DENA'INA
WELLNESS
CENTER

508 Upland St. • Kenai, AK 99611 | Phone: 907-335-7500 • FAX: 888-491-3360 | www.kenaitze.org

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
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
_____

YOUR RELATIONSHIP TO CONTACT
_____

ADDRESS_____

PHONE(S) _____

NEXT OF KIN
_____

YOUR RELATIONSHIP TO CONTACT
_____

ADDRESS_____

PHONE(S) _____

VETERAN STATUS: ____ VETERAN ___ NON-VETERAN ___ SERVED DURING VIETNAM ___ RECIEVING 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 than 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:

_____

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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

The information is to be disclosed by:		**And is to be released to:**	
Name of KIT Agency/Department		Name of Individual Receiving Records	
Address		Agency Name **DENA'INA WELLNESS CENTER** and Address **508 UPLAND ST**	
City, State, Zip		City, State, Zip **KENAI, AK 99611**	
Phone #	Fax #	Phone # **907-335-7500**	Fax # **888-490-2368**

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:

	Medical Records		Program Attendance/Compliance		Psychological/Psychiatric Assessment
	Lab / Pathology Reports		Substance Abuse Assessment		Discharge Summary, Plan, Status
	Radiology Reports		Mental Health Assessment		Diagnosis
	Medication list		Treatment Plan/Recommendations		School Performance/Records
	Dental /History /X-Ray		Sexually Transmitted Disease		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: _____ 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: _____

Documentation of Authority _____

□ **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