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 include your Provider, Nurses, Case Managers, Referral Care Coordinators, 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)
- ☐ 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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Section 1: Patient Demographics

Last Name:	**First Name:**	**Middle Name:**	**Suffix:**

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

Ethnicity:

☐Not Hispanic, Latino/a, or Spanish Origin ☐Unknown ☐Hispanic ☐Latino/a
☐Spanish Origin ☐Chicano/a ☐Puerto Rican ☐Cuban
☐Other Hispanic, Latino/a, or Spanish Origin ☐Mexican ☐Mexican American

Race:

☐American Indian or Alaska Native ☐Asian Indian ☐Black or African American ☐Chinese ☐Other Asian
☐Guamanian or Chamorro ☐Korean ☐Native Hawaiian ☐Samoan ☐Japanese
☐Other Pacific Islander ☐Filipino ☐Vietnamese ☐White ☐Unknown
☐Chose Not to Disclose ☐Other: _____

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

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

Email:	**Military Status:** ☐Active Duty ☐Veteran ☐N/A

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

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

Section 2: Employment

Employment Status: ☐Active Duty Military ☐Disabled ☐Part Time ☐Minor Child ☐Reserved National Guard
☐Self Employed ☐Unemployed ☐Student ☐Full Time ☐Retired - Date: _____

Section 3: Emergency Contact

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

Section 4: Household Information

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 health care costs. Please provide the number of people living in your household and your **approximate** annual or monthly household income, before taxes. *Household size is defined as all members of a household living at the same address who support each other financially and/or share resources.*

Household size (#): _____	**Household Annual Income:** _____ or **Household Monthly Income:** _____

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Section 5: Sliding Fee Discount Program (Insured & 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 ☐

Section 6: Legal Guardian(s)

☐ Self (Skip Section)

Name:	**Date of Birth:**	**Contact Number:**	
Mailing Address:	**City:**	**State:**	**Zip Code:**
Relationship to Patient:	☐ Financially Responsible		

Name:	**Date of Birth:**	**Contact Number:**	
Mailing Address:	**City:**	**State:**	**Zip Code:**
Relationship to Patient:	☐ Financially Responsible		

Section 7: Medical Insurance

PRIMARY Medical Insurance: _____

Member ID: _____ Group Number: _____

Subscriber Full Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

SECONDARY Medical Insurance: _____

Member ID: _____ Group Number: _____

Subscriber Full Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

Section 8: Dental Insurance

PRIMARY Dental Insurance: _____

Member ID: _____ Group Number: _____

Subscriber Full Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

SECONDARY Dental Insurance: _____

Member ID: _____ Group Number: _____

Subscriber Full Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

Section 9: Acknowledgments

On behalf of myself or the other patient named below, I acknowledge the statements made in this form:

SLIDING FEE DISCOUNT PROGRAM
I acknowledge 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.

FINANCIAL AGREEMENT
I acknowledge 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 and will update KANA on changes to my insurance information. I understand I am financially responsible to KANA for charges not paid by insurance or IHS, and the payment for those charges is due within 30 days of receiving my bill. I understand that in addition to my provider's bill, I may receive separate bills from laboratory, radiology, and other specialized services.

TELEHEALTH
I acknowledge 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.

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, healthcare operations activities, 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. 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.

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

CONSENT FOR CARE
I consent to care by the providers at KANA, which may include diagnostic procedures, treatment, communication of my information between KANA providers and programs, and such other care and services as my care team and providers consider necessary. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse plans of care, and to be told what might happen if I do. 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 intend that this consent is continuing in nature, and will remain in full force until revoked in writing.

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NOTIFICATION OF RELEASE FOR PAYMENT

I consent to KANA disclosing 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; excluding, records protected by CFR 42 Part 2 under HIPAA.

USE AND DISCLOSURE OF HEALTH INFORMATION

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.

COMMUNICATION ABOUT MY HEALTH CARE

By providing my phone number, I consent to 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.

By signing below, I certify that I have reviewed, acknowledged, and/or consented 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 Parent/Guardian Name & Relationship **Signature of Parent/Guardian**

OFFICE USE ONLY

Staff Initials _____

Patient MRN _____

_____

☐Patient refused to sign

☐Communication barriers prohibited obtaining acknowledgment

☐An emergency situation prevented obtaining acknowledgment

☐Other: _____