PRAIRE BAND POTAWATOMI HEALTH CENTER CHART APPLICATION
COVID-19 VACCINATION OUTREACH

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.

Are you registering as a/n:

☐ Eligible Indian: Tribal Affiliated ☐ Employee: PBPN Affiliated ☐ Non-Indian Spouse

☐ Household Member of Eligible Indian ☐ Non-Tribal Affiliated

Legal Name: _____ Alias/Maiden: _____

DOB: _____/_____/_____ Sex: ☐ M ☐ F City & State of Birth: _____

SSN: _____-_____-_____ Race: _____ Ethnicity: _____

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

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

Home Phone: ( )_____-_____ Work Phone: ( )_____-_____ Cell: ( )_____-_____

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

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.

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. 3/2021

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:

_____

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

HRN: _____
Staff Initials: _____ Est. 3/2021