooner in writing by parent or legal guardian and delivered to Lassen Indian Health Center. This authorization is given pursuant the provisions of article 25.8 of the Civil Code of California. To revoke this authorization, please send written notice to 795 Joaquin Street, Susanville CA 96130.

Name of Patient or Parent/Legal Representative *(print)*	Signature	Date
_____	_____	_____

Official Use Only:

Scanned/Copied to Chart by: _____ (Employee Name) _____ (Date)

LASSEN
INDIAN HEALTH CENTER

OFFICE POLICY REMINDER FOR PATIENTS

The professional staff at Lassen Indian Health Center provide medical and dental services for the entire Susanville community. The licensed providers and their respective staff have developed systems for treating all those who need help.

To effectively treat each and every person needing help, office polices have been developed to expedite the flow of patients through the respective clinics. It is imperative that each patient call for an appointment. If you cannot make an appointment, please notify the office as soon as you are aware. If notice is given less than one hour prior to the scheduled appointment time, it will be considered a same-day cancelation. If you miss your appointment or arrive 10 minutes after your scheduled appointment, the appointment will be considered a no-show and will need to be rescheduled.

Same-day cancelations and no-shows are recorded. After the third no-show in a six-month period, all future appointments will be canceled, and no further appointments can be scheduled for 3 months. The patient may only be seen on a walk-in basis based off medical necessity. If there is an excessive occurrence of same-day cancellations, the patient may also be moved to a walk-in basis.

I have read and understand the above-mentioned policy.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature (*Parent or Guardian if Minor*) Date