IFHC PATIENT REGISTRATION

OFFICE USE ONLY: NEW CHART: ☐ UPDATE: ☐

Section 1 – Personal Information

Name: _____
LAST NAME FIRST NAME MIDDLE NAME SUFFIX

Other Names Used: _____ **SEX: M OR F**

Date of Birth: _____ Age: _____ Social Security #: _____-_____-_____

Tribal Affiliation: _____

Enrolled: ☐ Yes – Enrollment Number: _____

☐ No – If no: Are you a Descendant: ☐ Yes ☐ No

Address: _____
Street Number or P.O. Box Number City State Zip Code

Present County: _____
County

Preferred Telephone: ☐ Home: (____) _____ Area Code ☐ Cell: (____) _____ Area Code

☐ Message: (____) _____ Area Code ☐ Work: (____) _____ Area Code

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed/Widower

Birth Place: _____
City/Town State

Section 2 – Reminders

HOW WOULD YOU LIKE TO RECEIVE REMINDERS? ☐ Telephone ☐ Mail

Can you access the Internet? ☐ Yes ☐ No

If yes, how do you have access? ☐ Home ☐ Health Care Facility ☐ School ☐ Work ☐ Library ☐ Mobile Device ☐ Tribal/ Community Center

Please mark all that apply.

Section 3 – Family Information

Father's Name: _____ Birthplace: _____
LAST NAME FIRST MIDDLE City/Town State

Mother's Maiden Name: _____ Birthplace: _____

Section 4 – Insurance Information

DO YOU HAVE ANY OF THE FOLLOWING FORMST OF INSURANCE?

Medicare: ☐ Yes ☐ No **Railroad Insurance: ☐ Yes ☐ No** **Other: ☐ Yes ☐ No**

Medicaid: ☐ Yes ☐ No **Private Insurance: ☐ Yes ☐ No**

If yes, please provide the following information and present your card, Thank You:

Policy Name: _____ Policy Number: _____ Effective Date: _____
Month/Day/Year

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Relationship to Insured: _____
Month/Day/Year

Group Name: _____ Group Number: _____

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Section 5 – Emergency Contact Information

Emergency Contact: _____ Relationship to You: _____
LAST NAME FIRST NAME

EC Address: _____
Street Number or P.O. Box Number State Zip Code

Telephone: (_____) _____
Area Code

Section 6 – Employment Information

If you are the parent or guardian completing this application for a minor dependent, please provide employment information as the guarantor of your dependent

If you are currently unemployed please check one of the following situations which apply:

□**RETIRED** □**SOCIAL SECURITY** □ **SSDI** □ **UNEMPLOYED**

Employer Name: _____

Employer Address: _____
City/Town State

Employer Phone Number: (_____) _____
Area Code

Section 7 – Veteran Information

ARE YOU A VETERAN OR CURRENTLY SERVIING IN THE MILITARY? □ No □ Yes

Section 8 – OPTIONAL – Ethnicity, Race, Language, Homeless, Migrant Worker, Household Size and Income

The Indian Family Health Clinic collects data in relation to ethnicity, race, language, homelessness, migrant worker status, household size and income for federal reporting purposes. The Indian Family Health Clinic uses this data to aid in maintaining the current level of services we provide and to procure additional funding when available to enhance already existing services and/or to add additional services.

Ethnic background is separate and different from race. An example of ethnicity in Native American Culture would be Blackfeet, Turtle Mountain Chippewa Cree, Fort Belknap Assiniboine or Fort Belknap Gros Ventre, Crow, Navajo. An example of race in Native American Culture is American Indian/Alaskan Native. The federal government has been collecting data in regards to Hispanic or Latino ethnicity and uses this data to provide a wide range of services in your community including health care services. Please check the following boxes as they pertain to your ethnicity and race. You are not required to answer these questions and you can decline to answer them.

Race:

□ Declined to Answer
□ American Indian/ Alaska Native
□ White
□ Black/African American
□ Native Hawaiian/ South Pacific Islander
□ Asian
□ Unknown

Ethnicity:

□ Declined to Answer
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown

PRIMARY LANGUAGE SPOKEN: _____ Other Language(s) Spoken: _____

Preferred Language: _____ Interpreter Required? □ Yes □ No

ARE YOU CURRENTLY HOMELESS? □ No □ Yes (If Yes, please provide the following information as to where you are residing):

□ Homeless Shelter
□ Transitional Facility
□ Doubling Up
□ Streets
□ Other
□ Unknown

ARE YOU CURRENTLY WORKING AS A MIGRANT WORKER? □ No □ Yes (If Yes, (please provide the following information):

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□ Migrant Agricultural Worker □ Migrant Agricultural Worker (Seasonal)

TOTAL NUMBER OF PEOPLE CURRENTLY RESIDING IN YOUR HOUSEHOLD: _____

TOTAL HOUSEHOLD INCOME OF ALL RESIDENTS: _____

Please indicate either: □ Weekly □ Bi-weekly □ Monthly □ Yearly

I understand the information given by me and/or collected is necessary for the Indian Family Health Clinic to provide services for my health care and well-being furthermore; I have been informed that my health records shall not be disclosed to any other agency or person. I certify the information given in this application for medical services provided at the Indian Family Health Clinic is true and accurate to the best of my knowledge.

Patient/Client Signature: _____ Date: _____
Month/Day/Year

IFHC

Notice for Disclosure of Information

Assignment of Benefits and Release of Information

This form allows us to bill your insurance and provide you medical treatment, products, supplies and/or services rendered by IFHC.

My signature on the line below authorizes any and all of the following:

I request payment of authorized Medicare, Medicaid, Private or other insurance be made on my behalf directly to the IFHC for any medical treatment, products, supplies or services rendered by the IFHC. I hereby authorize any holder of medical information about me to release to my insurance carrier or any agency or representative of said insurance company for the purpose of obtaining payment for services provided to me. I also authorized the review of my records including medical records by any Federal, State or accrediting body or agency as required by the regulatory, licensing or accrediting body. I will allow IFHC to obtain any information necessary in order to process my claim(s) and to contact me by phone or mail regarding my medical treatment, products, supplies, or services or other medical information.

Print Client Name: _____

Client Signature: _____ **Date:** _____

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SUMMARY Notice of Privacy Practices and Acknowledgment Form

This page describes how medical information about you may be used and shared and how you can get access to this information. ***Please review it carefully.***

Our Pledge Regarding Health Information:
We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of care and services you receive at the Indian Family Health Clinic (IFHC). We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by IFHC whether made by IFHC personnel or your doctor. This notice will tell you about the ways in which we may use and share medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

How We May Use and Share Health Information About You:
We may use your health information to provide you with medical treatment, and to arrange and coordinate your health care; to obtain payment for our services; and to conduct our health care operations, including quality assurance, fundraising, and general management and administration. We may disclose your health information for a variety of purposes in the public interest, as required or permitted by law. We will obtain your written authorization to use or disclose your health information for other purposes. There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared, such as when you receive services in a substance abuse treatment agency.

Your Health Information Rights:
You have a right to inspect, copy, and/or amend your health information. You also have a right to know with whom we shared your medical information. You have a right to request restrictions on the disclosure of health information to others. You have a right to confidential communications about your treatment or services.

Who Will Follow This Notice:

- This summary describes IFHC's practices and that of:
- All health care professionals authorized to see or enter information into your medical chart.
- All sites, locations, departments and units of IFHC.
- All employees, staff, consultants, volunteers and other health care personnel.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices.
- Follow the terms of the notice that are currently in effect.

If you believe that your privacy rights have NOT been maintained, you can file a complaint with the Secretary of the US Department of Health & Human Services, or with the IFHC's Executive Director. Submit your complaint in writing to Wes Old Coyote, Interim Executive Director, or by phone at (406) 268-1587.

This is a summary prior to your review of the complete Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Indian Family Health Clinic's Notice of Privacy Practices.

CLIENT PRINTED NAME	CLIENT SIGNATURE	DATE

Patient/Client declined to sign (staff signature)

STAFF NAME	DATE