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 with 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
NNOS 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 PRIMARY LANGUAGE___________________________________________

____* ALASKA NATIVE/AMERICAN INDIAN DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO

____ BLACK

____ HISPANIC

____ ASIAN

____ HAWAIIAN or PACIFIC ISLANDER

____ OTHER ____________________

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 _________)

________________________         _____________________________       _______________
Printed Name         Signature     Date

If not signed, reason why acknowledgement was not obtained:

__________________________________________________________________________________________
RELEASE OF INFORMATION

Please complete the following 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.
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**

<table>
<thead>
<tr>
<th>The information is to be disclosed by:</th>
<th>And is to be released to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of KIT Agency/Department</td>
<td>Name of Individual</td>
</tr>
<tr>
<td>Address</td>
<td>Agency Name</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td>DENA’INA WELLNESS CENTER</td>
</tr>
<tr>
<td></td>
<td>508 UPLAND ST</td>
</tr>
<tr>
<td>Phone #</td>
<td>Phone #</td>
</tr>
<tr>
<td>Fax #</td>
<td>Fax #</td>
</tr>
<tr>
<td></td>
<td>907-335-7500</td>
</tr>
<tr>
<td></td>
<td>888-490-2368</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Medical Records</th>
<th>Program Attendance/Compliance</th>
<th>Psychological/Psychiatric Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab / Pathology Reports</td>
<td>Substance Abuse Assessment</td>
<td>Discharge Summary, Plan, Status</td>
</tr>
<tr>
<td>Radiology Reports</td>
<td>Mental Health Assessment</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Medication List</td>
<td>Treatment Plan/Recommendations</td>
<td>School Performance/Records</td>
</tr>
<tr>
<td>Dental / History / X-Ray</td>
<td>Sexually Transmitted Disease</td>
<td>HIV Infection/AIDS</td>
</tr>
</tbody>
</table>

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:
Date:_______________________

__________________________
Signature of Parent/Guardian:  Date:_______________________

__________________________
Signature of Witness:  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 investigate or prosecute any alcohol or drug abuse client.

**Verification of Identity and Authority**

Form of Identification: _________________________________  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.

__________________________________________________________________________

__________________________________________________________________________

________________________________________  __________________________________  __________
Full Name (printed)                       Signature                                      Date

________________________________________  __________________________________  __________
Personnel Name                             Personnel Signature                         Date

________________________________________  __________________________________  __________
Program Director Name                      Program Director Signature                  Date