PONCA TRIBE of NEBRASKA

REGISTRATION FORM

(Please Print)

Today's date:			HRN#:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			Sex: ☐ M ☐ F	Birth date: / /	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):			
Street address:		Social Security no.:		Home phone #:	
				Message phone #:	
P.O. Box:	City:		State:	ZIP Code:	
Place of Birth (City, State):		Current Community:		Since:	

RELIGION/TRIBAL DATA/EMPLOYMENT			
Religious Preference:		Classification/Beneficiary: ☐ Indian/Alaska Native ☐ Other:_____	
Tribe of Membership:		Enrollment #:	Tribe Quantum:
Indian Blood Quantum:	☐ Full ☐ Half ☐ One-Fourth (1/4) ☐ Other: _____		
If you are less than 4/4(full) of the above tribe, what other tribe are you?			Tribe Quantum:
Father's Name:		Email address:	Phone #:
City/State of Birth		Tribe:	Alt. Phone #:
Mother's Maiden Name:		Email address:	Phone #:
City/State of Birth		Tribe	Alt. Phone #:
Employer Name:		Phone #:	☐ Full Time ☐ Part Time
Address/City/Zip:			
Spouse's Employer Name:		Phone #:	☐ Full Time ☐ Part Time
Address/City/Zip:			
Total # people in household:		Total Household Income:	

HOUSEHOLD MEMBERS (PLEASE LIST)

NAME	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH

EMERGENCY CONTACT/NEXT OF KIN

EC-Name:	Address/City/Zip:	Phone #:
Relationship:		
NOK-Name:	Address/City/Zip:	Phone #:
Relationship:		

INSURANCE INFORMATION

****Please give ALL your insurance card(s) to staff or provide a copy of the front and back of the card(s) if mailing****

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance *(Check all that apply)*	❑ Private Insurance: _____ (Please List Name) I.D.: _____ Effective Date:_____/_____/_____ ❑ Medical (Family/Self) ❑ Dental (Family/Self) ❑ Vision (Family/Self) ❑ Medicare: I.D. # _____ Part A Effective Date:_____/_____/_____ Part B Effective Date:_____/_____/_____ Part D Effective Date:_____/_____/_____ ❑ Medicaid I.D. # _____ Effective Date:_____/_____/_____

Are you a Veteran: ❑ Yes ❑ No	If yes, what is your serial number:	Which Branch did you serve in:	
Entry date:	Discharge date:	Group no.:	Policy no.:
Vietnam connected: ❑ Yes ❑ No		Service Connected: ❑ Yes ❑ No	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

PATIENT SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Ponca Tribe of Nebraska/Fred LeRoy Health & Wellness Center/Ponca Hills Health & Wellness Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Ponca Health Services

Consent to Receive Services
Release of Financial Responsibility
And Assignment of Benefits

I voluntarily consent to the provision of medical diagnosis, physical examination, screening, diagnostic procedures, treatment, nursing care and transportation as provided by Ponca Health Services.

I hereby authorize payment to Ponca Health Services for the amount of money to which I am due or allowed for medical, dental, and/or surgical expenses from any insurance company, payor, or other responsible third party for each claim submitted.

The Ponca Health Services will not assume responsibility or liability or be held responsible or liable for any services rendered outside Ponca Health Services. If I am referred out of the clinic to see a different provider, Ponca Health Services is not liable for any charges that are billed. If there is an insurance carrier in effect, they will be billed first then I, the patient, am responsible for whatever the insurance does not pay. If there is no insurance, I, the patient, will be held responsible for the whole bill.

The only possible exception would be if the clinic staff is unable to obtain a collection of blood or other specimen. Under these circumstances the Ponca Health Services may pay for that bill.

I understand all part of this form and I sign it knowingly and voluntarily.

Date: [{[DateSigned]}]

Patient/Guardian: [{[Signature]}]

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Ponca Health Services' Notice of Privacy Practices ("Notice") provides information about how we may use and disclose health care information about you. As provided in our Notice, the terms of our Notice may change. If we change the terms, you may obtain a revised copy.

I, , acknowledge that:

- I have received a copy of the Ponca Health Services' Notice of Privacy Practices.
- I have had an opportunity to read the Notice of Privacy Practices.
- I may ask questions to Ponca Health Services if I do not understand any information contained in the Notice of Privace Practices.

PATIENT/GUARDIAN SIGNATURE: [{[Signature]}]

DATE: [{[DateSigned]}]

RELATIONSHIP TO PATIENT:

Practice Site:

FOR HEALTH SERVICES USE ONLY

(Complete if signature requested but not obtained)

Staff member attempted to obtain written acknowledgement of receipt of Ponca Health Services' Notice of Privacy Practices, but, acknowledgement could not be obtained because:

- ☐ Patient/Parent/Legal Guardian refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other:

The Notice of Privacy Practices was provided to the Patient/Parent/Legal Guardian by:

- ☐ Handling or attempting to distribute the Notice of Privacy Practices to the Patient/Parent/ Legal Guardian but the Patient/Parent/Legal Guardian declined to sign the acknowledgment of recept of the Notice of Privacy Practices
- ☐ Patient/Parent/Legal Guardian stated that they had already received the Privacy Notice
- ☐ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian at the last known address of the patient
- ☐ Other:

[{[Signature]}] [{[DateSigned]}]

Signature of staff member Date

Ponca Health Services

HEALTH INFORMATION EXCHANGE OPT-IN CONSENT FORM

This form is to be used by patients who want to participate in the Health Information Exchange (HIE)

Ponca Health Services ("Health Services") participates in the _____health information exchange ("HIE"). The HIE is a way of allowing your health information to be shared by participating healthcare providers, hospitals, emergency rooms, pharmacies, and labs ("providers") through secure, electronic means. The purpose of the HIE is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you.

Your participation in the HIE is voluntary. Your receipt or payment for treatment will not be conditioned on whether or not you participate in the HIE. Even if information is in the HIE, Health Services and the HIE may only disclose information in accordance with the laws and rules that apply to them under HIPAA and 42 C.F.R. Part 2, including requiring your consent to re-disclose any substance use information protected by 42 C.F.R. Part 2 unless otherwise provided for by law.

Unless you opt-out, any authorized healthcare provider who participates in the HIE or is a member of an HIE that is connected to an HIE Health Services uses can electronically access and share your health information through the HIE in the provision of care to you.

Patient Name:	Date of Birth:	Chart #:	
Address:	City:	State:	Zip:

By signing this form, I hereby acknowledge and agree as follows:

$ I consent to my providers that participate in the HIE, including Health Services, to disclose my health information to the HIE and to share my health information with all participating providers of the HIE that are involved in my care. The HIE may also share my health informaiton with members of other health information exchanges to which the HIE connects who are involved in my care. It may take between 2-4 business days after receipt to process my consent and for the HIE to make my information available for sharing thorugh the HIE.

$ My health information that will be shared through the HIE will include health information from both before and after today's date and includes information about my diagnosis, test results (like x-rays or laboratory), and medications that have been prescribed to me. Such information may also include health information that may be considered particularly sensitive to me, including:

- Mental health information
- Alcohol/drug abuse treatment information
- HIV/AIDS information and test results
- Genetic information and test results
- STD treatment and test results
- Family planning information

$ I understand the health informaiton shared through the HIE may indicate the presence of a communicable or sexually transmitted disease, such as hepatitis, syphilis, gonorrhea, tuberculosis, the human immunodeficiency virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"). I expressly consent to the release of my health information and history through HIEs even when it indicates the presence of such a disease or condition.

$ The purpose of sharing and disclosing my information through the HIE is to give my participating providers the benefit of having access to my health information in order to treat me and provide healthcare to me.

$ Participating providers who receive health inforrmation about me thorugh the HIE, including Health Services, may copy or include my health information into their own records when caring for me. From then, such providers may further disclose such information only in accordance with the laws and rules that apply to it under HIPAA and 42 C.F.R. Part 2.

$ I understand my records related to alcohol and drug abuse are protected under HIPAA and 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for by law. Whenever a participating provider in the HIE requests records of Health Services related to alcohol and drug abuse through the HIE, the disclosure will include a notice that re-disclosure is prohibited under federal law, except as permitted with my consent or when required by law.

$ If I previously exercised my right to opt-out of the HIE, I have changed my mind and hereby revoke my prior decision to opt out of my health information being shared by Health Services through the HIE.

$ I understand that this consent will remain in effect until I cancel it. I may cancel this consent by completing and submitting the Health Services "Health Information Exchange Opt-Out Form" and submitting the completed form to Health Services. However, if I cancel this consent, it will not have any effeont on (1) any actions taken prior to Health Services receiving the cancellation, (2) to the extent action has been taken in reliance on this consent, (3) any health information participating providers in the HIE already accessed and copied, or (4) if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

$ I understand that I may decide not to sign this form and that my treatment, payment, enrollment, or eligility for benefits will not be conditioned on whether I sign this consent. I also have a right to receive a copy of this form after I have signed it.

[{[Signature]}] Date: [{[DateSigned]}]

Signature of the Individual Giving this Authorization

Name of the Individual Giving this Authorization

Relationship to Individual (if Individual not signing)

NOTICE TO RECIPIENT PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS

Information disclosed to you pursuant to this consent is from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of informaiton in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

FOR HEALTH SERVICES USE ONLY

Date revoked: Staff initials: