



SEMINOLE TRIBE OF FLORIDA HEALTH DEPARTMENT

**Big Cypress Health
Clinic**

**Betty Mae Jumper Health
Clinic**

**Brighton Health
Clinic**

**Immokalee Health
Clinic**

**Tampa Field
Office**

31055 Josie Billie Hwy.
Clewiston, FL 33440
Telephone (863) 983-5151
Fax (863) 983-2217

111 West Coral Way
Hollywood, FL 33021
Telephone (954) 962-2009
Fax (954) 965-1307

17201 Civic St.
Okeechobee, FL 34974
Telephone (863) 763-0271
Fax (863) 763-9698

1120 South 1st St.
Immokalee, FL 34142
Telephone (239) 867-3400
Fax (239) 657-2304

6401 Harney Rd., Suite E
Tampa, FL 33610
Telephone (813) 620-2860
Fax (813) 621-3581

REGISTRATION FOR HEALTH SERVICES

In order to register for health services at the Seminole Tribe of Florida Health Clinic you must complete a registration application and provide the required eligibility documents listed below.

- Photo I.D. (driver's license, state I.D.).
- Indian descent must be documented by one of the following:
 - Tribal Membership card or letter of enrollment; or
 - Certificate of Degree of Indian Blood (CDIB). If BIA issued also need documentation from Tribe of lineal descent; or
 - Proof by DNA test result that the individual is a first generation Descendant of the Seminole Tribe of Florida; or
 - Proof the individual is listed on the original ANCSA roll; or
 - Proof the individual is listed under the census roll of the Seminole Agency of 1957.
- Social Security card.
- Birth certificate.
- A copy of recent medical/dental records (i.e., labs, physicals, medication sheets, etc.).
- Legal documentation, if applicable (i.e., marriage/divorce certificates, adoption, legal custody, guardianship, etc.).
- Contact telephone number for Tribe (Tribe will be contacted to confirm descent) _____

STOF Newborn:

- Tribal Membership card from Indian mother or notarized paternity acknowledgement & financial responsibility form signed by the Indian father and the father's Tribal Membership card.

Non-Indian Pregnant Woman:

- Positive pregnancy test from a doctor or lab.
- Notarized paternity acknowledgement & financial responsibility form signed by the father and the father's Tribal Membership card.
- Proof of additional insurance with benefits for pregnancy or denial from Medicaid; Medicaid denial not required if married to a Seminole Tribe of Florida Member.

The Seminole Health Clinics (Big Cypress, Brighton, Hollywood and Immokalee) are federally funded Healthcare facilities. Services will be made available, as medically indicated, to persons of Indian descent from federally recognized Tribes in accordance with 42 CFR 136.11-136.25.

For Health Department use only – Confirmation of Indian descent:

Date confirmed

Name of Tribal representative

STOF staff initials



SEMINOLE TRIBE OF FLORIDA HEALTH DEPARTMENT

HEALTH SERVICES REGISTRATION FORM

Patient Name: _____
Last First Middle Suffix Nickname

Social Security #: _____ - _____ - _____ Date of Birth: _____ Sex: M F

Mailing Address: _____
(Street) (City) (State) (Zip)

Mother's Maiden Name (Biological): _____ Mother's DOB: _____ Mother's Blood Degree: _____

Father's Name (Biological): _____ Father's DOB: _____ Father's Blood Degree: _____

Adoptive Parent's Name, if Applicable: _____

Foster Parent/Legal Guardian's Name, if Applicable: _____

Race: _____ Language: _____ Religion: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Marital Status: S M D W

Student Status: Full-time Part-time Not a Student Are You a Veteran? Yes No

Home Phone: (____) _____ - _____ Day Phone: (____) _____ - _____

Alternate Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email: _____

Tribe of Membership: _____ Tribal Enrollment #: _____

Degree of Tribal Membership Blood: _____ Degree of Other Indian Blood: _____ Total Indian Blood Quantum: _____

Employer's Name: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Employer's Phone #: (____) _____ - _____ Status: Full-time Part-time Self Employed Not Employed

Primary Insurance Co: _____ Effective Date: _____

Policy #: _____ Group #: _____ Phone #: _____

Address: _____

Secondary Insurance: _____ Effective date: _____

Policy #: _____ Group #: _____ Phone #: _____

Address: _____

Do You Receive Medicare Part A Part B Effective Date: _____ Medicare #: _____

Do You Receive Medicaid: Yes No Effective Date: _____ Medicaid #: _____

City of Birth: _____ State of Birth: _____

Next of Kin: _____ Relationship: _____ Phone#: (____) _____ - _____

* By providing next of kin information, you are giving the STOF Health Department permission to contact this individual if needed.

Signature: _____ Date: _____

FOR HEALTH DEPARTMENT USE ONLY: Approval: Direct Care Only Purchased/Referred Care

Authorized By: _____ Date: _____



SEMINOLE TRIBE OF FLORIDA HEALTH DEPARTMENT

PATERNITY ACKNOWLEDGEMENT AND FINANCIAL RESPONSIBILITY FORM

I, _____ an enrolled member of the Seminole Tribe of Florida, acknowledge that I am the father of the unborn child carried by _____ a non-Seminole Tribe of Florida woman.

OR

I, _____ an enrolled member of the Seminole Tribe of Florida, acknowledge that I am the father of _____
Child's last name, first name

I understand and agree that if it is determined that the child is not of Seminole Tribe of Florida descent that I will be held responsible for reimbursing the Tribe for all medical expenses paid for the above referenced woman and/or child.

Signature

Date

Notarized:

Print, Type or Stamp Commissioned Name of Notary Public

Personally Known or Produced Identification

Type of I.D. Produced:

Notary's signature

Date



SEMINOLE TRIBE OF FLORIDA HEALTH DEPARTMENT

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

Treatment

I, the parent or legal guardian of _____, a minor child whose date of birth is _____ ("child"), hereby authorize and give my consent to the Seminole Tribe of Florida, Health Department, its physicians, dentists, and their authorized personnel to evaluate and administer medical treatment, dental treatment, medication, supplies and other items related to his/her healthcare as determined to be medically necessary to my Child. I understand that this consent is given before any specific diagnosis or treatment.

Emergency Medical Care

If Seminole Tribe of Florida Health Department personnel determine, in their professional judgment, that minor under my guardianship has an emergency medical condition and he/she needs emergency medical care and treatment, I hereby authorize the Seminole Tribe of Florida Health Department and its related health care providers to arrange for the care and treatment necessary to address his/her emergency medical condition, including but not limited to arranging for emergency transport to a hospital. I understand and agree that I may be responsible for all costs associated with such transportation and emergency care not covered by health benefits.

Other Individuals Authorized to Participate in the Child's Care

I authorize Physicians and Dentists and their authorized personnel to see, examine, evaluate and treat (including but not limited to administration of immunizations, lab work, medications, radiologic procedures and/or dental care) my Child when I am not physically present with my Child in accordance with the person(s) presenting the Child to the Health Department and who is known to my Child:

1. Primary Individual

Name and Relationship to Child

2. Secondary Individual

Name and Relationship to Child

3. Tertiary Individual

Name and Relationship to Child

This consent remains in effect for one (1) year from the date of my signature, or until revoked by me in writing or by completing a new authorization and consent for medical treatment form.

I agree that I will provide at least twenty-four (24) hour notice to the Seminole Tribe of Florida Health Department when making any changes to guardianship of minor or any changes of individuals allowed to participate in my child's care.

Parent/Legal Guardian Name (Please Print)

Signature of Parent/Legal Guardian

Date

Notary Seal

Notary's Signature

Date

Note: If you are acting in the capacity as a court ordered and appointed legal guardian, kindly supply us with a certified copy of the guardianship order evidencing such authority.

Parent or Guardian Refuses to Sign:

Signature of Seminole Tribe of Florida Health Department Staff Member

Date



**FAX REQUEST FORM TO:
(850) 922-5385**

Call (866) 804-9166 for more information regarding interpretation of results or visit www.floridanewbornscreening.com for more information about the Florida Newborn Screening Program

Results for children less than two years of age can be obtained online at: www.fnsr.net.

FS 383.14 (1) (c) allows the Department of Health to release newborn screening results to physicians, nurses, midwives, audiologists, nutritionists, and speech-language pathologists.
Please provide name & license number in the requested fields below.
Requests will not be returned without the professional license number included.

NOTES:

Requestor Contact Information

Requestor: _____

Phone #: (____) _____

License #: _____

Fax #: (____) _____

AY, ND, ME, MW, ARNP, RN, PN, OS, PA, SA

PLEASE WRITE LEGIBLY!!!!!!!

DOB	Baby's Name First & Last	Gender	Birth Order	Birth Hospital	Mother's Name First & Last	Mother's SS#

The information in this fax is confidential. Please deliver to the addressee. If you received this fax in error, please notify the sender and either destroy the faxed information, or, mail all pages back to the sender immediately. Newborn Screening is a public health function and exempt from HIPAA privacy regulations. (See: 45 CFR § 164.512(b)(i))
2014-07 Provider Request Form for NBS Results - USE THIS ONE.doc



SEMINOLE TRIBE OF FLORIDA HEALTH DEPARTMENT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Patient:** _____
Date of birth: _____ **Last 4 digits of Social Security #:** _____
Address: _____

<p>2. <input type="checkbox"/> I authorize the Seminole Tribe of Florida Health Department to release information TO:</p> <p>_____</p> <p>Name of Provider or Facility</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip Code</p> <p>_____</p> <p>Phone #/Fax # (Include area code)</p>	<p>And/Or</p> <p> </p>	<p><input type="checkbox"/> I authorize the Seminole Tribe of Florida Health Department to obtain information FROM:</p> <p>_____</p> <p>Name of Provider or Facility</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip Code</p> <p>_____</p> <p>Phone #/Fax # (Include area code)</p>
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3. **Purpose of disclosure (check one):** Patient's request Treatment purposes Assistance with legal matters
 Other _____

4. **Protected health information to be disclosed (check all that apply):**
 Entire medical record Medical records from (date) _____ through and including (date) _____
 Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)
 Description of documents or dates of service (be specific): _____

Note: Notwithstanding selections made in Section 4, "sensitive patient information" cannot be disclosed except as specifically authorized in Section 5 below.

5. **Sensitive Patient Information.** "Sensitive patient information" means information related to HIV/AIDS testing/treatment/referrals; communicable diseases, including sexually transmitted diseases; pregnancy terminations; mental health conditions/treatment (but not psychotherapy notes, which require a separate authorization form); and alcohol/drug abuse treatment/referrals. You can also attach to this form a written description of any other information that you reasonably consider to be sensitive in nature and the Department will treat that information as "sensitive patient information" too. Make your specific authorization regarding sensitive patient information:

No authorization is given to release any sensitive patient information **OR**

Disclose all information that is encompassed by my selection(s) in Section 4, even information that is related to (check all that apply):

- HIV/AIDS testing/treatment/referrals
- Communicable diseases, including sexually transmitted diseases
- Pregnancy terminations
- Mental health conditions/treatment (but not psychotherapy notes, which require a separate authorization form)
- Alcohol/drug abuse treatment/referrals
- Description of other information reasonably considered to be sensitive in nature that is to be disclosed (be specific): _____

6. Requested format: Paper format Electronic format

7. Expiration: So long as this authorization has not been canceled, this Authorization remains in effect for one (1) year from the date of my signature, unless I have specified a different expiration date or event below:

Date (optional): _____ OR Event (optional): _____

8. Explanation of rights. I understand that:

- I can revoke this Authorization at any time by giving my written revocation to: Seminole Tribe of Florida Health Department, 111 West Coral Way, Hollywood, FL 33021. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
- I may refuse to sign this Authorization. The disclosing Provider or Facility may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization, unless (1) treatment is research-related, (2) treatment is provided solely for the purpose of creating protected health information for disclosure to a third party, or (3) the disclosure is necessary to determine payment of a claim and the Authorization is not for disclosure of psychotherapy notes.
- I may inspect or copy the information to be used or disclosed under this Authorization. For protected health information that is created as part of a clinical trial, my right to access may be suspended until the clinical trial is completed, to the extent such suspension is consistent with applicable laws.
- I understand that my health information is protected under the Health Insurance Portability and Accountability Act (HIPAA). I understand that my health information specified above will be disclosed pursuant to this authorization and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy laws.
- A copy of this Authorization will be given to me.

Signature of Patient/Guardian/Legal Representative*

Date

Witness Signature

Witness's Printed Name

Legal Representative's Relationship to Patient (if applicable)

Legal Representative's Printed Name (if applicable)

**If Guardian or Legal Representative is signing on behalf of individual, please get a copy of the document showing authority of Guardian/Legal Representative to act on behalf of Individual. Examples include: Tribal Council Resolution or Order, court order appointing person, form designating person as health care surrogate or power of attorney for health care decisions.*

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE TREATED AS AN ORIGINAL

WITHDRAWAL OF AUTHORIZATION

I withdraw my authorization for the release of the information described above.

Patient signature: _____

Date: _____

Parent/Guardian/Legal Representative* signature: _____

Date: _____

Witness signature: _____ **Date:** _____

**If Guardian or Legal Representative is signing on behalf of individual, please get a copy of the document showing authority of Guardian/Legal Representative to act on behalf of Individual. Examples include: Tribal Council Resolution or Order, court order appointing person, form designating person as health care surrogate or power of attorney for health care decisions.*

**Seminole Tribe of Florida Health Department
Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Name: _____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Seminole Tribe of Florida Health Department Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Health Department's Privacy Officer:

Privacy Officer
Seminole Tribe of Florida Health Department
111 W Coral Way
Hollywood, FL 33021
954-962-2009

Signature of Individual **Date**

Signature of Parent, Guardian or Personal Representative* **Date**

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Individual Refuses to Acknowledge Receipt:

Signature of Seminole Tribe of Florida Health Department Staff Member **Date**

**NOTICE OF PRIVACY PRACTICES
FOR THE
SEMINOLE TRIBE OF FLORIDA HEALTH DEPARTMENT**

Effective Date: May 1, 2005

Revised: May 1, 2020

This notice describes how health/medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Legal Duty

We, the Seminole Tribe of Florida Health Department ("Health Department"), are required by law to maintain the privacy of your health information that we use or receive. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices described in this Notice while they are in effect.

This Notice provides you with the following information:

- How we may use and disclose your health information;
- Your privacy rights regarding your health information; and
- Our obligations concerning the use and disclosure of medical information.

We reserve the right to change our privacy practices and the terms of this Notice at any time. Any revision or amendment will be effective for all information held by us. A copy of this Notice will be posted in the waiting room of all Health Department facilities and you may request a copy of this Notice at any time.

Use and Disclosure of Health Information

We may receive or maintain health information about you for treatment and payment purposes. We also may hire business associates to help us in providing services to you. Our business associates may use the health information about you for our healthcare operations and payment, if applicable.

Treatment. We may use or disclose your protected health information ("PHI") to provide, coordinate, or manage your health care and any related services, including coordinating or managing your care with other health care providers.

Uses for Payment. If applicable, we may use and disclose your health information to obtain payment for your health care services. For example, obtaining approval for payment of services from your health plan may require that your PHI be shared with your health plan. We may also provide your PHI to our business associates such as billing companies, collection agencies, and vendors who mail billing statements.

Uses for Healthcare Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to appropriate employees in the Health Department to:

- Provide to you appointment reminders or information about treatment alternatives;
- Run the department and improve the care we provide to you; or
- Conduct training programs; or
- Arrange for accounting and legal services, business planning, business management and general administrative activities.

To You or Your Authorized Representative. We must provide your health information to you upon request, as more fully described in the "Your Rights to Health Information" section of this Notice. We will disclose your health information to an individual designated as your personal representative, attorney-in-fact, guardian, etc., so long as we receive documentation of that person's authority to act on your behalf. We can refuse to disclose information to your personal representative if we have a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- Treating such person as your personal representative could endanger you; and
- In our professional judgment, it is not in your best interest to treat the person as your personal representative.

Individuals Involved in Your Care or Payment for Your Care. We may share your health information with a friend, family member, or another person you identify who is involved in your care or payment for care if you do not object to the disclosure or you agree to share your information with them. If, for some reason such as a medical emergency, you are not able to agree or disagree, we may use our professional judgment to decide whether sharing your information is in your best interest. This includes sharing information about your location and general condition. We may also share information about you to an organization assisting in a disaster relief effort so they can notify your family about your condition, status and location.

Permitted by Law. Except as described in "Your Authorization," we may use or disclose your health information where permitted by law. For example, we may disclose information for the following purposes:

- **Assist with public health and safety issues:** We can share health information about you for certain situations such as:
 - preventing disease;
 - reporting suspected abuse, neglect or domestic violence;
 - preventing or reducing a serious threat to anyone's health or safety; or
 - assisting law enforcement officials in their law enforcement duties.
- **Research:** We do not share your identifiable health information for research purposes.
- **Comply with the law:** We will share information about you if laws require it, including sharing information with the US Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
- **Address workers' compensation, law enforcement and other government requests:** We can use or share health information about you:
 - for workers' compensation claims;
 - for law enforcement purposes or with a law enforcement official;
 - with health oversight agencies for activities authorized by law; or
 - for special government functions such as military or national security.
- **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- **Organ and Tissue Donation:** If you are an organ donor, we can share information about you for organ, eye or tissue donation purposes; provided we follow applicable laws.
- **Coroners, Medical Examiners and Funeral Directors:** We can share information about you to coroners, medical examiners or funeral directors to carry out their duties.
- **Inmates:** We can share information about you to a correctional institution having lawful custody of you that is necessary for your health and the health and safety of other individuals.

Sale of Your Health Information. We will never sell your health information without your prior authorization.

Marketing Products or Services. "Marketing" means to make a communication to you that encourages you to buy or use a product or service. We will not use or disclose your health information for marketing communications without your prior written authorization.

We may also communicate with you about health related products or services (including information about who participates in our provider network), treatment, case management or case coordination (including recommending alternative treatment, providers or settings for care.) We do not receive any payment for making these communications.

Your Authorization. Except in the situations described above, we will use and share your PHI only with your written authorization. We are not permitted to sell or rent your PHI and may not use or share your PHI for marketing or fundraising purposes without your authorization. Except in very limited circumstances, we may not use or disclose psychotherapy notes without your authorization.

In some situations, applicable law may provide special protections for sharing specific kinds of PHI and require authorization from you before we can share that specially protected medical information. For example, information about treatment for alcohol or drug abuse, HIV/AIDS and sexually transmitted diseases, and mental health may be specially protected. In these situations, and for any other purpose, we will contact you for the necessary authorization. If you give us an authorization, you may later revoke it in writing at any time.

Your Rights to Your Health Information

We may maintain records containing your health information. In some cases, our business associates will possess the information that is responsive to any of the individualized requests detailed in this section. You may contact the business associate to review that information. The business associate is obligated to provide you with the same rights as those described in this Notice. You have the following rights regarding health information that we maintain about you:

- **Access.** With limited exceptions, you have the right to review or obtain copies of your health information in electronic or paper format. We will provide a copy or summary of your health information, usually within 30 days. You also have the right to request that we send your health information to another person. Your request must be in writing and include the name and address of the person who is to receive the records.

If we do not maintain the health information that you request, but we know where the information is maintained, we will let you know where to send your request.

- **Disclosure Accounting.** You have the right to receive a list of instances in which we, or our business associates, have disclosed your health information for purposes other than treatment, payment, healthcare operations, or where you have provided us with an authorization for disclosure. You may request this list for any disclosures made in the previous 6 years.
- **Request Restrictions.** You have the right to request that we place additional restrictions on our use or disclosure of your health information, including restricting uses and disclosures to family members, relatives, friends, or other persons you have identified who are involved in your care or payment for your care. We are not required to agree to these additional restrictions except where, if applicable, you have paid for medical services out-of-pocket in full and have requested that we not disclose your PHI to a health insurance plan for payment or health care operations purposes. In that case we will agree to the restriction unless a law requires us to share that information.
- **Alternative Communications.** You have the right to request in writing that we communicate with you about your health information by alternative means or at an alternative location. Your request must specify the alternative location. For example, you can ask that we only contact you at work or by mail.

- **Amendments.** You have the right to request that we amend your health information contained in our records. Your written request must explain why the information should be amended. We may deny your request under certain circumstances.
- **Electronic Notice.** If you receive this Notice in electronic form, you have the right to request a paper copy of this Notice at any time. We will promptly provide you with a paper copy.
- **Privacy Breach Notice.** You have the right to receive a notice if we or a business associate discover a breach of your unsecured PHI and determine through an investigation that notice is required.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact the Privacy Officer at (954) 962-2009. The Privacy Officer is responsible for handling any grievances associated with our uses and disclosures of your health information. The Privacy Officer's address is:

Privacy Officer
Seminole Tribe of Florida Health Department
111 W Coral Way
Hollywood, FL 33021

If you are concerned that we may have violated your privacy rights, or you disagree with a decision made about access to your health information, or in response to a request you made related to the "Your Rights to Health Information" section of this Notice, you should contact the Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services, at the Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, D.C., 20201.

We support your right to the privacy of your health information. We will not retaliate in any way if you file a complaint with us or with the Office for Civil Rights of the U.S. Department of Health and Human Services.



ATTENTION

Please keep this brochure
for your future reference.

Thank You

SEMINOLE TRIBE OF FLORIDA HEALTH PLAN

- 111 West Coral Way
Hollywood, FL 33021
1-866-505-6789
(954) 981-7410
Fax (954) 981-1671

SEMINOLE TRIBE OF FLORIDA HEALTH CLINICS

- Betty Mae Jumper Health Clinic
111 West Coral Way
Hollywood, FL 33021
(954) 962-2009
- Big Cypress Health Clinic
31055 Josie Billie Hwy.
Clewiston, FL 33440
(863) 983-5151
- Brighton Health Clinic
17201 Civic Street
Okeechobee, FL 34974
(863) 763-0271
- Immokalee Health Clinic
1120 S. 1st Street
Immokalee, FL 34142
(239) 867-3400
- Tampa Field Office
6401 Harney Road, Suite E
Tampa, FL 33610
(813) 620-2860



Seminole Tribe of Florida
Health Department
September 2020

**SEMINOLE TRIBE OF FLORIDA
HEALTH DEPARTMENT
111 WEST CORAL WAY
HOLLYWOOD, FL 33021
(954) 962-2009**



**PATIENT BILL of RIGHTS
and RESPONSIBILITIES**



Patient Bill of Rights and Responsibilities:

This protects and supports the basic rights of an individual as it relates to basic actions of getting information, seeking healthcare, and making decisions that impact your health and wellbeing.

- **The patient has the right to:**
- be informed of your rights as a patient, prior to receiving care or upon discontinuing care.
- receive quality care and services in a dignified manner, regardless of race, sex, age, sexual orientation, or cultural, religious, economic, or educational background.
- receive comprehensive care considerate of your psychosocial, cultural, and spiritual background, delivered in a respectful manner as well as in a safe environment that supports confidentiality and privacy.
- know the name and educational background of the primary care physician, as well as other physicians and health care providers involved in your care.
- receive information from the healthcare provider regarding illness, treatment options, diagnosis, and expected recovery in easy-to-understand terms, as well as information regarding a description of procedures, its risks, and risks involved with non-treatment.

- individually, or together with your family, participate in the development and implementation of your plan of care.
- refuse treatment as permitted by law.
- formulate Advance Directives and have caregivers comply with the directives.
- be given information regarding the Seminole Health Department grievance process.
- access medical records or information, within a reasonable timeframe.

When seeking healthcare, it is the patient's responsibility to:

- provide accurate information regarding your health status, symptoms, medications, past medical conditions, and anything that applies to your current health.
- report changes in conditions.
- seek clarification and ask questions when you do not understand information received.
- follow instructions given to you.
- keep appointments and reschedule in a timely manner, if needed.
- if desired, complete Advance Directives and identify a Healthcare Surrogate in the event that you cannot make decisions about healthcare and treatment.
- behave in a courteous and respectful manner.

Seminole Tribe of Florida Health Administration

111 West Coral Way
Hollywood, FL 33021
(954) 962-2009

