Data Entry _____
Verified _____
HRN _____

COWLITZ INDIAN TRIBE

☐ New Patient
☐ Update
☐ CHS/PRC

Health Services Registration Form

Legal Name: _____ DOB: _____
Preferred Name (optional): _____ Maiden/Other: _____
Gender Assigned at Birth: ☐F ☐M ☐Intersex ☐Not listed: _____
Gender Identity (optional): ☐ Two Spirit ☐Woman ☐Man ☐Transgender ☐Trans Man
☐Trans Woman ☐Nonbinary ☐Agender ☐Genderfluid ☐Not listed: _____
Preferred Pronouns (optional): ☐She/Her ☐He/Him ☐They/Them ☐Not listed: _____
Social Security #: _____ Marital Status: ☐S ☐M ☐D ☐W ☐Other: _____
Physical Address: _____ Or: ☐Unsheltered ☐No Fixed Address
City: _____ State: _____ Zip: _____ County: _____
Mailing Address (if different): _____
City: _____ State: _____ Zip: _____ County: _____
Primary Phone: _____ Permission to leave general message: ☐Yes ☐No
Secondary Phone: _____ Email: _____
Emergency Contact: _____ Relationship: _____
Address: _____ Phone: _____
Work Status: ☐Full Time ☐Part Time ☐Retired ☐Disabled ☐Unemployed ☐Student
Student Status: ☐K-12 ☐College ☐Full Time ☐Part Time ☐School: _____
Employer Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

(☐) *I do not have primary insurance* _____ *(initials)*
Medical Insurance: _____ Phone: _____
Address: _____ Effective Date: _____
Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other: _____ ☐Purchased Through Health Plan Finder
Policy Holder Name (if other than self): _____
Policy Holder DOB: _____ Social Security No. (if other than self): _____
Employer Providing Coverage (if applicable): _____ Phone: _____
ID #: _____ Group #: _____ Rx Name/ID#: _____
Dental Insurance Name/ID#: _____
Optical Insurance Name/ID#: _____

SECONDARY INSURANCE

(☐) *I do not have secondary insurance (initials)*
Medical Insurance: _____ Phone: _____
Address: _____ Effective Date: _____
Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other: _____
Policy Holder Name (if other than self): _____
Policy Holder DOB: _____ Social Security # (if other than self): _____
Employer Providing Coverage (if applicable): _____ Phone: _____
ID #: _____ Group #: _____ Rx Name/ID#: _____
Dental Insurance Name/ID#: _____
Optical Insurance Name/ID#: _____

TRIBAL AFFILIATION INFORMATION

Name of Tribe or Corporation: _____

☐ Enrollment #: _____ ☐Non-Enrolled Descendent (supporting documents required)

Please provide name(s), date(s) of birth, and relationship for other Native members of your household:

_____

Race/Ethnicity: _____ Language: _____ Interpreter Needed: ☐Yes ☐No

LEGAL DOCUMENTS

Do you have legal documents that pertain to your health and wellness? ☐Yes ☐No

If yes, please list and provide copies (i.e., advanced directives, power of attorney, living will, guardianship, custody, etc.):

_____

VETERAN STATUS

Are you a US Veteran? ☐Yes (Thank you for your service!) ☐No (skip to next section)

If Yes, Entry Date: _____ Do you have a service-connected disability? ☐No ☐Yes

AUTHORIZATIONS

_____ **Initial here** confirming you have received a copy of the Notice of Privacy Practice.

_____ **Initial here** confirming you have received a copy of the Patient's Rights and Responsibilities.

_____ **Initial here** confirming you have been notified that most laboratory services will be performed and billed by a facility outside of the Cowlitz Indian Tribe (CIT) and you understand that you and/or your insurance provider are responsible for costs associated with these services.

_____ **Initial here** confirming the following **(COWLITZ TRIBAL MEMBERS ONLY):** I understand 42 CFR 136.23 mandates that I provide true and accurate information used to make an eligibility determination prior to approval of federal funds being expended on my behalf. I understand that information provided on my application may be verified to ensure compliance with federal law and the Cowlitz Tribe's Self Governance Agreement. I understand that providing false or incomplete information could result in non-compliance with federal regulations, and to the best of my knowledge, I attest to the accuracy of the information submitted on this application. I understand 42 CFR 136.61 mandates that CHS/PRC is a payor of last resort and that I am required to apply for and utilize all alternate resources available to me. If I am un-insured or underinsured, I will be required to apply for state medical/dental coverage and that I may only decline if there is a cost associated with accepting coverage. I am aware that as a CIT Member I must maintain residency in the Tribe's designated service delivery area to access federal funds. If I relocate, I must notify the CHS/PRC program of my new residency. If I relocate to attend college and maintain status as a full-time student, I may remain eligible for CHS/PRC while in attendance. I am aware that demographic (phone/address) information may be shared with the Enrollment Department if applicable.

ALL CLIENTS/PATIENTS: My signature indicates, to the best of my knowledge, that all information provided is true and accurate. I understand that providing false or incomplete information could result in non-compliance with federal regulations and I could lose my right to services. My signature authorizes the release of medical and insurance information necessary for diagnosis, treatment, and billing. I hereby authorize billing and payment of services, assign benefits otherwise payable to me to CIT, and request that payment be made to CIT directly from any insurances I have. I authorize CIT to review insurance websites for any of my insurance information needed to receive reimbursement for my services with all insurance companies. I consent to CIT billing any insurance without further consent that I have listed above or that CIT discovers that I didn't list while billing for my services rendered. I agree to CIT searching for any necessary insurance information and billing whoever necessary to receive reimbursement for services rendered to me. I agree to remit to CIT any payments sent directly to me for services provided by CIT.

Print Name: _____ **Relationship to Patient**: _____

Signature: _____ **Date**: _____