Eastern Aleutian Tribes, Inc.
PATIENT REGISTRATION

CHART NUMBER:	1) Personal Information
Legal Last Name, First Name, Middle Initial:	
Birth Date:	Mother's Maiden Name:
SSN:	No SSN: ☐Not Available ☐Refused
Ethnicity: Hispanic or Latino: ☐Yes ☐No ☐Unknown	Indian Blood Quantum: ☐1/8 ☐1/4 ☐1/2 ☐3/4 ☐Full ☐None ☐Other:
Tribal/Native Corporation:	Tribal Enrollment #:
Veteran: ☐Yes ☐No	Service Branch:
Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Native Hawaiian ☐Pacific Islander ☐Other:	

2) Patient Info			
Address:	City:	State:	Zip:
Country:	Community:	Email:	
Home Phone:	Work/Cell Phone:	Preferred Contact Phone #:	
Preferred Contact Method: ☐Phone ☐Letter ☐No Preference ☐Patient Portal- My ANMC			

3) Patient Info Personal Data	
Homeless? ☐Yes ☐No Couch Surfing/Doubled Up? ☐Yes ☐No	Migrant/Seasonal Worker? ☐Yes ☐No
Is your Primary Language English?: ☐Yes ☐No Do you need an interpreter? ☐Yes ☐No Preferred Language if not English: ☐Aleut ☐Japanese ☐Russian ☐Spanish ☐Other:	
Religious Preference:	Donor? ☐Yes ☐No
Marital Status: ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed ☐Unknown	

4) Patient Info Employer Info	
Employment Status: ☐Active Military Duty ☐Disabled ☐Full-Time ☐Part-Time ☐Self-Employed ☐Unemployed ☐Minor Child ☐Student ☐Retired Date of Retirement_____	
Employer:	Phone Number:
Address:	City, State, Zip:

Select Household Size and Annual Household Income (Circle Below)

Household Size: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Annual Household Income:

0	5,000	10,000	15,000	20,000
25,000	30,000	35,000	40,000	45,000
50,000	55,000	60,000	65,000	70,000
80,000	90,000	100,000	120,000	140,000

Refused:	Other:

5) Guarantor *if under 18*		
Relationship to Patient:	Responsible Person (Guarantor):	
Birth Date (guarantor):	Gender: ☐Male ☐Female ☐Unknown ☐Unspecified	SSN:
Address: City	State:	Zip:
Country:	Phone #:	Alternate Address:
Employment Status: ☐Active Military Duty ☐Disabled ☐Full-Time ☐Part-Time ☐Self-Employed ☐Unemployed ☐Minor Child ☐Student ☐Retired Date of Retirement_____		
Employer:	Phone #:	
Address: City	State:	Zip:

6) Insurance Information (Must Complete)		
Medicare: ☐Yes ☐No Medicaid: ☐Yes ☐No Private Insurance: ☐Yes ☐No Company:		
Policy Holder:	Relationship:	Policy #:
Policy Holder DOB:	SSN:	Employer:

7) Emergency Contact Information (Must Complete)	
Emergency Contact:	Relationship:
Address:	Home Phone:
City, State, Zip:	Work Phone:

8) Next of Kin Information (Must Complete)	
Next of Kin:	Relationship:
Address:	Home Phone:
City, State, Zip:	Work Phone:

9) Local Contact	
Local Contact:	Relationship:
Address:	Home Phone:
City, State, Zip:	Work Phone:

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.

Gender Identity: ☐Male ☐Female ☐Something Else ☐ Don't Know ☐Refuse
☐Transgender Male/ Female-to-Male ☐Transgender Female/ Male-to-Female

Sexual Orientation: ☐Straight ☐Homosexual ☐Bisexual ☐Something Else ☐Don't Know ☐Refuse

I validate that all information stated in this document is accurate to my best knowledge.

Signature: _____ Date: _____

Eastern Aleutian Tribes, Inc.

CONSENT FOR TREATMENT
AND RELEASE OF INFORMATION TO INSURANCE

1. CONSENT FOR TREATMENT
(initials_____)

I, _____, consent to the examination and procedures which may be performed during this village clinic visit, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examinations, medical treatment or procedures, rendered to me as the patient or to _____as his/her legal guardian under the general and special instructions of the patient's health aide(s), physicians(s), or practitioner(s).

2. ASSIGNMENT OF MEDICAL INSURANCE BENEFIT (initials_____)

I assign Eastern Aleutian Tribes (EAT), and the health aide, attending providers and consulting physicians, radiologists, and pathologists, performing duties at the village clinic hereafter referred to as "providers" all benefits now due and to become due and payable to me under medical insurance policies, by virtue of my village clinic treatment, to EAT. I direct my medical insurance or payors to pay such benefits directly to the providers in consideration of medical care and services furnished by the providers. The insurance company is authorized to deduct payments from its obligations to me for medical benefits provided under my policy. I certify the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I understand that I remain financially responsible to the providers for charges not met by the proceeds of this assignment. Medicare, government agencies and insurance companies may not pay for treatment they identify as maintenance or custodial care.

3. AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES (initials_____)

I authorize EAT to disclose medical information, i.e. diagnosis, discharge summary, providers' orders, progress notes and other related documents to the extent required to assure payment to any agency which is liable under a contract including benefits assigned by Title XVIII of the Social Security Act. This would include any drug, alcohol, mental health diagnosis and/or treatment, (Federal Regulation 42CFR, Pt. 2) or HIV "AIDS" diagnosis or treatment that I may receive during the course of this treatment/admission.

4. PRIVACY ACT (initials_____)

I have received the Notice of Privacy Practices. I have been informed that my record is or will be kept in the Health and Medical Record System(s) at EAT. I understand that the information given by me and/or collected and stored in my health record is necessary to provide service for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use, without my signed consent.

5. ADVANCE DIRECTIVES (initials_____)

I have Advance Directives, also known as living will, durable power of attorney, Do Not Resuscitate order, etc. ☐ Yes ☐ No ☐ Patient younger than 18 years ☐ Unable to assess

Reason:_____

If yes, I have provided a copy of any of the above documents to the village clinic, Alaska Native Medical Center, or South Central Foundation. ☐ Yes ☐ No

If no, would you like additional information regarding Advance Directives? ☐ Yes ☐ No

This authorization is valid until account is paid or upon my election to terminate the contract. Any termination must be in writing.

_____ _____
Signature of Patient/Legal Guardian If other than patient, indicate relationship

_____ _____
Witness Date

Consent for Treatment/Release of Information to Insurance 4/14/03; Revised 04/17/14: Revised 02.18.16

Eastern Aleutian Tribes, Inc.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information may be used and disclosed and how you can get access to this information.

Each time you visit one of our clinics, a health care record is made for you. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment and plan for the future care or treatment and billing-related information. This notice applies to all records of your care generated here. Other hospitals or doctors' offices may have different policies or notices regarding use and disclosure of your medical information.

Our responsibilities

We are required by law to maintain the privacy of your health and provide you a description of our privacy practices. We will abide by the terms of this notice.

How we may use and disclose medical information about you

FOR TREATMENT: We may use your medical information to provide you treatment or services. We may disclose your medical information to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in your care.

FOR PAYMENT: We may use and disclose your medical information, your treatment and services to bill and collect payment from you, your insurance or a third-party payor. For example, we may need to give your insurance company information about your medical visit so they will pay us. We may also tell your health plan about treatment you are going to get to determine whether your plan will cover it.

FOR HEALTH CARE OPERATIONS: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and similar cases. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine medical information about patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other medical professionals for educational purposes, and we may combine medical information we have with that of other hospitals to see where we can make improvements. We will remove information that identifies you from this set of medical information to protect your privacy.

We may also disclose your medical information to:

* Billing associates
* To assess your satisfaction with our services
* For population-based activities relating to improving health or reducing health care costs
* To remind you that you have an appointment
* To tell you about possible treatment alternatives
* For conducting training programs or reviewing competence of health care professionals

* BUSINESS ASSOCIATES: There are some services provided in our organization through contracts with business associates. Examples include physician services in emergency departments and radiology, certain laboratory tests, and physical or occupational therapy services. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

INDIVIDUALS INVOLVED IN PAYMENT FOR YOUR CARE:

* Alaska Native Medical Center
* South Central Foundation
* Your private physician or care provider
* Division of Medicaid and Medicare
* State of Alaska Division of Public Health
* Public Health Nurses
* Center for Disease Control
* Your Insurance Company

This information relates to the information provided on the Health Improvement and Portability Accountability Act of 1996.

Notice of Privacy Practices 04/01/03; revised 02/22/07