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 ☐ 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 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 ☐ 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**

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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 updated 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: _____