PRAIRE BAND POTAWATOMI HEALTH CENTER CHART APPLICATION

Please complete one Chart Application for every patient. Please PRINT CLEARLY.
Present this completed form along with copies in order to establish a new patient chart, reactivate or update.

Legal Name: ____________________ Alias/Maiden: ____________________

DOB: ____/____/______ Sex: ☐ M ☐ F City & State of Birth: ____________________

SSN: ______-______-______ Race: ____________________ Religious Preference: ____________________

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

Primary Language: ______________ Preferred Language: ______________

Physical Address *City, State, Zip*: ____________________ P.O. Box #: ________

Home Phone: ( )______-________ Work Phone: ( )______-________ Cell: ( )______-________

What Date Did You First Reside At This Address: ____/____/______

Minor's Information

Minor's Mother Legal Name: ____________________ Alias/Maiden: ____________________

Physical Address *City, State, Zip*: ____________________ P.O. Box #: ________

Home Phone: ( )______-________ Work Phone: ( )______-________ Cell: ( )______-________

Minor's Father Legal Name: ____________________ Alias/Maiden: ____________________

Physical Address *City, State, Zip*: ____________________ P.O. Box #: ________

Home Phone: ( )______-________ Work Phone: ( )______-________ Cell: ( )______-________

Whom does the minor primarily reside with? ☐ Mother ☐ Father Other: ____________________

Whom has legal custody of the minor? ☐ Mother ☐ Father Other: ____________________ *Provide Court Order*

Applicant Employer Name: ____________________ Employer Phone: ( )______-________

Physical Address *City, State, Zip*: ____________________ P.O. Box #: ________

☐ Fulltime ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Military ☐ Temporary ☐ Unemployed

Spouse Employer Name: ____________________ Employer Phone: ( )______-________

Physical Address *City, State, Zip*: ____________________ P.O. Box #: ________

☐ Fulltime ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Military ☐ Temporary ☐ Unemployed

Number Living in Household: ______ *(optional)*Total Household Income: $__________ *-Per?* ☐ Week ☐ Month ☐ Year

HRN: ____________

Staff Initials: ______

Do you have Internet Access? ☐ Yes ☐ No If Yes, Where? ______________ Email Address: ________________________

Preferred Method of Communication: ☐ Letter ☐ Phone

Emergency Contact Name & Address: ____

Relationship to Applicant: ________________________ Best Contact Number: (   )______-________

Applicant's Mother Legal Name: ______________________________ Alias/Maiden: ________________

Applicant's Mother City & State of Birth: ______________________________

Applicant's Father Legal Name: ______________________________ Alias/Maiden: ________________

Applicant's Father City & State of Birth: ________________________

Next of Kin Name & Address: ____

Relationship to Applicant: ________________________ Best Contact Number: (   )______-________

Tribal Affiliation: ____________________________ Tribal Blood Quantum: ______ Total Native Blood Quantum: _______

Have you served in the Military? ☐ Yes ☐ No If Yes, What Branch? ______________ Date of Entry: ___/___/____

Date of Discharge: ___/___/____ Do you have a Valid VA Card? ☐ Yes ☐ No Vietnam Service Connected? ☐ Yes ☐ No

Service Connected Disability? ☐ Yes ☐ No Describe Disability: ______________________________

Do you have Private Insurance? ☐ Yes ☐ No Do you have State Medicaid? ☐ Yes ☐ No

Do you have Medicare? ☐ Yes ☐ No Do you have Retirement Railroad Coverage? ☐ Yes ☐ No

If you have insurance please provide the card to the Registration Personnel for scanning and complete an Assignment of Benefits & Authorization to Bill form.

Is today's visit related to a new or pending workplace or home accident or injury? ☐ Yes ☐ No

If Yes, date of accident: ___/___/____ If Yes, have you filed a workmans comp or home insurance claim ? ☐ Yes ☐ No

If Yes, please provide the Claim Number: ______________________________

Name & Phone Number of contact Claim: ____

Is today's visit related to a reported auto accident? ☐ Yes ☐ N If Yes, date of accident: ___/___/____
If Yes, please provide the insurance claim number: ____________________________

I understand that after verifying eligibility and completing the Chart Application along with providing all required information, an electronic health record may be created, reactivated or updated within the Prairie Band Potawatomi Health Center. I certify that the above information is true to the best of my knowledge and that no information provided is deliberately falsified.

____ ___/___/____

Signature of Patient or Parent/Legal Guardian of Minor **Date**

HRN: ____________

Staff Initials: ______

Est. 12/2017

Prairie Band Potawatomi Health Center

11400 158th Road
Mayetta, KS 66509

Phone: (785) 966-8200
Fax: (785) 966-8393

ASSIGNMENT OF BENEFITS (A.O.B.) & AUTHORIZATION TO BILL

I have requested services from the Prairie Band Potawatomi Health Center on behalf of myself and or my dependents. I hereby assign all benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) or other benefits plan, to issue payment/reimbursement directly to Prairie Band Potawatomi Health Center for services rendered to myself and or my dependents regardless of my/our insurance benefits plan or health center network status.

I hereby authorize the Prairie Band Potawatomi Health Center to disclose all or part of my record as necessary and compliant with the Notice of Privacy Practices. I understand that this authorization may include information such as drug abuse, alcoholism, mental healthcare, sickle cell anemia, communicable or venereal diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS),

This A.O.B. & Authorization to Bill, is valid for all administrative and judicial reviews under the health care reform legislation, and applicable federal, state and tribal laws. Furthermore, I understand that it is my responsibility to notify the Prairie Band Potawatomi Health Center of any changes in my health care coverage or personal information.

I, of competent mind, attest to having read and understand this agreement as witnessed by my signature below.

Patient Name/Representative & relationship (printed): ______________________________

Signature: ______________________________ Date: ____/____/____

Legal Name of Policy Holder (if different than patient): ______________________________

Name of Insurance: ______________________________ Policy Holder D.O.B.: ______________

Policy/Member Number: ______________________ Group Number: ______________

Policy Holder's Employer Name, Address & Phone: ______________________________

HRN: ______________
Staff Initials: ________

Est. 12/2017

Prairie Band Potawatomi Health Center

11400 158th Rd
Mayetta, KS 66509

Phone: (785) 966-8200
Fax: (785) 966-8393

AUTHORIZATION FOR VERBAL DISCLOSURE AND COMMUNICATIONS

Patient Name:____ **Date of Birth:**____/____/____

I voluntarily consent to the verbal disclosure and communication (both in person and telephone) of my medical information including developmental disabilities and financial information by providers and personnel of the Prairie Band Potawatomi Behavioral Health Center to the persons stated below. I understand that in order to communicate with the persons listed below, they will be first asked to verify my name and date of birth and to verify their date of birth. I understand that this form will expire one year from the date signed, unless otherwise indicated below by a date occurring prior to one year. I also understand a new Authorization for Verbal Disclosure and Communications form will need to be completed if I wish to continue to consent beyond one year. If at any time I wish to revoke this Authorization for Verbal Disclosure and Communications, I must contact the Health Information Department of the Prairie Band Potawatomi Health Center and state my intent. After I state my intent I understand I will be asked to complete and sign the bottom portion of the Authorization for Verbal Disclosure and Communications form. By signing below, I affirm I have read this statement and agree with its intended use for continuity of care while protecting my health information.

____________________________ ____/____/____ ____________________
Printed Legal Name of Individual Date of Birth Relationship to Patient

____________________________ ____/____/____ ____________________
Printed Legal Name of Individual Date of Birth Relationship to Patient

I wish to exclude the following medical conditions from verbal communications: ____________________________

I wish to limit this Authorization for Verbal Disclosure and Communications to thefollow date: ____/____/____

This document does not authorize the release of any written health information. This document also does not authorize disclosure of information regarding Mental Health, HIV, AIDS, Treatment for Sexually Transmitted Diseases, Alcohol Drug and Substance Abuse and Psychotherapy Notes unless specifically indicated otherwise below endorsed by my written initials.

☐Alcohol, Drug, and Substance Abuse ☐Mental Health *(other than psychotherapy notes)*

☐Treatment/Referral Sexually Transmitted Diseases ☐HIV/AIDS related treatment

☐Psychotherapy Notes *(by checking this box, I am waiving any psychotherapist-patient privilege)*

____________________________ ____________________
Patient Signature **Date**

I wish to ***REVOKE*** the Authorization for Verbal Disclosure and Communication dated____/____/____.

____
Patient Signature & Date

HRN: __________
Staff Initials: ________

SUMMARY OF YOUR PRIVACY RIGHTS EFFECTIVE APRIL 25TH 2018

PRAIRIE BAND POTAWATOMI HEALTH CENTER

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.

SUMMARY OF YOUR PRIVACY RIGHTS

A. Understand your Medical record/Information. Each time you visit Prairie Band Potawatomi Health Center (PBPHC) for services, a record of your visit is made. If you are referred by PBPHC through the Purchased Referred Care (PRC) program, PBPHC also keeps a record of your PRC visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, referred to as your medical record, serves as a :

1) Plan for your care and treatment.
2) Communication source between health care professionals.
3) Tool with which we can check results and continually work to improve the care we provide.
4) Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
5) Tool for education of health care professionals.
6) Source of information for public health authorities charged with improving the health of the people.
7) Source of data for medical research and facility planning.
8) Legal document that describes the care you receive.

B. Understanding what is in your medical record and how the information is used helps you to:

1) Ensure its accuracy.
2) Better understand why others may review your health information.
3) Make an informed decision when authorizing disclosures.

C. Your Medical Record/Information Rights. Your medical record is the physical property of PBPHC, but the information belongs to you! You have a right to:

1) Inspect and receive a paper or electronic copy of your health information.
2) Receive notification of a breach of your unsecured protected health information.
3) Request a restriction on uses and disclosures of your health information to include certain disclosures of protected health information to your health plan. PBPHC is not required to agree to the requested restriction except when the disclosure would be for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI relates solely to a healthcare item or service for which the individual has paid the covered entity in full.
4) Request a correction or amendment to your health information. PBPHC may amend your record or include a statement of disagreement.
5) Request confidential communications about your health information.
6) Request and obtain a listing of certain disclosures PBPHC has made of your health information.
7) Revoke your written authorization to use or disclose health information.
8) Request and obtain a paper or electronic copy of the PBPHC Privacy Practices.

D. PBPHC Responsibilities. PBPHC understands that health information about you is personal and is committed to protecting your health information. PBPHC is required by law to:

1) Maintain the privacy of your health information.
2) Inform you about our privacy practices regarding health information we collect and maintain about you.
3) Notify you if we do not agree to a requested restriction.
4) Notify you of our decision regarding a request for correction or amendment.
5) Accommodate reasonable requests you may have to communicate health information by alternate means or to an alternate location.
6) Promptly notify you of a breach of unsecured protected health information (PHI).
7) Honor the terms of this notice or any subsequent revisions of this notice.

REVISED NOTICE OF PRIVACY PRACTICES

Prairie Band Potawatomi Health Center (PBPHC) reserves the right to change its privacy practices and to make the new provisions effective for all PHI it maintains. The PBPHC will post any revised Privacy Practices within and throughout the Health Center.

PBPHC will not use or disclose your health information without your permission, except as described in the Privacy Practices and as permitted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the genetic Information Nondiscrimination Act (GINA) of 2008. The following categories describe how we may use and/or disclose your health information.

A. Treatment. We will use and/or disclose your health information to provide your treatment. For example:

1) Your personal information will be recorded in your medical record and used to determine the course of treatment for you. Your Health Care provider will document in your medical record their instructions to members of your health care team. The actions taken and the observations made by the members of your health care team will be recorded in your medical record so your healthcare provider will know how you are responding to treatment.
2) If you are referred or transferred to another facility or provider for further care and treatment, PBPHC may disclose information to that facility or provider to enable them to know the extent of treatment you have received and other information about your condition.
3) Your health care provider may give copies of your health information to others, including health care professionals or personal representatives, to assist in your treatment.

B. Payment Purposes. We will use and disclose your health information for payment purposes. For example:

1) If you have private insurance, Medicare, or Medicaid, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for treatment.
2) If you are referred to another health care provider under the PRC program, PBPHC may disclose your health information to that provider for health care payment purposes.

C. Health Care Operations. We will use and disclose your health information for health care operations. For example:

1) We may use your health information to evaluate your care and treatment outcomes with out quality improvement team. This information will be used to continually improve the quality of the services we provide.

D. Business Associates. PBPHC provides some healthcare services and related functions through the use of contracts with business associates. When these services are contracted, PBPHC may disclose your health information to business associates so that they can perform their jobs. PBPHC requires our business associates to protect and safeguard your health information in accordance with applicable Federal laws.

E. Notification. PBPHC may use or disclose your health information to notify or assist in the notification of a family member, personal representative, or other authorized person responsible for your care, unless you notify us that you object.

F. Communication with Family. All PBPHC health providers may use or disclose your health information to others involved with and/or responsible for your care unless you object. For example, PBPHC may provide your family members, other relatives, close personal friends, or any other person you identify, with health information that is relevant to that person's involvement with your care or payment for such care.

G. Adults and Emancipated Minors with Personal Representatives. PBPHC may disclose health information to a personal representative of an individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction.

H. Interpreters. In order to provide you proper care and services, the PBPHC may use the services of an interpreter. This may require the disclosure of your health information to the interpreter.

I. Research. PBPHC may use or disclose your health information for research purposes when approved by the Prairie band Potawatomi Nation Tribal Council and an Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information. PBPHC may also use or disclose your health information for non-IRB approved research purposes based on your written authorization.

Health Center Privacy Practices

Prairie Band Potawatomi Health Center
11400 158th Road
Mayetta, KS 66509
(785) 966-8200

Prairie Band Potawatomi Health Center

11400 158th Road
Mayetta, KS 66509

Phone: (785) 966-8200
Fax: (785) 966-8393

RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices at Prairie Band Potawatomi Health Center.

_______________________________ ____/____/____
Printed Name of Patient | Patient D.O.B.

_______________________________ ____/____/____
Patient Signature | Date

If the patient is a minor or unable to sign due to mental or physical incapacity, complete patient information and this section:

____
Printed Name of Legal Representative

_______________________________ ____/____/____
Signature of Legal Representative | Date

_______________________________ ____/____/____
Signature of PBP Health Center Employee Witness | Date

If the patient has no representative, complete the patient information and this section:

Staff Only: Patients Unable to Acknowledge Receipt
I hereby certify that the patient was unable to acknowledge receipt of the Notice of Privacy Practices due to:
State reasons patient was not able to acknowledge:

____

_______________________________ ____/____/____
Signature of PBP Health Center Employee Witness | Date

HRN: ____________
Staff Initials: _______

Est. 12/2017