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

## Verifications Needed

*Please provide the following the cards or documents only if they have been updated or renewed since your last visit.*

- ☐ Identification Card (ID)
- ☐ Insurance Cards
- ☐ Proof of Tribal Enrollment (If Applicable)
- ☐ Proof of Guardianship (If Applicable)

***FRONT OFFICE USE ONLY:***

Packet Reviewed for Completeness by (*initials*):_____ Date Recieved: _____

HRN Number Assigned:_____ Date Entered in RPMS: _____

Copies of Verifications Provided:

| *Yes* | *No* | |
|---|---|---|
| ☐ | ☐ | Identification Card |
| ☐ | ☐ | Insurance Cards |
| ☐ | ☐ | Proof of Tribal Enrollment (if applicable) |
| ☐ | ☐ | Proof of Guardianship (if applicable) |

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# 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

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# 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 |
|---|---|---|
| _____ | _____ | _____ |

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# 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)

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# OFFICE POLICY REMINDER FOR PATIENTS

The professional staff at Lassen Indian Health Center are committed to providing Medical and Dental services to the entire Susanville community. Our licensed providers and support teams have established systems to ensure that all patients receive timely and appropriate care.

To help us serve every patient efficiently, we have implemented office policies designed to streamline patient flow through our clinics. All patients are required to call ahead to schedule an appointment. We recommend arriving at least **15 minutes prior** to your scheduled time to allow for check-in and any updates.

If you are unable to keep your appointment, please notify the office as soon as possible. Cancellations made less than **one hour before** the scheduled appointment time will be considered a *same-day cancellation.*

Appointments will be considered a *no-show* if you:

- Miss your appointment, or
- Arrive **more than 7 minutes late**

In these cases your appointment will need to be rescheduled

Same-day cancellations and no-shows are tracked. If a patient has **three no-shows within a six-month period**, all future appointments will be canceled, and no new appointments may be scheduled for **three months**. During this time, patients may be seen on a *walk-in basis only*, depending on medical necessity.

Additionally, frequent same-day cancellations may result in the patient being moved to walk-in status.

*I have read and understand the above-mentioned policy.*

_____ _____
Patient Name Date of Birth

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