COWLITZ INDIAN TRIBE

HEALTH & HUMAN SERVICES

Tribal Clinic

In order to complete and/or update your registration for Direct Care Services, the following information is needed:

( ) New Patient Registration Form

( ) Driver's License ***or*** State ID Card ***or*** Social Security Card & Birth Certificate

( ) A Copy of Your Primary Insurance Card (Medicaid, Medicare, Regence, etc.) **OR** Proof of completed application for health care coverage

( ) Tribal ID Card or Certificate of Indian Blood (CIB)

( ) Patient Rights and Responsibilities (please sign and return)

If you are registering as a Direct Descendent, additional documents are required:

( ) Birth Certificate

( ) Parent's Tribal ID and/or Certificate of Indian Blood (CIB)

( ) Driver's License ***or*** State ID Card ***or*** Social Security Card

If you are registering as a Self-Attesting, Non-Native, State Recognized or First Nations member, you must also submit:

( ) Family Tree and Native American Heritage Questionnaire

( ) Cowlitz Indian Tribe Financial Agreement

( ) Driver's License ***or*** State ID Card ***or*** Social Security Card

Please return the necessary documents as soon as possible. If you have any questions please feel free to contact our office at the number below.

Sincerely,

Cowlitz Indian Tribal Health

MAIL TO: P.O. Box 2429 ~ Longview, WA 98632
360-575-8275 ~ Fax: 360-575-1952
Located: 1044 11th Avenue | www.cowlitz.org

OFFICE USE ONLY
Input By_____

Checked By_____

New Patient Registration

OFFICE USE ONLY
Health Record#_____
CHS_____ Direct_____
Non Native_____ Self Identify _____
NWPS_____CHS Card_____

Patient Name:_____

Maiden Name/Other Name Used:_____

Date of Birth: _____ **Social Security #:**_____ **Sex: M** ◯ **F** ◯ **Marital Status: S** ◯ **M** ◯ **D** ◯ **W** ◯

Mailing Address:_____ **City** _____ **State**_____ **Zip**_____

Physical Address:_____ **City**_____ **State**_____ **Zip**_____

County:_____

Previous Address:_____ **City**_____ **State**_____ **Date Moved:**_____

Home Phone:_____ **Is this your preferred number? Y** ◯ **N** ◯ **May we leave a message? Y** ◯ **N** ◯

Cell Phone:_____ **Is this your preferred number? Y** ◯ **N** ◯ **May we leave a message? Y** ◯ **N** ◯

Internet Access? Y ◯ **N** ◯ **Email Address:**_____

Work Status: FT ◯ **PT** ◯ **Unemployed** ◯ **Retired** ◯ **Self-Employed** ◯ **Disabled** ◯

Student: FT ◯ **PT** ◯ **Where:**_____

Patient Employer:_____ **Work Phone:**_____

Employer Address:_____**State:**_____ **Zip**_____

Does your employer offer health insurance? Y ◯ **N** ◯

Primary Insurance/Health Coverage Information

Insurance/Coverage Name:_____ **Phone:**_____

Eligibility Start Date:_____ **Policy Holder: Self Other**_____

ID#:_____ **Group#:**_____

Dental Insurance:_____ **Vision Coverage:**_____ **Rx:**_____

(Name of Insurance/Policy#) (Name of Insurance/Policy#) (Name of Insurance/Policy#)

Policy Holder Information

Policy Holder Name:_____

Date of Birth:_____ **Social Security#:**_____ **Sex: M** ◯ **F** ◯

Phone:_____

Address:_____ **City**_____ **State** _____ **Zip**_____

Employer Name:_____ **Phone:**_____

Employer Address:_____**City**_____ **State** _____ **Zip**_____

Secondary Insurance/Health Coverage Information

Insurance/Coverage Name:_____ **Phone:**_____

Eligibility Start Date:_____ **Policy Holder: Self Other**_____

ID#:_____ **Group#:**_____

Dental Insurance:_____ **Vision Coverage:**_____ **Rx:**_____

(Name of Insurance/Policy#) (Name of Insurance/Policy#) (Name of Insurance/Policy#)

Policy Holder Information

Policy Holder Name:_____

Date of Birth:_____ **Social Security#:**_____ **Sex: M** ◯ **F** ◯

Phone:_____

Address:_____ **City**_____ **State** _____ **Zip**_____

Employer Name:_____ **Phone:**_____

Employer Address:_____**City**_____ **State** _____ **Zip**_____

INDIAN HEALTH SERVICES INFORMATION

Native American: Y ◯ N ◯ Tribe: _____
Enrolled: Y ◯ N ◯ Descendent: Y ◯ N ◯ Birthplace: (City)_____ (State)_____
Tribal Blood Quantum: _____ Total Blood Quantum:_____ Enrollment #:_____
Father's Name:_____ Tribe:_____
Father's Birthplace: (City)_____ (State)_____
Mother's Name:_____ Tribe:_____
Mother's Maiden Name:_____
Mother's Birthplace: (City)_____ (State)_____

Are you receiving services at a Tribal/IHS Clinic? Y ◯ N ◯ If yes, Clinic Name:_____
What types of services? (Circle all that apply): Medical ☐ Dental ☐ Pharmacy ☐
Behavioral Health ☐ Other:_____

Emergency Contact:_____ Relationship:_____
Home Phone:_____ Alternative Phone:_____
Address:_____ City:_____ State:_____ Zip:_____

Other members of your household:

Name	Sex	Relationship	Birth date	Tribe Enrolled

Do you Have Advance Directives on file with any organization? Y ◯ N ◯
If yes, what type? Power of Attorney ◯ Living Will ◯ Other_____ Where?_____
If no, would you like to file advance directives at the Cowlitz Indian Tribal Health Clinic? Y ◯ N ◯

Veteran Status: US Veteran? Y ◯ N ◯ (If no, skip this box) Service Entry Date: _____/_____/_____
Vietnam Service: Y ◯ N ◯ Service Related Disability: Y ◯ N ◯ Separation Date: _____/_____/_____
Disability Claim#:_____ Type of Disability:_____
Valid VA Card?: Y ◯ N ◯ Are you receiving services at your nearest VA Facility?: Y ◯ N ◯

Are you Hispanic or Latino? Y ◯ N ◯ Unknown ◯ Seasonal Migrant Farmworker? Y ◯ N ◯
Do you speak any language other than English? If so, what language?_____
Homeless? Y ◯ N ◯ Type: Transitional ◯ Shelter ◯ Doubling up ◯ Street ◯ Other ◯

AUTHORIZATION

I hereby authorize the release of any medical or other information necessary to process this claim.
I also authorize payment of medical benefits either to myself or to the party who accepts assignment.
I hereby assign benefits otherwise payable to me, to Cowlitz Indian Tribal Health Clinic.
I also understand I am financially responsible for any balance not covered by insurance company.
YOUR SIGNATURE INDICATES THAT YOU ARE ACCEPTING FINANCIAL RESPONSIBILITY

Printed Name:_____ Signature:_____ Date: _____

Relationship to Patient: _____

Cowlitz Indian Tribal Medical Clinic – Patient Rights and Responsibilities

Patient Rights

1. You have the right to safe, high quality medical care without discrimination that is compassionate and respects your personal dignity, values, and beliefs.

2. You have the right to participate and make decisions about your care and pain management including refusing care to the extent permitted by law. Your care provider will explain to you the medical consequences of refusing recommended treatments.

3. You have the right to have your illness, treatment, pain, alternatives, and likely outcomes explained to you in a manner you can understand including provision of interpretation services if needed.

4. You have the right to know the name and title of your health care providers. At your request, you have the right to a second opinion.

5. You have the right to request that a family member, friend, or outside physician be notified that you are under the care of this facility.

6. You have the right to be informed if your care will be provided by another organization or facility including an explanation of alternatives to a transfer.

7. You have the right to know about the policies used by the organization that may affect your care and treatment.

8. You have the right to participate in, or decline to participate in, research studies. You may decline participation without compromising your access to care, treatment, or services.

9. You have the right to private and confidential treatment, communications, and patient records as permitted by law.

10. You have the right to receive information concerning advance directives (living wills, power of attorney, and mental health advance directives) and these will be respected during treatment to the extent permitted by law.

11. You have the right to access your personal medical records within a reasonable timeframe to the extent permitted by law.

12. You have the right to be informed of charges and receive counseling on the availability of known financial resources for your health care.

13. You have the right to be free from abuse including accessing advocacy or protective service agencies.

14. You have the right to voice compliments, concerns, or complaints without compromising your access to care, treatment, or services. (For concerns/complaints/grievances please see the Patient/Client Grievance Policy.)

15. You have the right to change providers if other qualified providers are available.

Cowlitz Indian Tribal Medical Clinic – Patient Rights and Responsibilities

16. You have the right to refuse observation or treatment by student or other non CITHC credentialed provider.

Patient Responsibilities:

1. You are responsible for providing accurate and timely information about your health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities, and insurance benefits.

2. You are responsible for asking our health care provider if you do not understand the medical terminology being used or instructions relating to your plan of care.

3. You are responsible for following your plan of care. If you are unable or unwilling to follow this plan, you are responsible for informing your health care provider. The provider will then explain the medical consequences of not following the recommended treatment and you are responsible for any outcomes related to not following your plan of care.

4. You are responsible for following the rules, regulations, and policies of the facility.

5. You are responsible for acting in a manner that is respectful to other patients, staff, and Tribal property.

6. You are responsible for meeting your financial obligations to the facility.

Patient Agreement:

I have read and understand my patient rights and responsibilities. Furthermore I understand and agree to the following:

1. I have received a copy of this facility's notice of privacy practices.
   _____ (initial)

2. I have been informed that most lab services conducted at this facility are provided by a private lab, not the Cowlitz Indian Tribe, and those services will be billed to my insurance provider and/or to me personally. I will be notified and accept financial responsibility before receiving lab services that will be billed to me and/or my insurance provider.
   _____ (initial)

3. I have provided current insurance information and have authorized the Cowlitz Indian Tribe to bill my insurance provider. I will notify the clinic of changes to my insurance coverage.
   _____ (initial)

_____ _____
Print Patient Name Date

_____
Patient Signature

COWLITZ INDIAN TRIBE
HEALTH & HUMAN SERVICES

Patient Financial Agreement

I agree to pay Cowlitz Indian Tribal Health Services in accordance with its regular scheduled rates and terms for all charges and services rendered to myself (or the patient if a minor) by Cowlitz Indian Tribal Health Services.

I authorize the release of any medical or other information necessary to process my medical claims.

I assign and authorize payment of medical benefits directly to Cowlitz Indian Tribal Health Services for all insurance benefits including government benefits otherwise payable to me. I understand that if charges are not covered by insurance of any type it is nevertheless my personal obligation to pay for all charges billed.

Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at legal rate.

By signing below, I also acknowledge that I have been given a copy of this agreement.

_____

Patient Name Printed

_____ _____

Patient Signature (if under age 18 requires parent signature) Date

_____ _____

Parent or Legal Guardian (if the patient is under 18 years old) Date

_____ _____

Staff Signature Date

Federally recognized Native Americans and Alaskan Natives receiving services at Cowlitz Indian Tribal Health Services will not be charged for deductibles, co-pays, co-insurance, or any other patient responsible portion.

1044 11th Avenue ~ P.O. Box 2429 ~ Longview, WA 98632 ~ 360-353-9494 ~ Fax: 360-353-9440

COWLITZ INDIAN TRIBE

HEALTH & HUMAN SERVICES

Contract Health Services

CHS 102

To be eligible for Contract Health Services (CHS) I, _____, understand that under Federal Regulations I am required to provide true and accurate information pertaining to:

- **PHYSICAL RESIDENCY**: Residency it determined by both the **physical presence** of an individual in a CHS delivery area combined with the intent of the individual to remain there permanently. (Proof in the form of a utility bill, cable invoice and/or school enrollment must accompany CHS registration).
- **MEDICAL HISTORY**
- **ALTERNATE RESOURCES** (CHS, by Federal Regulation is considered a payer of last, accordingly, the CHS program will not be responsible for or authorize payment for services if a member is or would be eligible for other resources. Examples include: private insurance, Medicaid, Medicare, Veterans Administration, etc. **Summary, if you quality for another source of health care you must accept it.**)
- **TRIBAL AFFILIATION**

I am aware that providing false information may result in the loss of CHS coverage and/or legal action.

I also understand that I am responsible:

- Of notifying CHS if I am to be absent from the service area in which I am eligible and understand that I will remain CHS eligible for 90-days from such departure. If upon moving or returning to the service area I must inform CHS and provide proof of physical residency.
- I must notify CHS with at least 72-hours notice prior to each and every appointment to include ongoing dental or physical therapy visits. Notification required within 72-hours of receiving emergency care.

Name		**Date of Birth**	
Physical Address	**City**	**State**	**Zip**
Mailing Address	**City**	**State**	**Zip**

Signature (I attest to the accuracy of the information being provided above) ***Date***

******The information provided above also pertains to the following dependent Tribal Member(s) and/or descendant(s):***

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

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