



DENA'INA  
WELLNESS  
CENTER

www.kenaitze.org

Phone: 907-335-7500 • FAX: 888-491-3360

508 Upland St. • Kenai, AK 99611

## Documents Needed to Register

### New Adult Patients

- Completed registration
- Initialed and signed HIPAA
  - Must have valid photo ID
- CIB and/or tribal card
- Insurance card(s) if applicable
- Adults with CIB will be PRC & Direct and Beneficiary
- Adults without CIB yet, will be Pending and Non-Beneficiary

### Non-Native Spouse

- Completed registration
- Initialed and signed HIPAA
- Valid photo ID (Patient and Spouse) CIB and Marriage Certificate
- Insurance card(s) if applicable
- Must have social security number for billing purposes
- Non-native spouse will be billed for visit after insurance has been billed if applicable
- Add non-beneficiary

### New Child Patients

- Completed registration
- Initialed and signed HIPAA by parent/guardian
- CIB or parent's CIB/tribal card\*
  - \*Birth certificate is needed if using a parent's CIB
- Insurance(s) if applicable

**Adopted children** – Able to use parents CIB until the age of 18

**Step-children** – Able to use step-parents CIB until the age of 18.

Child with own CIB will be PRC & Direct and Beneficiary

Child without CIB will be Pending and Non-Beneficiary

Child with parent CIB AND birth certificate will be Beneficiary and Pending

(If only one of the above, child is Non-Beneficiary and Pending)

### Non Native Significant Other (NNOS) Pregnant

- Statement of paternity
- Verification of pregnancy if available
- Photo ID of both him and her
- His tribal card/CIB
- Eligibility is Direct only and Non-beneficiary
- NNSO is only eligible for services during pregnancy
- NNOS must provide statement of paternity with each pregnancy

Remember to enter in notes when receiving documents such as:

- CIB/tribal card
- Insurance cards
- Paternity statements
- Authorization to share information



# Dena'ina Wellness Center Registration

DATE \_\_\_\_\_

ADULT  YOUTH  MALE  FEMALE

NAME \_\_\_\_\_ PREVIOUS NAMES USED \_\_\_\_\_  
FIRST MIDDLE LAST SUFFIX IF APPLICABLE

DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
ADDRESS CITY STATE ZIP

PHYSICAL ADDRESS \_\_\_\_\_

HOW LONG HAVE YOU LIVED HERE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_  
CITY STATE

PREFERRED METHOD OF CONTACT – HOME  CELL  EMAIL  \_\_\_\_\_

RACE: (check as many as apply)

- WHITE
- \*ALASKA NATIVE/AMERICAN INDIAN
- BLACK
- HISPANIC
- ASIAN
- HAWAIIAN or PACIFIC ISLANDER
- OTHER \_\_\_\_\_

PRIMARY LANGUAGE \_\_\_\_\_

DO YOU NEED AN INTERPRETER?  YES  NO

EMERGENCY CONTACT  
\_\_\_\_\_

NEXT OF KIN  
\_\_\_\_\_

YOUR RELATIONSHIP TO CONTACT  
\_\_\_\_\_

YOUR RELATIONSHIP TO CONTACT  
\_\_\_\_\_

ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE(S) \_\_\_\_\_

PHONE(S) \_\_\_\_\_

VETERAN STATUS:  VETERAN  NON-VETERAN  SERVED DURING VIETNAM  RECEIVING DISABILITY

BRANCH \_\_\_\_\_ SERVICE ENTRY DATE \_\_\_\_\_ SERVICE SEPARATION DATE \_\_\_\_\_

DO YOU HAVE A VALID VA CARD: \_\_\_ YES \_\_\_ NO \*if yes, please provide card to receptionist

\*PARENT/ GUARDIAN INFORMATION - FOR YOUTH

FATHERS NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_ EMPLOYER \_\_\_\_\_

MOTHERS MAIDEN NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_ EMPLOYER \_\_\_\_\_

\*INSURANCE – PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) TO RECEPTIONIST\* IF YOU DON'T HAVE A CARD AVAILABLE, COMPLETE THE FOLLOWING:

\_\_\_ MEDICAID OR DENALI KID CARE ID # \_\_\_\_\_

\_\_\_ MEDICARE ID # / SUFFIX \_\_\_\_\_ PART B EFFECTIVE DATE \_\_\_\_\_

\_\_\_ PRIVATE INSURANCE \_\_\_\_\_ ID # \_\_\_\_\_

GROUP # \_\_\_\_\_ POLICY HOLDER/SPONSOR NAME \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_ SELF PAY

NUMBER IN HOUSEHOLD \_\_\_\_\_ ARE YOU HOMELESS \_\_\_ YES \_\_\_ NO ARE YOU A MIGRANT WORKER \_\_\_ YES \_\_\_ NO

ANNUAL HOUSEHOLD INCOME -  \$0-25,000  \$25,001-40,000  \$40,001-70,000  \$70,001 +

DO WE HAVE PERMISSION TO SEND GENERIC INFORMATION  YES  NO

DO YOU HAVE INTERNET ACCESS? YES  NO  E-MAIL \_\_\_\_\_

WHAT LOCATIONS DO YOU ACCESS THE INTERNET?  HOME  WORK  SCHOOL  MOBILE  LIBRARY

HAVE YOU EVER BEEN SEEN AT ALASKA NATIVE MEDICAL CENTER OR SOUTH CENTRAL FOUNDATION? \_\_\_ YES \_\_\_ NO

YOU MAY BE ELIGIBLE FOR ADDITIONAL HEALTH CARE RESOURCES? WOULD YOU BE INTERESTED IN SPEAKING WITH ONE OF OUR FAMILY HEALTH RESOURCE TECHS TO FIND OUT IF YOU QUALIFY? \_\_\_ YES \_\_\_ NO

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## IMPORTANT AUTHORIZATION and NOTICES

### CONSENT FOR TREATMENT (Initials \_\_\_\_\_)

I, \_\_\_\_\_, authorize the staff of the Kenaitze Indian Tribe's Dena'ina Wellness Center to render services that are deemed necessary for the care of myself or my minor child.

### ASSIGNMENT OF MEDICAL BENEFIT (Initials \_\_\_\_\_)

I authorize direct payment to Kenaitze Indian Tribe of any insurance benefits filed on behalf of the patient; I understand and agree that I am ultimately responsible for all charges associated with treatment. And if after 45 days the insurance company has not settled billed claims, I will be responsible for the balance in full at that time.

### AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES (Initials \_\_\_\_\_)

I authorize Kenaitze Indian Tribe to furnish information regarding my treatment to my insurance company or, in the case of continued care, the requesting facility/physician. I understand that any insurance claim made on my behalf by Kenaitze Indian Tribe is strictly a courtesy provided by the staff. Except for Medicaid and Denali KidCare.

### NOTICE OF PRIVACY PRACTICES and PATIENT RIGHTS (Initials \_\_\_\_\_)

I further acknowledge that I have had the opportunity to read and receive a copy of the Notice of Privacy Practices and the Patient's Rights and Responsibilities as provided by Kenaitze Indian Tribe.

### OFFICE BILLING POLICY:

I understand that it is KIT's office policy to be paid at the time of service. If covered by insurance (after verification by the billing department), I will be responsible for any and all portions not covered by my insurance. To include, but not limited to, co-pay's, deductibles, etc. I will be required to pay for any non-covered services at the time of service. (Initials \_\_\_\_\_)

I understand that if I fail to supply Medicaid/Denali KidCare information as required by state law, that I will be responsible for all charges for services received at Kenaitze Indian Tribe. (Initials \_\_\_\_\_)

I understand that Kenaitze Indian Tribe uses an outside collection agency for delinquent accounts.

(Initials \_\_\_\_\_)

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Printed Name

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Signature

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Date

*If not signed, reason why acknowledgement was not obtained:*

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DENA'INA  
WELLNESS  
CENTER

## RELEASE OF INFORMATION

Please complete the follow paperwork; this will allow your new provider access to records that may be pertinent to your continuing care.

- Complete one form for each provider/facility where you have received care in the last 5 years.
- Include all specialty clinics

FRONT DESK STAFF IS AVAILABLE TO ASSIST YOU.

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## KENAITZE INDIAN TRIBE HEALTH SERVICES

### AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Records needed for continuing medical care are provided free, there may be a charge for other requests

Authorization for Release of Confidential Health Information is specific to the following KIT Program:

- Medical    
  Dental    
  Behavioral Health    
  Chemical Dependency    
  School Based

Name of Patient/Client (Last, First, MI)	Date of Birth	Previous or Other Names used
Address	City, State, Zip	Telephone # Alternate #

#### REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION ALONG WITH THIS FORM

<b>The information is to be disclosed by:</b>		<b>And is to be released to:</b>	
Name of KIT Agency/Department		Name of Individual Receiving Records	
Address		Agency Name <b>DENA'INA WELLNESS CENTER</b> and Address <b>508 UPLAND ST</b>	
City, State, Zip		City, State, Zip <b>KENAI, AK 99611</b>	
Phone #	Fax #	Phone # <b>907-335-7500</b>	Fax # <b>888-491-3360</b>

I authorize the communication to be exchanged in/by:  
 Writing  
 Verbally  
 Electronically  
 Fax

I authorize the use/disclosure of health information about the above name individual/entity as described below for the following dates and purposes:

- From \_\_\_\_\_ to \_\_\_\_\_
- Only information related to (Specify injury, accident or particular illness/treatment): \_\_\_\_\_  
 Entire record for all dates of service.  
 Billing statements for the following dates/treatment: \_\_\_\_\_  
 Other information specified below.

**Description of specific, including sensitive, information to be disclosed, please initial all applicable box(s) below:**

<input type="checkbox"/>	Medical Records	<input type="checkbox"/>	Program Attendance/Compliance	<input type="checkbox"/>	Psychological/Psychiatric Assessment
<input type="checkbox"/>	Lab / Pathology Reports	<input type="checkbox"/>	Substance Abuse Assessment	<input type="checkbox"/>	Discharge Summary, Plan, Status
<input type="checkbox"/>	Radiology Reports	<input type="checkbox"/>	Mental Health Assessment	<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Medication list	<input type="checkbox"/>	Treatment Plan/Recommendations	<input type="checkbox"/>	School Performance/Records
<input type="checkbox"/>	Dental /History /X-Ray	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	HIV Infection/AIDS

The information will be disclosed for the following purposes (**REQUESTOR MUST CHOOSE ONE OF THE FOLLOWING**):

- Customer Transferring Care to Other Hospital/Clinic  
 Attorney  
 Insurance  
 Disability  
 Military  
 At the request of the individual or Personal Representative

For Court Ordered Individuals:

\_\_\_\_ (initials) I understand this Release of Information is a condition of my treatment and services will not be provided should I refuse to sign.

I understand that my records are protected under HIPAA and may also be further protected under 42 CFR, Part 2 (substance abuse diagnosis or treatment related records). I understand these records cannot be disclosed without my written consent, unless otherwise provided for by law, and that in most cases (see exception for court ordered participation), KIT cannot condition my treatment, enrollment in a health plan, or eligibility for health care benefits on my failure to sign the authorization. I am aware that, but for records protected under 42 CFR Part 2, there is a potential that records disclosed under this authorization are subject to re-disclosure and are no longer protected under HIPAA. I am aware that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires:

\_\_\_\_\_ One year from date signed, or: \_\_\_\_\_

Signature of Individual: \_\_\_\_\_  
 Signature of Parent/Guardian: \_\_\_\_\_  
 Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_

This information has been disclosed to you from records protected by Federal Confidentiality Rules, including HIPAA and potentially 42 CFR Part 2). If these records are governed by 42 CFR Part 2, you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains to or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally and investigate or prosecute any alcohol or drug abuse client.

**Verification of Identity and Authority**

Form of Identification: \_\_\_\_\_  
 Documentation of Authority \_\_\_\_\_

Date Received: \_\_\_\_\_

- Original** authorization maintained in Health Record/EHR    
 **Copy** of form to patient

**Instructions for Completing Kenaitze Indian Tribe Health Services  
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. Print legibly in all fields using dark permanent ink. Incomplete information may cause a delay in the process.
2. Print your legal name or the legal name of the individual whose information is to be released.
3. Print the name, address and phone number of the facility releasing the information.
4. Provide the name of the person, agency name, address and phone number that will receive the information.
5. Provide a reason why the information is required, e.g. disability claim, continuing medical care, legal, etc.
6. If a *different* expiration date is desired, specify a new date. The date cannot extend past one year.
7. A copy of this completed *Authorization to Release Information* form will be provided to you.
8. Please note: Release of Records is usually processed and completed within 10 working days. However, the process may take longer if your records have been archived. Requests are responded to in the order received.

**Revocation of Consent for Release of Confidential Information**

I, \_\_\_\_\_, hereby revoke the authorization to release information I provided to Kenaitze Indian Tribe Health Services (Dena'ina Health Clinic, Dena'ina Dental Clinic, and Nakenu Family Center) to use and disclose my protected health information as I outlined on the authorization form, which I signed on \_\_\_\_\_ (**Date of Authorization**) for release of my protected health information to \_\_\_\_\_ (**Name of Person or Entity**). I understand that this revocation does not apply to any action of the Kenaitze Indian Tribe Health Services has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to the Kenaitze Indian Tribe Health Services.

**SPECIAL PROVISIONS (optional)**

In this section, the individual should outline any special provisions regarding the revocation of authorization.

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<hr/> Full Name (printed)	<hr/> Signature	<hr/> Date
<hr/> Personnel Name	<hr/> Personnel Signature	<hr/> Date
<hr/> Program Director Name	<hr/> Program Director Signature	<hr/> Date