

DO YOU HAVE HEALTH CARE COVERAGE? Yes No

What Type? Medicare Part A Medicare Part B Medicaid Veterans **Private or Kaiser**

If you do not have any of the above, have you applied for the OREGON HEALTH PLAN?

Yes No If yes, when? _____

PLEASE GIVE US A COPY OF YOUR INSURANCE CARD

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.

NOTICE OF PRIVACY PRACTICES

You will receive a copy of the Siletz Tribal Health Department, Notice of Privacy Practice, (HIPPA) 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 please report them to the Privacy Officer at the 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 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 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.

Your Signature: _____ Date: _____