



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 integrated 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 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 907-486-9870.

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



KODIAK AREA NATIVE ASSOCIATION HEALTH SERVICES

New Patient Update MRN:

Section 1: Patient Demographics					
Last Name		First Name		Middle Initial	Suffix
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other* <i>for additional options.</i>		Social Security Number		Birth Date	
Ethnicity <input type="checkbox"/> Chose not to disclose <input type="checkbox"/> Unable to Provide Information <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino			Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> White		
Mailing Address		City		State	Zip Code
Home Phone	Cell Phone		Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other:		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> No	Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Housing <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Tagalog <input type="checkbox"/> Spanish <input type="checkbox"/> Other:				Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MyHealth Portal: Email Address:					
Section 2: Employment					
Employment Status <input type="checkbox"/> Active Military Duty; <input type="checkbox"/> Decline; <input type="checkbox"/> Disabled; <input type="checkbox"/> Full Time; <input type="checkbox"/> Minor Child; <input type="checkbox"/> Part-Time; <input type="checkbox"/> Reserve National Assignment; <input type="checkbox"/> Retired – Date: _____ <input type="checkbox"/> Self Employed; <input type="checkbox"/> Student Full-Time; <input type="checkbox"/> Student Part-Time; <input type="checkbox"/> Unemployed; <input type="checkbox"/> Unknown					
Section 3: Household Income					
<i>KANA receives Federal funding that requires us to ask household income and household size for reporting purposes. Additionally, this is used to screen you for alternate funding sources to assist with co-pays and co-insurance; such as Sliding Fee Scale eligibility.</i>					
INCOME: Please fill in your monthly or annual income				Total Members in Household	
Monthly \$ _____		OR; Annual \$ _____			
Section 4: Emergency Contact					
Emergency Contact Name		Emergency Contact Number		Emergency Contact Relationship	
Section 5: Guarantor					
Who is financially responsible for services					
Relationship to guarantor: <input type="checkbox"/> Self (skip); <input type="checkbox"/> Parent (if patient is under 18yo); <input type="checkbox"/> Other please specify:					
Last Name		First Name		Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City		State	Zip Code
				Phone	

Section 6: Medical Insurance

Primary Medical Insurance	Group Number	Subscriber ID Number	
Subscriber Full Name	Subscriber Date of Birth	Subscriber SSN	Co-Payment
Secondary Medical Insurance	Group Number	Subscriber ID Number	
Subscriber Full Name	Subscriber Date of Birth	Subscriber SSN	Co-Payment

Section 7: Dental Insurance

Primary Dental Insurance	Group Number	Subscriber ID Number	
Subscriber Full Name	Subscriber Date of Birth	Subscriber SSN	Co-Payment
Secondary Dental Insurance	Group Number	Subscriber ID Number	
Subscriber Full Name	Subscriber Date of Birth	Subscriber SSN	Co-Payment



KODIAK AREA NATIVE ASSOCIATION
HEALTH SERVICES

Section 8: OPTIONAL (Over 18yrs old)

The following information is NOT a requirement to receive care at KANA. However, because KANA accepts federal funding, we are required to ask these questions to individuals 18 years and older 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.

<p>Gender Identity</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Transgender Female/Male-to-Female</p> <p><input type="checkbox"/> Transgender Male/Female-to-Male</p> <p><input type="checkbox"/> Gender Queer</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Not applicable</p>	<p>Sexual Orientation</p> <p><input type="checkbox"/> Heterosexual (Straight)</p> <p><input type="checkbox"/> Homosexual (Gay/Lesbian)</p> <p><input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> Something else</p> <p><input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Not applicable</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------



KODIAK AREA NATIVE ASSOCIATION
HEALTH SERVICES

Section 9: 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. I understand that KANA operates as an integrated-care medical home and that my treatment team is comprised of a team of health care professionals who span both medical and behavioral health care disciplines.

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: _____