SILETZ COMMUNITY HEALTH CLINIC
REGISTRATION FORM

ELIGIBILITY STATUS: WKER ID
DIRECT: ( ) CONTRACT: ( ) INELIGIBLE: ( )
CHART #:_____

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

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

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

Street: ❑ Mailing ❑ Physical _____

_____
City State ZIP

Street: ❑ Mailing ❑ Physical _____

_____
City State ZIP

LAST DATE MOVED: _____PRIMARY LANGUAGE: _____

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

CONTACT PREFERENCE FOR APPOINTMENT REMINDERS: E-mail ❑ Text ❑ Phone Call ❑ to: Home ❑ or Cell ❑

Home #:_____ Cell #:_____ Alternate #:_____

E-mail address:_____

EMPLOYER:_____ Phone:_____

Address:_____
City State ZIP

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

EMERGENCY CONTACT:

Name:_____ Relationship:_____

Address:_____
City State ZIP

Home #:_____ Cell #: _____

ARE YOU A VETERAN? ❑ Yes ❑ No **ARE YOU A FULL TIME COLLEGE STUDENT?** ❑ Yes ❑ No

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

IF you are NATIVE AMERICAN or a dependent of a Native American, you must complete this section (must be a Federally Recognized Tribe):

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

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

PRIMARY INSURANCE: ❑ Private ❑ Medicaid ❑ Medicare – **YOU MUST ALSO PROVIDE A COPY OF ALL INSURANCE CARDS**

Insurance Company Name:_____ Insurance ID#:_____

Insurance Company Phone #:_____ _____ Group #: _____

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

Relationship to Patient:_____ Subscriber's Employer:_____

Siletz Community Health Clinic - PO Box 320 Siletz, OR 97380 – Phone: 541.444.1030

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

SECONDARY INSURANCE:

Insurance Company Name:_____ Insurance ID#:_____

Insurance Company Phone #:_____ _____ Group #: _____

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

Relationship to Patient:_____ Subscriber's Employer:_____

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

DENTAL INSURANCE:

Insurance Company Name:_____ Insurance ID#:_____

Insurance Company Phone #:_____ _____ Group #: _____

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

Relationship to Patient:_____ Subscriber's Employer:_____

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

OPTOMETRY INSURANCE:

Insurance Company Name:_____ Insurance ID#:_____

Insurance Company Phone #:_____ _____ Group #: _____

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

Relationship to Patient:_____ Subscriber's Employer:_____

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

PHARMACY INSURANCE:

Insurance Company Name:_____ Insurance ID#:_____

Insurance Company Phone #:_____ _____ Group #: _____

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 the 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 the Clinic for the cost of care. I will be informed of any amounts for which I am financially responsible.

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 the clinic 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 the clinic 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:**_____