



# COWLITZ INDIAN TRIBE

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HEALTH & HUMAN SERVICES  
Tribal Clinic

**In order to complete your registration for Direct Care Services, the following information is needed:**

- (X) New Registration Patient Information Form
- (X) Driver's License or State ID Card or Social Security Card & Birth Certificate
- (X) A Copy of Your Primary Insurance Card (Medicaid, Medicare, Regence, etc.) **OR** Proof of completed application for health care coverage
- (X) Tribal ID Card or Certificate of Indian Blood (CIB)
- (X) Patient Rights and Responsibilities Acknowledgment (please sign and return)
- (X) 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)

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

- ( ) Cowlitz Indian Tribe Financial Agreement

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

OFFICE USE ONLY  
Input By \_\_\_\_\_  
Checked By \_\_\_\_\_



# New Registration Patient Information Form



OFFICE USE ONLY  
Health Record# \_\_\_\_\_  
CHS \_\_\_\_\_ NWPS \_\_\_\_\_  
Direct \_\_\_\_\_ Self-Identify \_\_\_\_\_  
Non Native \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Maiden Name/Other Name Used: \_\_\_\_\_ Marital Status: S M D W O  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: M F O  
Mailing Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
County: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Preferred number? Y N May we leave a message? Y N  
Cell Phone: \_\_\_\_\_ Preferred number? Y N May we leave a message? Y N  
Email Address: \_\_\_\_\_ @ \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_  
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

**WA Apple Health Coverage Information**

Eligibility Start Date: \_\_\_\_\_ ID#: \_\_\_\_\_  
Managed Care Information  
Insurance Name (ie: Molina, CHPW, CUP, etc.): \_\_\_\_\_  
Eligibility Start Date: \_\_\_\_\_ ID#: \_\_\_\_\_

**Primary Private 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#)

**Insured 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 \_\_\_\_\_

**Other 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#)

**Insured 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 \_\_\_\_\_

**Responsible Party (Person Responsible for Payment)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

**Other members of your household:**

Name	Sex	Relationship	Birth date	Tribe Enrolled

Work Status: FT PT Unemployed Retired Self-Employed Disabled  
Student: FT PT Where: \_\_\_\_\_  
Patient/Guardian Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Branch of Service: \_\_\_\_\_  
Disability Claim#: \_\_\_\_\_ Type of Disability: \_\_\_\_\_  
Valid VA Card?: Y N Are you receiving services at your nearest VA Facility?: Y N

**Optional Indian Health Services Data**

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 Annual Income: \_\_\_\_\_

★ **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**

Signature- Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



## 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

***This form does not apply to anyone eligible for Direct Care or Contract Health Services. 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.***

## **Cowlitz Indian Tribal Medical Clinic - Patient Rights and Responsibilities**

### **YOUR RIGHTS:**

1. You have the right to be treated with respect, compassion, dignity, and with consideration for your values and beliefs.
2. You have the right to appropriate privacy and confidentiality of your health information.
3. You have the right to review your records and refuse or allow the release of your personal health information, except as otherwise required by law.
4. You have the right to safe, high quality medical care, and to make decisions about the care you receive, including refusing care to the extent permitted by law. Your provider will explain to you the medical consequences of refusing recommended treatments.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment, and prognosis. If it is not medically advisable to give you such information, you may legally designate someone to receive this information for you.
6. You have the right to know the name, title, and credentials of your health care providers, and at your request, you have the right to be seen by another provider if available.
7. You have the right to request that a family member, friend, or outside physician be notified that you are receiving care at this facility.
8. You have the right to timely notification and assistance if your care is transferred to another facility.
9. You have the right to be informed about policies and procedures which may affect your care and treatment.
10. You have the right to accept or decline participation in any research activities that are being conducted at the Tribal Medical Clinic, without compromising your ability to access quality care.
11. 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 your care to the extent permitted by law.
12. You have the right to be informed about fees and payment policies, and to receive counseling regarding available financial resources for your health care.
13. You have the right to put forward informal or formal complaints, and the right to be given information about the formal grievance process.
14. You have the right to be informed about other services offered at this facility and to be informed of how to access after-hours emergency services.

### **YOUR RESPONSIBILITIES:**

1. You are responsible for providing timely, complete and accurate information, to the best of your ability, regarding your health, allergies or sensitivities, medications, and over-the-counter products and dietary supplements.
2. You are responsible for asking questions if you do not understand information that your provider or the clinic provides to you.

## **Cowlitz Indian Tribal Medical Clinic - Patient Rights and Responsibilities**

3. You are responsible for following the plan of care, prescribed for you by your provider. If you are unable or unwilling to follow this plan, you are responsible for informing your health care provider, so that they can explain the medical consequences.
4. You are responsible to have a capable adult available to provide transportation for you to and from your appointment(s), and stay with you for 24 hours if requested by your provider.
5. You are responsible for informing your provider if you have a living will, medical power of attorney, or any other directive that may affect your care.
6. You are responsible for following applicable policies, rules and regulations of the Tribal Medical Clinic, and for acting in a manner that is respectful to other patients, staff, and Tribal property.
7. You are responsible for keeping the clinic informed of all health care payment resources and any change in their status. You must provide current photo identification and Insurance or Medicare/Medicaid cards at each visit.
8. You are responsible for following through with applying for eligible benefits and other resources as recommended by the clinic.
9. You are responsible for all personal financial obligations to the clinic. You are responsible for discussing with your clinic provider the costs and benefits of all services you agree to receive at this facility, including labs.

### **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 Tribal Health Clinic  
Patient Rights & Responsibilities Acknowledgment



**Patient Rights:** A copy of my patient rights was made available to me.

**Patient Responsibilities:** A copy of my responsibilities as a patient was made available to me.

**Direct Care Services:** I understand that payment for all services performed and contracted outside of the Cowlitz Indian Tribal Health Clinic (CITHC) will be my responsibility. Examples of **non-covered** services may include: **lab and pathology tests**, pharmaceutical, radiological services and specialty care (urology, oncology, neurology, etc.). The CITHC is contracted with LabCorp for all labs drawn within the clinic. Some labs may be covered under Direct Care, while others may not, please ask for possible lab charges in the event of a lab draw.

**Non-Native Services:** *Non-Native Services refers to patients who are receiving care, and are not a member, or direct descendent, of a federally recognized tribe.* I understand that I am being seen at the CITHC based on an eligibility criteria set by the Cowlitz Indian Tribal Health Board. I also understand that I am financially responsible for all services rendered by the CITHC. I am fully aware that if I lose my billable resource, my health care will be transferred to another facility.

Direct Care Only

CHS and Direct

Non-Native Services

**Patients may be terminated from the clinic for any of the following reasons:**

1. Any threats, intimidation or acts of violence directed towards staff, volunteers or other patients
2. Bringing drugs, alcohol or other controlled substances on the premises
3. Bringing weapons on the premises
4. Attempts to steal from and/or cause the loss of property
5. Giving false or misleading statements, information and/or documentation
6. Forgery
7. Breach of the CITHC "Narcotic Agreement"

**Additional Treatment Information:** If narcotic pain medication is required during the course of general medical care the following will apply:

- Only a CITHC provider may renew my narcotic pain medication
- If I receive pain medication from another provider, I must notify my CITHC provider
- If I fail to notify my provider, I understand that they will no longer provide me with pain medication
- I understand and agree that my pain medication will be stopped if I fail to abide by this agreement

**My signature below indicates that I have read, understand and agree to the information above.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# COWLITZ INDIAN TRIBE

HEALTH & HUMAN SERVICES

Contract Health Services

**For CHS Eligible Cowlitz Tribal Members Only**

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

- **PHYSICAL RESIDENCY** (Proof in the form of a utility bill, cable invoice and/or school enrollment must accompany CHS registration to be complete)
- **MEDICAL HISTORY**
- **ALTERNATE RESOURCES** (Insurance, other liable parties and/or DSHS application approval or denial information)
- **TRIBAL AFFILIATION**

I am aware that providing false information may result in the loss of Contract Health Services (CHS) and/or legal action. Per Federal Regulation (42 CFR 2-3.7), CHS eligibility is dependent upon full-time residency in a tribe's designated Contract Health Service Delivery Area (CHSDA). The only exception being made for tribal members living outside of the CHSDA is for full-time college students (additional regulations do apply).

\_\_\_\_\_  
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 descendent(s):

\_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Name Date of Birth