



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 medical care teams; which includes your provider, nurses, case managers, navigators and Scheduling and Registration Specialists. Your 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 returned 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 scheduled 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number			Birth Date		
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race (check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Native Hawaiian <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	
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
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Section 2: 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 annual 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	\$18,810	\$28,215	\$32,918	\$37,620	\$37,621
2	\$25,540	\$38,310	\$44,695	\$51,080	\$51,081
3	\$32,270	\$48,405	\$56,473	\$64,540	\$64,541
4	\$39,000	\$58,500	\$68,250	\$78,000	\$78,001
5	\$45,730	\$68,595	\$80,028	\$91,460	\$91,461
6	\$52,460	\$78,690	\$91,805	\$104,920	\$104,921
7	\$59,190	\$88,785	\$103,583	\$118,380	\$118,381
8	\$65,920	\$98,880	\$115,360	\$131,840	\$131,841

Section 3: 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 <input type="checkbox"/> Male <input type="checkbox"/> 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	



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Section 9: Acknowledgments

On Behalf of myself or other patient named below, I acknowledge and consent to the statements made in this form:

CONSENT FOR CARE

I consent to the plan of care proposed by the providers at Kodiak Area Native Association (KANA). 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 authorize payment from my insurance directly to KANA and will update KANA of changes to my insurance information. 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 have been given the opportunity to apply for this program.

USE AND DISCLOSURE OF HEALTH INFORMATION

I acknowledge that I have been offered and have reviewed KANA's Notice of Privacy Practices (NPP), which describes the ways in which KANA may use and disclose my healthcare information for its treatment, payment, operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the NPP if I have a question or a complaint. To the extent permitted by law, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices. 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.

TELEHEALTH

I understand that KANA provides certain services by remote telehealth technology. Telehealth often involves the transmission of video, audio, images, and other types of data. The remote Provider will determine whether the condition

being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment or prescription. I understand that I may have to travel to see a Provider in-person for certain diagnosis and treatment matters. I understand that the laws that protect privacy and confidentiality of protected health information also apply to telehealth.

PATIENT RIGHTS AND RESPONSIBILITIES

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

COMMUNICATIONS ABOUT MY HEALTHCARE

By providing my phone number, I agree that the employees, contractors, or other representatives of KANA, and/or any party contracted on their behalf, may contact me using automated dialing, pre-recorded script, interactive voice response, and/or

text messaging technologies for health care related or account administration related communications, including but not limited to appointment reminders, prescription refill notifications, care or benefit coordination activities, collection of financial liabilities owed, and customer service or quality improvement operations. I understand that I may opt out of these types of communication methods without impacting my ability to receive care and that data usage and other charges may apply.

KANA EMERGENCY ROOM POLICY (IHS Beneficiaries)

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

By signing below, I certify that I have reviewed and acknowledge and consent to the terms described above. I was given the opportunity to have my questions answered, if needed, and if I have any further questions I will contact KANA for clarification.

Date

Print Patient Name

Signature of Patient

Print Name of Guardian / Relationship to Patient

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: _____



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Alternate Resource Agreement (ARA) for Contract Health and Paid and Referred Service

Eligibility:

If you are a beneficiary of the Indian Health Services (IHS), you are eligible to receive DIRECT services (provided within KANA). You must provide proof of eligibility in the form of a Certificate of Indian Blood (CIB) or Federally Recognized Tribal Enrollment Card with blood quantum listed within 30 days of your annual sliding fee application. Copies will be kept on file with your medical record.

Alternate Resources:

If you have or are eligible for other resources to cover the expenses associated with your healthcare (Insurance, Medicaid, Medicare, VA Benefits, Fisherman's Fund, Worker's Compensation, etc.) please provide the information to KANA upon your visit or as soon as you are aware of alternate coverage. Providing an insurance card is the preferred method but we will take verbal information over the phone for insurance. Billing the appropriate insurance will extend current funds to serve you and other KANA patients.

Contract Health or Paid & Referred Services:

When need arises, Contract Health or Paid and Referred Services (CHS or PRS) funds may be available to assist with payment of INDIRECT services (those services provided by other outside agencies, example: Hospital, Lab, X-ray, Surgical, Physical Therapy, etc.). Federal regulations governing Contract Health Service Funds must be followed and are listed below:

1. Updated patient registration/Alternate Resource Agreement signed annually.
2. You MUST be a Kodiak Resident to qualify for KANA Contract Health/Paid and Referred Service funding. You must show proof of Kodiak Residency for at least 90 consecutive days to qualify for Contract Health/Paid and Referred Service Funding. You are only eligible for DIRECT CARE service until you meet the 90 day residency requirement. If you are vacationing, are seasonally employed or temporarily residing in Kodiak, you are not eligible to receive INDIRECT services funded by KANA. You will be charged separately by the outside service provider and payment of such bills will be your sole responsible.
3. If additional tests or exams (labs, X-ray, physical therapy, surgical exams, etc.) by an outside provider are requested by a KANA physician, a Contract Health Referral Form must be attached to the physician's order and alternate resource screening must take place to guarantee payment.
4. If you do not have insurance and initial screening indicates you may qualify for the Alaska Medicaid Program, we will assist you to apply and a grace period of 30-days will be applied to return the approval or denial letter from Medicaid before making final decisions on coverage of the bill. Please note: If you delay in applying, do not provide complete information requested by Medicaid or cannot provide a letter of denial, KANA Contract Health, Paid and Referred will deny payment of your indirect bill.
5. If you or your family members use Providence Kodiak Island Medical Center (PKIMC) Emergency Room (ER) for LIFE THREATENING emergency, CHS/PRS office (486-9861) must be notified within 72 hours (3 days) or payment may be denied. The responsibility to report to KANA CHS/PRS is yours.

Alternate Resource Agreement (ARA) for Contract Health and Paid and Referred Service

6. KANA CHS/PRS will not pay for abusive/repetitive non-emergent Emergency Room use.
7. KANA CHS/PRS excludes payments for alcohol or detox and mental health including anxiety related admissions.

If you have further questions, please contact the KANA Contract Health Office at 486-9861. By signing the Alternate Resource Agreement (ARA) form, you confirm that you have read, understood and agreed to the above. Your signed ARA will be scanned into your Electronic Health Record.

Date

Print Patient Name

Signature of Patient

Print Name of Guardian / Relationship to Patient

Parent/Guardian Signature