Kewa Pueblo Health Corporation

P.O. BOX 340 85 W. HIGHWAY 22
SANTO DOMINGO PUEBLO, NEW MEXICO 87052
TELEPHONE (505) 465-3060 FAX (505) 465-1178

Santo Domingo Health Center
Patient Acknowledgement Form

Initials

_____ **A) RELEASE OF INFORMATION AND ELECTRONIC HEALTH INFORMATION EXCHANGE**

Santo Domingo Health Center (SDHC) may disclose all or any reasonable part of the patient's electronic medical record to include information pertaining to medical history mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing or continuation of care to include, but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any purposes reasonably related to these activates. I understand that this authorization will remain in effect for a long term period of inpatient and outpatient services, unless revoked in writing prior to that date.

____ **B) ACKNOWLEDGEMENT OF RECEIPT OF SANTO DOMINGO HEALTH CENTER (SDHC) NOTICE OF PRIVACY PRACTICE**

I acknowledge that I have received the Notice of Privacy Practices. The Santo Domingo Health Center (SDHC) Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we are providing you, copies of the current notice are available by accessing our website at www.kp-hc.org and may be obtained throughout SDHC.

____ **C) PATIENT RIGHTS AND RESPONSIBILITY ACKNOWLEDGEMENT**

SDHC is committed to providing quality healthcare. It is our pledge to provider this care with respect and dignity. Therefore, I acknowledge I have received the Patient Rights and Responsibilities Acknowledgement form. I accept my rights and responsibilities as a patient in the educational materials given to me and consent to upload my rights and my responsibilities as a patient receiving treatment and services provided by Santo Doming Health Center.

____ **D) AMERICAN INDIANS/ALASKA NATIVES**

SDHC regulations require all patients to provide proof of Tribal Membership with a federally recognized tribe. Eligibility to receive medical services are determined by verification of tribal enrollment. Patients who do not have tribal enrollment information in their medical file are required to provide this information **within 30 days**. The Certificate of Indian Blood or other tribal enrollment identification is accepted as proof of Indian Blood. You hereby acknowledge the responsibility to provide **Proof of Indian Blood (CIB)**. This facility may bill you for any services rendered. Information on tribal enrollment may be provided to you by your respective tribal offices and/or agencies.

____ **E) MEDICAL PHOTOGRAPHY**

I consent for medical photographs to be taken of me by any KPHC provider. I understand that the information may be used in my medical records and/or for purposes of medical teaching. I understand that I will not receive payment from any party.

____ **F) MEDICAL CONSENT TO RECEIVE TREATMENT AT SDHC**

I hereby authorize and consent to receive Medical, Dental, Optometry, Behavioral Health services and any other specialty service/treatment deem necessary during appointments/walk-in visits by a licensed provider at Santo Domingo Health Center. I also understand that each clinic may have additional Treatment Consent Forms which need to be completed depending on the type of procedure performed on the visit.

____ **G) ASSIGNMENT OF BENEFITS**

Private Insurance/ Medicaid/ Medicare

I authorize the release of any medical or other information necessary to determine benefits payable for related services rendered at Santo Domingo Health Center (SDHC) by my insurance carrier. Santo Domingo Health Center (SDHC) may disclose all or any part of the patient's protected health information (PHI) to other medical entities including, but not limited to, hospital or medicals services companies, insurance companies, workmen' compensation carriers, welfare funds or the patient's employer.

I hereby assign to the Santo Domingo Health Center (SDHC) such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the SDHC valid for one year from the date listed below. I authorize payment to such benefits (if any) directly to SDHC. I understand that this assignment applies to Medical, Dental, Behavioral Health, Optometry, Pharmacy and any other services and supplies furnished to me during the period designated. Releases of protected health information (PHI) to substantiate appropriate insurance claims are authorized.

I have read and understand the contents above. Interpretation of this agreement was explained to me in English and/ or in my native language.

_____	_____	_____	_____
Patients/ Legal Guardian Signature	Patient Name (Print)	Date of Birth	Date
_____	_____	_____	
SDHC Witness Signature (PRNITED NAME)	Date	Medical Record #	

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Santo Domingo Health Center

Patient's Written Consent for Text and Instant Messaging Communication

Santo Domingo Health Center may use automatic dialers, pre-recorded voice messages, e-mails or text messaging when it communicates with you through Electronic Messaging.

How we will use Electronic Messaging: Santo Domingo Health Center may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- Reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services.
- Cancelation of appointments or clinic closures.
- How to participate in patient satisfaction surveys.
- How to use our secure patient portal.
- Information regarding the status of your referral.
- Information regarding insurance, billing, and eligibility for programs/benefits, and account balances.

Conditions for the use of Electronic Messaging: Santo Domingo Health Center will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911**.
- Urgent messages or needs should be relayed to SDHC by using regular telephone communication.
- Non-urgent messages or needs should be relayed to SDHC by using regular telephone communication or secure patient portal.
- Santo Domingo Health Center is not liable for breaches of confidentiality caused by you or any third party.
- You are responsible to report any changes to your phone number or email address to the clinic for messaging system(s) to be updated.
- Message and Data Rates May Apply and are the responsibility of the patient.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the use of Electronic Messaging between Santo Domingo Health Center, and I consent to the conditions and instructions outlined.

I understand Santo Domingo Health Center will send Electronic Messaging to the telephone number and email address in my patient chart:

- ❒ I request to receive text messages ONLY.
- ❒ I request to receive e-mail messages ONLY.
- ❒ I request to receive **both** text messages and e-mail messages.
- ❒ I decline any electronic messages.

_____	_____	_____	_____
Patient/ Legal Guardian (*Signature)*	**Patient Name (Print)**	**Date of Birth**	**Date**

_____ **Patients Cell phone # to leave messages**

_____ **Patients Email Address to send messages**