KODIAK AREA NATIVE ASSOCIATION

HEALTH SERVICES

Patient Registration Packet

Welcome to the Kodiak Area Native Association

Thank you for choosing KANA for your health care and social service needs. We deliver patient-centered care to the communities of Kodiak Island as part of our belief that healthy individuals live in healthy communities.

Our clinics provide health care in an outpatient setting to increase the accessibility and affordability of care for our communities. Health services are delivered through integrated care teams so that patients are able to choose their own Providers, who work closely with an assigned team of staff, including nurses, case managers, dental, behavioral health consultants, wellness center staff, ILP, WIC, and more, to ensure the needs of our patients are met.

In order to best serve you, we ask that you register in advance of your first appointment and bring the following information with you:

☐State ID or Driver's License
☐Certificate of Indian Blood (if applicable)
☐Federally Recognized Tribal Enrollment Card (if applicable)
☐Insurance Card(s)
☐Birth Certificate
☐DD214 to enroll in Veterans Administration (if applicable)
☐Medical Records (optional)

Return completed applications; in person, by mail, or email registration@kodiakhealthcare.org
For further assistance, contact our registration staff at 907-486-9800.

Our mission is "*To Elevate the Quality of Life of the People We Serve.*"

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☐ New Patient ☐ Update | Veteran: ☐ Yes ☐ No

Section 1: Patient Information

Last Name	First Name	Middle Initial	Suffix

Gender ☐Male ☐Female☐Other* *If you selected other see reverse for additional options.*	Social Security Number	Birth Date

Ethnicity
☐Chose not to disclose ☐Unable to Provide Information
☐Hispanic or Latino ☐Unknown
☐Not Hispanic or Latino

Race
☐American Indian or Alaska Native ☐Asian
☐Native Hawaiian or Pacific Islander ☐Other
☐Black or African American ☐White

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Preferred Phone

Marital Status ☐Single; ☐Married; ☐Divorced; ☐Widowed; ☐Separated	Homeless ☐Yes ☐No	Public Housing ☐Yes ☐No

Language(s)	Interpreter Required? ☐Yes ☐No

Employment Status
☐Active Military Duty; ☐Decline; ☐Disabled; ☐Full Time; ☐Minor Child; ☐Part-Time; ☐Reserve National Assignment;
☐Retired – Date: _____ ☐Self Employed; ☐Student Full-Time; ☐Student Part-Time; ☐Unemployed; ☐Unknown

Employer Name	Street Address	City	State	Zip Code

Phone Number	☐Monthly _____ OR; ☐Annual Household Income _____	Total in Household

Emergency Contact Name	Emergency Contact Number	Emergency Contact Relationship

Section 2: Guarantor/Legal Guardian

Relationship to patient
☐Self (skip); ☐Spouse; ☐Parent; ☐Child; ☐Other:

Last Name	First Name	Birth Date	Gender ☐Male ☐Female	Social Security Number

Mailing Address	City	State	Zip Code	Phone

Section 3: Primary and Secondary Insurance

Insurance Company Name	Group Number	Subscriber ID Number

Subscriber Full Name	Co-Payment

Insurance Company Name	Group Number	Subscriber ID Number

Subscriber Full Name	Co-Payment

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Section 4: OPTIONAL

You are NOT required to provide this information. However, because KANA accepts federal funding, we are required to ask these questions and report the TOTAL NUMBER of voluntary responses we receive for each category or question. We do not include your individual response or other identifying information in these reports.
If you are comfortable providing this information, we appreciate your confidential responses, as this helps KANA meet its federal reporting obligations. Thank you.

Gender Identity	**Sexual Orientation**
☐Male	☐Heterosexual (Straight)
☐Female	☐Homosexual (Gay/Lesbian)
☐Transgender Female/Male-to-Female	☐Bisexual
☐Transgender Male/Female-to-Male	☐Something else
☐Gender Queer	☐Don't know
☐Other	☐Other
☐Choose not to disclose	☐Choose not to disclose
☐Not applicable	☐Not applicable

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Section 5: Acknowledgement

_____ **CONSENT TO CARE**

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my health care and will make my wishes known. I understand that KANA participates in the training of physicians and other healthcare providers and will be told when trainees take part in my care.

_____ **NOTIFICATION OF RELEASE FOR PAYMENT**

I understand that KANA will disclose any diagnoses and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical, dental and behavioral health.

_____ **FINANCIAL AGREEMENT**

I understand that any applicable co-payments, sliding fee discount and prompt pay charges are due at time of service, including fees for services not covered by the IHS, if I am an eligible beneficiary. I assign payment from my insurance directly to KANA. I understand I am financially responsible to KANA for charges not paid by insurance and that payment for those charges is due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from laboratory, radiology and other specialized services.

_____ **SLIDING FEE DISCOUNT PROGRAM**

I understand that KANA offers a sliding fee discount program for eligible individuals. The discount categories have been explained to me and I believe that the fees are reasonable. I have been given the opportunity to apply for this program.

_____ **NOTICE OF PRIVACY PRACTICES**

I acknowledge and agree that I have reviewed a copy of KANA's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of this notice at any time.

_____ **KANA EMERGENCY ROOM POLICY**

I acknowledge that I have received or have been offered a copy of KANA's Emergency Room Usage Policy.

I have read the above and initialed my consent and financial responsibility for services at KANA. If I have a question about my visit or any financial liability I will contact KANA Registration prior to my appointment.

Date: _____ **Patient Signature:** _____

Parent/Guardian Signature: _____

OFFICE USE ONLY

Staff Initials _____

Patient MRN _____

Date Entered into EHR _____

☐Patient refused to sign

☐Communication barriers prohibited obtaining acknowledgement

☐An emergency situation prevented obtaining acknowledgement

☐Other: _____