KODIAK COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

MR#_____

PLEASE GIVE YOUR INSURANCE CARD AND PICTURE ID TO THE FRONT DESK

Our federal grant requires us to collect and report on this information, in an effort to provide culturally competent healthcare services. The information is reported on the population as a whole, not by specific individual.

PATIENT DEMOGRAPHICS

Patient's **First Name**: **Middle:** **Last Name:**

Social Security Number: | **Sex:** ☐ F ☐ M | **Date of Birth:** | **Age:** | **Patient is a Minor:** ☐ Yes ☐ No

Mailing Address: | **City and State:** | **Zip:**

Home Phone Number: ( ) | **Work Phone Number:** ( ) | **Mobile Phone Number:** ( ) | **Text for appt reminders:** ☐ Yes ☐ No **# to Text:**

E-mail: | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Language Spoken: ☐ English ☐ Spanish ☐ Tagalog ☐ Other: | **Veteran Status:** ☐ Yes ☐ No

Ethnic Group: ☐ Hispanic ☐ Non- Hispanic ☐ Patient Refused ☐ Other:

Race: ☐ Asian ☐ White/ Caucasian ☐ Black/ African American ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian ☐ Alaskan Native ☐ Patient Refused ☐ Other:

ADDITIONAL DEMOGRAPHICS

Sexual Orientation

☐ Straight (not lesbian or Gay) ☐ Something Else
☐ Lesbian or Gay ☐ Don't Know
☐ Bisexual ☐ Choose Not to Disclose

Gender Identity

☐ Female ☐ Transgender Female
☐ Male ☐ Transgender Male
☐ Other ☐ Choose Not to Disclose

Preferred Pronoun: ☐ she/ her ☐ he/him ☐ they/ them ☐ ze/zim ☐ declines to answer ☐ unknown

EMERGENCY CONTACT

Name of Emergency Contact:	Legal guardian: ☐ Yes ☐ No	Relationship to patient:	Home Phone No:	Cell Phone No:
Name of Emergency Contact:	Legal guardian: ☐ Yes ☐ No	Relationship to patient:	Home Phone No:	Cell Phone No:

EMPLOYMENT INFORMATION

Employment Status: (part/ full time, etc.) | Employer: | Address:

INSURANCE INFORMATION

Financially Responsible Party Name (who is paying): | Relationship to patient: | Social Security Number: | Date of Birth:

Do you have Insurance? ☐ Yes ☐ No | Insurance Name:

Subscriber Name: | Subscriber DOB: | Subscriber SSN:

FEDERAL POVERTY INCOME GUIDELINES

Interested in Sliding Fee Discount Program: ☐ Yes ☐ No | **Living in Public Housing: ☐ Yes ☐ No**

Annual Income: Circle the number of people living in your household and household income (or range) on the same line where the household size is circled. This information is NOT associated with the Sliding Fee Discount Program.

Household Size	Less Than	Between	Between	Between	More Than
1	14,840	14,841 – 19,737	19,001 – 24,000	24,001 – 29,000	29,001
2	20,020	20,021 – 26,627	26,001 – 33,000	33,001 – 40,000	40,001
3	25,200	25,201 – 33,000	33,001 – 41,000	41,001 – 50,000	50,001
4	30,380	30,001 – 40,000	40,001 – 50,000	50,001 – 60,000	60,001
5	35,560	35,001 – 47,000	47,001 – 59,000	59,001 – 71,000	71,001
6	40,740	40,001 – 54,000	54,001 – 67,000	67,001 – 81,000	81,001
7	45,920	45,001 – 61,000	61,001 – 76,000	76,001 – 91,000	91,001

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize KCHC or insurance company to release any information required to process my claims.

_____

Patient/Guardian Signature **Date**

KODIAK COMMUNITY HEALTH CENTER

MR #_____
1911 East Rezanof Dr
Kodiak, AK 99615
Phone: (907) 481-5000
Fax: (907) 481-5030

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician credentialing.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Kodiak Community Health Center has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Signature:
I have received a copy of the Notice of Privacy Practices for Kodiak Community Health Center and understand the above information.

_____
Name of Patient (Print)

_____
Patient's Date of Birth

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

KODIAK COMMUNITY HEALTH CENTER

MR #_____
1911 East Rezanof Dr
Kodiak, AK 99615
Phone: (907) 481-5000
Fax: (907) 481-5030

CONSENT TO TREAT & PATIENT RESPONSIBILITIES

Patients have responsibilities, and we ask that you make every effort to:

1. Follow all Kodiak Community Health Center rules and policies.
2. Attend appointments on time.
3. Call to reschedule or cancel appointments within 24 hours **prior** to your scheduled appointment time.
4. Consider the rights of others and treat them with respect, including other patients and KCHC staff.
5. Conduct yourself appropriately to all KCHC staff.
6. Using profanity, raising your voice, or making threats are grounds for immediate discharge of your patient care and you will no longer be eligible to be seen at KCHC.
7. The services provided at the KCHC are a privilege and we reserve the right to refuse service to anyone.
8. Make a good faith effort to meet all financial obligations and to provide all documentation necessary to apply for our Sliding Fee Discount Program if applying.
9. Follow the recommended treatment plan.
10. Provide KCHC with full information about your medical/dental history and health care.
11. Know what medications that you are taking, why you are taking them and the proper way to take them.
12. Inform KCHC of the effectiveness of the treatment that you are receiving.
13. Inform your health care provider of any changes in your health.
14. Contact us immediately if you have any questions about your bill or you have financial problems.
15. Provide us with full information about availability of any health insurance coverage. I authorize KCHC or insurance company to release any information required to process claims, and I will provide all documentation to bill my insurance company effectively.
16. I authorize my insurance benefits be paid directly to the physician.
17. I understand that I am financially responsible for any balance. Should the account be referred to a collection agency I shall pay all delinquent accounts and bear the payment of accrued interest and fees.
18. I agree to notify KCHC immediately of any changes to my address, telephone number and/or insurance eligibility status.
19. **I AUTHORIZE TREATMENT AT KCHC. I have read and understand the Patient Responsibilities:**

_____ _____

Signature of Patient/Guardian **Date**

_____

Printed Name of Patient

_____ _____

Witness Date

KODIAK COMMUNITY HEALTH CENTER

1911 E. Rezanof Dr.
Kodiak, AK 99615
Phone: (907) 481-5000
Fax: (907) 481-5030

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to the information and records we have about your health, health status, and the healthcare and service you receive at this office. This notice describes information about the privacy practices that are followed by our employees. We are required by law to give you this notice. It will tell you about the ways in which we may disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, healthcare operations and special situations allowed or required by law.

Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. Some examples of this would include a physical examination, or a referral to a specialist.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Special Situations may include subpoena, workers' compensation, law enforcement, coroners, health oversight activities, situations to avert a serious threat to health or safety, or other situations allowed or required by law. An example would be a subpoena received from a court of law requesting health information.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

We may use your health information to contact you to confirm your appointments.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Kodiak Community Health Center
Attn: Director of Operations
1911 E. Rezanof Dr.
Kodiak, AK 99615
(907) 481-5000

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address above.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date of this Notice

This Notice is effective on or after January 6, 2004.

Requesting an appointment has never been so easy

Sign up for *MyChart*, our *FREE* patient website to access your KCHC health records. Sign up is fast, easy, and you never have to listen to on-hold music again!

- Request or change an appointment
- Securely email your KCHC Provider
- View lab results
- Request prescription refills
- View your medical records
- Use the search engine to find current healthcare information

Sign up for *MyChart* today!

For more information ask at the Front Desk
Or visit our website at ***www.kodiakchc.org***

Kodiak Community Health Center