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 medical care teams; which includes your provider, nurses, case managers, navigators and behavioral health consultants. Your integrated medical care team will work closely with dental providers, behavioral health providers, wellness center staff, and community services providers to ensure all of your health care and well-being needs are met.

REGISTRATION REQUIREMENTS

In order to best serve you, we ask that you register in advance of your first appointment. Registration packets are available to be picked up at any KANA location and are also available online. Completed registration packets may be retuned in person, by mail, or emailed to registration@kodiakhealthcare.org. If your registration packet cannot be completed prior to your first appointment, please arrive 15 minutes earlier to your schedule appointment time.

Please be prepared to provide a copy of the following documents.

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

For further assistance or questions, please contact our registration staff at 907-486-9870.

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

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☐New Patient ☐Update MRN:

Section 1: Patient Demographics

Last Name	**First Name**	**Middle Initial**	**Suffix**

Sex at Birth ☐Male ☐Female	**Social Security Number**	**Birth Date**

Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino

Race *(check all that apply)*
☐American Indian or Alaska Native ☐Black or African American ☐Asian
☐Other Pacific Islander ☐Native Hawaiian ☐White

Mailing Address	**City**	**State**	**Zip Code**

Home Phone	**Cell Phone**	**Preferred Phone:** ☐Home ☐Cell ☐Other:

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated	**Veteran Status:** ☐Yes ☐No	**Homeless** ☐Yes ☐No	**Public Housing** ☐Yes ☐No

Primary Language: ☐English ☐Tagalog ☐Spanish ☐Other:	**Interpreter Required?** ☐Yes ☐No

Email Address:

Section 2: Employment

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

Section 3: Emergency Contact

Emergency Contact Name	**Emergency Contact Number**	**Emergency Contact Relationship**

Section 4: Household Income

*Providing Household Income information helps us to meet federal grant requirements and to see if you and your family may be eligible for additional programs to help cover your healthcare costs. Please circle the number of people living in your household and your **approximate** household income, before taxes, on the same line where the household size is circled.*

Household Size	Less Than	Less Than	Less Than	Less Than	More Than
1	$16,990	$25,485	$29,733	$33,980	$33,981
2	$22,890	$34,335	$40,058	$45,780	$45,781
3	$28,790	$43,185	$50,383	$57,580	$57,581
4	$34,690	$52,035	$60,708	$69,380	$69,381
5	$40,590	$60,885	$71,033	$81,180	$81,181
6	$46,490	$69,735	$81,358	$92,980	$92,981
7	$52,390	$78,585	$91,683	$104,780	$104,781
8	$58,290	$87,435	$102,008	$116,580	$116,581

Section 5: Sliding Fee Discount Program (Insured and Uninsured Patients)

KANA offers Medical, Dental, and Behavioral Health services at discounted rates to all eligible patients regardless of insurance status. Discounted fees can be applied to self-pay, as well as insurance co-pays and deductibles. The discounted fees for service are based on an individual's ability to pay as determined by annual household income and household size, if your income range falls within the less than column above, you may be eligible.

Please check here if you are interested in learning more and/or completing an application ☐

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Section 6: Financially Responsible Party

Who is financially responsible for services:
☐Self (**skip**); ☐Parent (if patient is under 18yo); ☐Other, please specify:

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

Mailing Address	**City**	**State**	**Zip Code**	**Phone**

Section 7: Medical Insurance

Primary Medical Insurance	**Group Number**	**Member ID Number**	
Subscriber Full Name (if other than self)	**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 8: Dental Insurance

Primary Dental Insurance	**Group Number**	**Member ID Number**	
Subscriber Full Name (If other than self)	**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**

Section 9: Permission to Release Patient Information (18 Years & Older)

We will not give information out to anyone else but you unless their name(s) is written below and signed by you. This release of information does not include record requests to/from other doctor's offices, requests by insurance companies or other outside agencies; additional Release of Information Consent forms are required for these purposes.

I hereby give permission to KANA to release the following information to those individuals listed below. **Check all that apply:**

☐ Verify or change my appointments
☐ Discuss billing and payment information

Name _____ Relationship _____

Name _____ Relationship _____

***OR, I do not allow any information about me released to anyone*: ☐**

Patient /Guardian Signature:_____

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Section 10: Acknowledgements

Please Review and Initial the Following:

_____ **CONSENT FOR 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 discounts, and/or other associated charges are due at time of service, including fees for services not covered by the IHS (if an eligible IHS 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 receiving my bill. 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 that I have been offered and have reviewed KANA's Notice of Privacy Practices that's been made available to me. I understand that I may request a copy of this notice at any time.

_____ **HEALTH INFORMATION EXCHANGE**

I acknowledge that KANA participates in a Health Information Exchange, of which I can opt out at any time.

_____ **PATIENT RIGHTS AND RESPONSIBILITIES**

I acknowledge I have reviewed and understand my rights and responsibilities as a KANA patient.

_____ **KANA EMERGENCY ROOM POLICY (IHS Beneficiaries)**

I acknowledge 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 for clarification.

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: _____