REGISTRATION FORM INFORMATION

Contract Health Services requires you to update your application if any information changes. Addresses, name changes, phone numbers, employment, and insurance information can be changed by completely filling out an updated application. An application must be filled out for each individual person. You will be required to update yearly as well. You may also access an application by going to www.ctsi.nsn.us, click on Health Care, click on Contract Health, then on registration form.

****The following documentation is needed for various changes****

- **Name change:**
  If you have a name change we need legal documentation in the form of a state ID card, marriage certificate, divorce decree or other court documentation.

- **Moving back into the 11 county service area:**
  When moving back into the service area we require you to provide documentation of your physical address. We accept a state ID with the *current physical address* listed or a utility bill in *your* name with the *current physical address* (we do not accept Tribal ID, envelopes addressed to your address or any other form of documentation with a PO BOX on it).

- **Newborn child:**
  If you are registering a newborn child please provide a copy of one of the following:
  - Hospital announcement with both mother and father's name printed
  - Birth certificate
  - Newspaper announcement with both mother and father's name printed

~ If you currently have any private insurance (Blue Cross, OHP, HMO, Medicare, HMA, etc) please provide a copy of the front and back of your insurance card with your registration form.

~ Failure to update your registration annually may leave you responsible for any and all of your health care bills. Your Caremark card (Pequot) may subsequently be held in our office until you have updated.

Please be sure to fill out the entire application. Do not forget to sign and date the application, as this may hold up your registration process.

You may return your form with proper documentation either by mail to:
Siletz Contract Health
PO Box 320
Siletz, OR 97380

Or you may fax to: **541-444-9645**

If you have any questions, please call CHS at 541-444-1236

SILETZ COMMUNITY HEALTH CLINIC
REGISTRATION FORM

ELIGIBILITY STATUS: WKER ID

DIRECT: ( ) CONTRACT: ( ) INELIGIBLE: ( )

CHART #:_____

PATIENT LEGAL NAME: _____
(Please Print) LAST FIRST MIDDLE

SOCIAL SECURITY NUMER: _____ BIRTHDATE: _____ AGE:_____ SEX: Male / Female

Street: ❑ Mailing ❑ Physical _____

_____
City State ZIP

Street: ❑ Mailing ❑ Physical _____

_____
City State ZIP

LAST DATE MOVED: _____ PLEASE LIST YOUR PRIMARY LANGUAGE:_____

MARITAL STATUS: Single ❑ Married ❑ Domestic Partner ❑ Divorced ❑ Separated ❑ Widow/er ❑ Other ❑

CONTACT PREFERENCE: Cell ❑ Home ❑ Work ❑ Alternate ❑ Cell #:_____

Home#:_____ Work#:_____ Alternate#:_____

E-mail address:_____

EMPLOYER:_____ Phone:_____

Address:_____
City State ZIP

Occupation:_____ Are you a full-time college student? ❑ Yes ❑ No

Spouse's Employer:_____

Father's Name:_____ Mother's Full Maiden Name:_____

IF MINOR CHILD: Father's Employer:_____ Mother's Employer:_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____

Address:_____
City State ZIP

Telephone Number:_____

ARE YOU HOMELESS? ❑ Yes ❑ No **If Yes** (circle one): Homeless Shelter / Transitional / Doubling Up / Street / Other / Unknown

ARE YOU A MIGRANT WORKER? ❑ Yes ❑ No If yes, which type? (circle one): Migrant Agriculture Seasonal Agriculture

RACE (circle any): American Indian/Alaska Native White African American Hispanic Asian or Pacific Islander

ETHNICITY (circle): Declined to specify Hispanic or Latino Not Hispanic or Latino Unknown/Not Reported

ARE YOU A VETERAN? ❑ Yes ❑ No

IF you are NATIVE AMERICAN or a dependent of a Native American, you must complete this section:

Name of Tribe enrolled in:_____ Tribal Blood Quantum:_____

If you are a dependent, WHO is enrolled?_____ Roll #:_____

MEDICAL

PRIMARY INSURANCE

❑ Private ❑ Medicaid ❑ Medicare

Insurance Company Name:_____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Phone:_____

Relationship to Patient:_____ Subscriber's Employer:_____

Subscriber's SSN:_____ Subscriber's DOB:_____

SECONDARY INSURANCE

Insurance Company Name:_____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Phone:_____

Relationship to Patient:_____ Subscriber's Employer:_____

Subscriber's SSN:_____ Subscriber's DOB:_____

DENTAL

PRIMARY INSURANCE

❑ Private ❑ Medicaid ❑ Medicare

Insurance Company Name:_____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Phone:_____

Relationship to Patient:_____ Subscriber's Employer:_____

Subscriber's SSN:_____ Subscriber's DOB:_____

SECONDARY INSURANCE

Insurance Company Name:_____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Phone:_____

Relationship to Patient:_____ Subscriber's Employer:_____

Subscriber's SSN:_____ Subscriber's DOB:_____

OPTOMETRY

PRIMARY INSURANCE

❑ Private ❑ Medicaid ❑ Medicare

Insurance Company Name:_____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Phone:_____

Relationship to Patient:_____ Subscriber's Employer:_____

Subscriber's SSN:_____ Subscriber's DOB:_____

SECONDARY INSURANCE

Insurance Company Name:_____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Phone:_____

Relationship to Patient:_____ Subscriber's Employer:_____

Subscriber's SSN:_____ Subscriber's DOB:_____

ASSIGNMENT OF BENEFITS * SCHC FINANCIAL POLICIES

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICIES

All professional services rendered are charged to the patient. All necessary forms will be completed to expedite insurance carrier payments. Please understand that insurance coverage is an agreement between you and your insurance company to pay certain amounts for your medical care. Our office will not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Any monies received from an insurance company for services provided by the SCHC are owed to the clinic.

All patients are required to utilize any alternate resources available to them. Alternate resources (including IHS facilities) are any that are available and accessible to an individual. They would include but not be limited to such sources as Medicare, Medicaid, Vocational Rehabilitation, Veterans administration, Crippled Children, Private Insurance, Workers Compensation, Motor Vehicle Insurance, and other programs. Congress passed a law that allows us to bill health insurance carriers for care provided to Native American patients who use IHS facilities. Federal Regulations waive the Native American patient's responsibility to pay co-pays or deductibles for office visits. All patients are screened for Medicaid/OHP prior to receiving services and **ARE REQUIRED** to apply if eligible.

I hereby authorize Siletz Community Health Clinic to furnish information to insurance carriers concerning my illness and treatments and hereby assign to SCHC all payments for services rendered to my dependents or myself. I understand that patients are financially responsible for the cost of their health care services. This cost will normally be reimbursed (or covered) by my insurance or by the Indian Health Service. To the extent it is not covered by other legally responsible sources, however, I understand I remain liable for reimbursing SCHC for the cost of care. I will be informed of any amounts for which I am financially responsible.

NOTICE OF PRIVACY PRACTICES

You will receive a copy of the Siletz Community Health Clinic, Notice of Privacy Practices (HIPAA), effective date April 14, 2003. Please review the policy and sign the receipt of notice. Copies of the privacy practices are available at the reception area. If you have questions regarding the Notice of Privacy Practices please report them to the Privacy Officer at SCHC.

RESPONSIBILITIES OF PATIENTS

You are responsible for making and keeping appointments. If you are not able to keep an appointment, it is your responsibility to call SCHC to cancel or reschedule at least 24 hours prior to your cancellation so that someone else HAS THE OPPORTUNITY TO BE SEEN. You are responsible for informing SCHC of any changes in your personal status, including changes in your address or phone number, legal name changes, and changes in eligibility or health insurance coverage.

I understand that my signature authorizes treatment at the Siletz Community Health Clinic for the duration of one year from the date of my signature. I have read and understand the above information and hereby give authorization for payment of insurance benefits to be made directly to the SCHC for services rendered. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature:_____ **Date:**_____

SILETZ COMMUNITY HEALTH CLINIC
NOTICE OF PRIVACY PRACTICES

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

April 14, 2003

I. Understanding Your Health Record/Information

Each time you visit the Siletz Community Health Clinic facility for services, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment
- Communication source between health care professionals
- Tool with which we can check results and continually work to improve the care we provide
- Means by which Medicare, Medicaid or private insurance payers can verify the services billed.
- Tool for education of health care professionals
- Source of information for public health authorities charged with improving the health of the people
- Source of data for medical research, facility planning and marketing
- Legal document that describes the care you receive

Understanding what is in your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

II. Your Health Information Rights

Although your health record is the physical property of the Siletz Community Health Clinic, the information belongs to you.

You have the right to:

- **Inspect and receive a copy of your health record**
- **Request a restriction** on certain uses and disclosures of your health information. For example, you could ask that we not disclose your health information about the treatment you received to a family member. SCHC is not required to agree to your request; but if we do, we will comply with your request unless the information is needed to provide you with emergency services.
- **Request an amendment to your health record** if you believe the health information we have about you is incorrect or incomplete.
- **Request confidential communications about your health information.** You may ask that we communicate with you at a location other than your home or by a different means of communications such as telephone or mail.
- **Receive a listing of certain disclosures SCHC has made** of your health information upon request. This information is maintained for six years or the life of the record, whichever is longer.

- **Revoke your written authorization to use or disclose health information**. This does not apply to health information already disclosed or used or in circumstances where we have taken action on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.
- **Obtain a paper copy of the SCHC Notice of Privacy Practices** upon request

III. SCHC' Responsibilities

The Siletz Community Health Clinic is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Honor the terms of this notice or any subsequent revisions of this notice.

SCHC reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. SCHC will post any revised Notice of Privacy Practices at public places in this facility and on its web site at http://www.ctsi.nsn.us, on or after the effective date of the revision, and you may request a copy of the notice.

SCHC understands that health information about you is personal and is committed to protecting your health information. **SCHC will not use or disclose your health information without your permission, except as described in this notice and as permitted by the SCHC Policy and Procedures.**

IV. How SCHC may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

We will use and disclose your health information to provide your treatment.

> **For example:** Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider will document in your health record her/his instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your health record so your health care provider will know how you are responding to treatment.
>
> If SCHC refers you to another health care facility under the Contract Health Service (CHS) program, SCHC may disclose your health information with that health care provider for treatment decisions.
>
> If you are transferred to another facility for further care and treatment, SCHC may disclose information with that facility to enable them to know the extent of treatment you have received and other information about your condition.
>
> Your health care provider(s) may give copies of your health information to others to assist in your treatment.

We will use and disclose your health information for payment purposes.

For example: If you have private insurance, Medicare, or Medicaid coverage, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.

If SCHC refers you to another health care provider under the Contract Health Service (CHS) program, SCHC may disclose your health information with that provider for health care payment purposes.

We will use and disclose your health information for health care operations.

For example: We may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under Contract Health Services (CHS) program.

Business Associates: SCHC provides some healthcare services and related functions through the use of contracts with business associates. Examples include: emergency room physicians, podiatry medicine, radiology, laboratory tests, and medical transcription. When these services are contracted, SCHC may disclose your health information to business associates so that they can perform their job. We require our business associates to protect and safeguard your health information in accordance with all applicable federal laws.

Directory: SCHC may disclose your name, general condition, religious affiliation, and location within our facility, for facility directory purposes, unless you notify us that you object to this information being listed. This information may be provided to members of the clergy and others who ask for you by name.

Notification: SCHC may use or disclose your health information to notify or assist in the notification of a family member, personal representative or other authorized person(s) responsible for your care concerning your location or general condition, unless you notify us that you object.

Communication with Family: SCHC health providers may disclose your health information to others authorized in the responsibility of your care unless you notify us that you object. For example, SCHC may provide your family members, other relatives, close personal friends or any other person you identify with health information which is relevant to that person's involvement with your care or payment for such care.

Interpreters: In order to provide you proper care and services, SCHC may use the services of an interpreter. This may require disclosure of your personal health information to the interpreter.

Research: SCHC may use or disclose your health information for research purposes that has been approved by an SCHC Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Uses and Disclosures about Decedents: SCHC may disclose health information about decedents to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. SCHC also may disclose health information to funeral directors consistent with applicable law as necessary to carry out their duties. In addition, SCHC may disclose protected health information about decedents where required under the Freedom of Information Act or otherwise required by law.

Organ Procurement Organizations: Consistent with applicable laws, SCHC may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Treatment Alternatives and Other Health-related Benefits and Services: SCHC may contact you to provide information about treatment alternatives or other types of health-related benefits and services that may be of interest to you. For example: we may contact you about the availability of new treatment or services for diabetes.

Appointment Reminders*:* SCHC may contact you with a reminder that you have an appointment for medical care at our facility or to advise you of a missed appointment.

Food and Drug Administration (FDA): SCHC may disclose your health information to the FDA in connection with an FDA-regulated product or activity. For example: we may disclose to the FDA information concerning adverse events involving food, dietary supplements, product defects or problems, and information needed to track FDA-regulated products or to conduct product recalls, repairs or replacements, or post marketing surveillance.

Workers Compensation: SCHC may disclose your health information for workers compensation purposes as required by law.

Public Health: SCHC may disclose your health information, as required by law, to public health or other appropriate government authorities: (1) authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations , and interventions; (2) authorized by law to receive reports of child abuse or neglect, and (3) authorized by law to receive reports of other abuse, neglect, or domestic violence (other than child abuse). Where authorized by law, SCHC may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. In some situations (for example, if you are employed by SCHC or another component of the Department of Health and Human Services, or in compelling circumstances affecting the health and safety of an individual), SCHC may disclose to your employer health information concerning a work-related illness or injury or a workplace-related medical surveillance.

Correctional Institution: If you are an inmate of a correctional institution, SCHC may disclose to the institution, health information necessary for your health and the health and safety of other individuals.

Law Enforcement: SCHC may disclose health information for law enforcement purposes as required by law or in response to an order from a court of competent jurisdiction, or in response to a valid request from an authorized law enforcement official, as permitted under federal law.

Members of the Military: If you are a member of the military services, SCHC may disclose your health information to your military command authorities.

Health Oversight Authorities: Where required by law or necessary for an employee of the Department of Health and Human Services to perform his or her official duties, SCHC may disclose your health information to health oversight agencies for activities authorized by law. These oversight activities include: investigations, audits, inspections and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance. SCHC is required by law to disclose protected health information to the Secretary of HHS to investigate or determine compliance with the HIPAA privacy standards.

Compelling Circumstances: SCHC may use or disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances: (1) we may disclose limited protected health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; (2) if you are believed to be a victim of a crime, a law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency circumstances, we may disclose the requested

information if we determine that such disclosure would be in your best interests; and (3) we may use or disclose protected health information as we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person.

Non Violation of this Notice: SCHC is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses protected health information under the following circumstances:

1. **Disclosures by Whistleblowers:** If an SCHC employee or contractor (business associate) in good faith believes that SCHC has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by SCHC has the potential of endangering one or more patients or members of the workplace or the public and discloses such information to:

    a. A Public Health Authority or Health Oversight Authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions, or the suspected violation, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by SCHC; or
    b. An attorney on behalf of the workforce member, or contractor (business associate) or hired by the workforce member or contractor (business associate) for the purpose of determining their legal options regarding the suspected violation.

2. **Disclosures by Workforce Member Crime Victims:** Under certain circumstances, an SCHC workforce member (either an employee or contractor) who is a victim of a crime on or off the hospital premises may disclose information about the suspect to law enforcement official provided that:

    a. The information disclosed is about the suspect who committed the criminal act.
    b. The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time. (Such revocation would not apply where the health information already has been disclosed or used or in circumstances where SCHC has taken action in reliance on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.)

To exercise your rights under this Notice, to ask for more information, or to report a problem contact the Service Unit Director/Chief Executive Officer or the Service Unit Privacy official in writing at:

SILETZ COMMUNITY HEALTH CLINIC
ATTN: BEVERLY RECTOR, RHIT, PRIVACY OFFICER
PO BOX 320
SILETZ, OR 97380
541-444-1030

If you believe your privacy rights have been violated, you may file a written complaint with the above individual(s) or the Secretary of Health and Human Services, U.S. Department of Health and Human Services, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

Effective Date: April 14, 2003

Acknowledgement of Receipt of SCHC Notice of Privacy Practices

I hereby acknowledge receipt of the Siletz Community Health Clinic (SCHC) Notice of Privacy Practices at:

SILETZ COMMUNITY HEALTH CLINIC
PO BOX 320
SILETZ, OR 97380

Signature of Patient	Date
Signature of Patient Representative (state relationship to patient) Witness (if signature is by thumb print or mark)	Date
Signature and Title of SCHC Employee	Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the SCHC Notice of Privacy Practices because:

Signature of SCHC Employee	Date