Data Entry _____
Verified _____
HRN _____

COWLITZ INDIAN TRIBE

☐ Update
☐ Other

Health Services Registration Short Form

Legal Name: _____ DOB: _____
Preferred Name (optional): _____ Maiden/Other: _____
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: _____
Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other: _____
Primary Address: _____ Or: ☐Unsheltered ☐No Fixed Address City: _____ State: _____ Zip: _____ County: _____
Primary Phone: _____ Permission to leave general message: ☐Yes ☐No
Secondary Phone: _____ Email: _____
Emergency Contact: _____ Contact Phone: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION

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 (list, if applicable): _____

AUTHORIZATIONS

_____ **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(s) are responsible for costs associated with these services.

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: _____

Signature: _____

Relationship to Patient: _____

Date: _____