KODIAK COMMUNITY HEALTH CENTER

Registration Packet

KODIAK COMMUNITY HEALTH CENTER 1191 E Rezanof Dr. Kodiak, AK 99615

KODIAK COMMUNITY HEALTH CENTER

MRN #____________
1911 East Rezanof Dr
Kodiak, AK 99615
Phone: (907) 481-5000
Fax: (907) 481-5030

PATIENT DEMOGRAPHICS			
Patient's First name:		**Middle:**	**Last Name:**
Preferred Name:	**Social Security Number:**	**Date of Birth:**	**Age:**
Mailing Address:		**City and State:**	**Zip:**
Home Phone Number: ( )	**Work Phone Number:** ( )	**Mobile Phone Number:** ( )	**Email Address:**
Preferred Primary Care Provider:	**Free interpreter services available.** **Do you need interpreter?** ☐ Yes ☐ No **If yes, what language?**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐ Domestic Partner ☐ Significant Other ☐ Other	
Veteran status: ☐ Yes ☐ No ☐ Active Duty ☐ Inactive Duty	**Ethnic Group:** ☐ Hispanic or Latino/a ☐ Non-Hispanic or Latino/a ☐ Patient Refused ☐ Unknown	**Race:** ☐ Asian ☐ White/Caucasian ☐ Native Hawaiian ☐ Pacific Islander ☐ Black/ African American ☐ American Indian ☐ Alaskan Native ☐ Patient Refused ☐ Unknown	

ADDITIONAL DEMOGRAPHICS

Please note: It is important we collect the Sexual Orientation and Gender Identity (SOGI) information below. This is used in the health care setting to improve culturally sensitive care, reduce health disparities, and allow for more patient-centered care. SOGI is widely considered crucial to providing adequate care to the LGBTQ community

Sexual Orientation	Patient's Sex Assigned at Birth
☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Queer ☐ Asexual ☐ Pansexual ☐ Omnisexual ☐ Choose Not to Disclose	☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-binary/genderqueer ☐ Questioning ☐ Two Spirit ☐ Other ☐ Choose not to disclose
Gender Identity ☐ Female ☐ Male ☐ Two Spirit ☐ Questioning ☐ Transgender Female ☐ Transgender Male ☐ Non-binary/Genderqueer ☐ Choose not to disclose ☐ Other	**Preferred Pronoun:** ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Patient's Name ☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs ☐ Xe/Xem/Xyrs ☐ Ve/Vir/Vis ☐ Other ☐ Declines to answer ☐ Unknown

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Emergency Contact

Name of Emergency Contact:	Legal Guardian: ☐ Yes ☐ No	Relationship to Patient:

PATIENT'S EMPLOYMENT INFORMATION

Employment Status: (full/part time etc.)	Employer:	Address:	Work Status: ☐ Migrant ☐ Seasonal ☐ Neither

FINANCIALLY RESPONSIBLE PARTY

Who's Financially Responsible (who's paying)	Relationship to Patient:	Social Security Number:	Date of Birth:

INSURANCE INFORMATION

Living in Public Housing? ☐ Yes ☐ No ☐ Decline	Do you have insurance? ☐ Yes ☐ No	Interested in Sliding Fee Discount Program? Based on income and Household size: ☐ Yes ☐ No	
Primary Insurance Company:		ID#	Group#
Subscriber Name:		Subscriber DOB:	Subscriber SSN:
Secondary Insurance Company:		ID#	Group#
Subscriber Name:		Subscriber DOB:	Subscriber SSN:

FEDERAL POVERTY INCOME GUIDELINES

Annual Income: Please let us know the number of people living in your household and estimated household income in the slots provided below. This information is NOT associated with the Sliding Fee Discount Program and does not affect your care or billing.
You are NOT required to provide this information. However, because KCHC receives federal based funding we are required to report the total number of voluntary responses we receive for each question. We appreciate your confidential responses as this helps KCHC meet federal reporting guidelines.

Estimated yearly household income: $ __________	Number of people (including children) living in your household? __________

Housing Status:

☐ At risk for Homeless ☐ Currently not Homeless, was in the last 12 months ☐ Homeless unknown Shelter ☐ Living in shelter
☐ Living with others ☐ Permanent Supportive Housing ☐ Single Occupancy Hotel ☐ Not homeless ☐ Street, Camp, Bridge
☐ Transitional Housing ☐ Child at Risk for Homeless ☐ Veteran at risk for homeless

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand t
I am financially responsible for any balance. I also authorize KCHC or insurance company to release any information required to process my clai

Patient/Guardian Signature: Date:

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Patient Rights and Responsibilities

Patient's Rights:

All patients of Kodiak Community Health Center have the following rights:

- Patients have the right to receive health care services regardless of age, race, creed, color, sex, sexual orientation, religion, national origin, geographic residency, or the ability of an individual or family to pay or their insurance status.
- Patients have the right to be treated in a caring, polite, and professional way.
- Patients have the right to the facts about their diagnosis, treatments, and possible outcomes and be an active participant in decision making.
- Patients have the right to refuse treatment.
- Patients have the right to review their medical records and obtain a copy for a reasonable fee, if applicable.
    - Medical records are available digitally via MyChart free of charge.
    - Patients also have the right to request a review to amend their health care information.
- The patient, family, or guardian has the right to inform us when something is seriously wrong by presenting a complaint.
    - KCHC has a policy of non-retaliation. If a complaint is given, it will not affect patient's care. If the patient has a complaint or issue that cannot be resolved by the provider, caregiver or other staff, patients may contact the KCHC Quality team.

Patient's Responsibilities

Prior to receiving care at Kodiak Community Health Center patients are informed of the following responsibilities:

- Patients are responsible for being honest and informing their provider about their present and past diagnosis, illnesses, hospitalizations, medications, and other matters relating to health history that would assist in their treatment.
- Patients should provide accurate and complete information for:
    - Advance directives
    - Insurance coverage and/or alternative payment arrangements
    - Authorization of family members and/or appointees with whom their treatment can be reviewed
- Patients are responsible to contact KCHC immediately with any questions regarding a bill or if they need to discuss alternative payment options in the case of financial hardship.
- Patients are required to provide full information about availability of any health insurance coverage.
    - By receiving services patients authorize KCHC to release information only as required to process claims and will provide all documentation to bill insurance company effectively.

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- Patients are financially responsible for any balance. Failure to pay account balance can result in the account being referred to a collection agency
- Patients are responsible for respecting provider time and schedules by stating their most pressing complaint first while understanding that other complaints may be addressed only if time allows.
- Patients are responsible for notifying the KCHC front desk staff if they are unable to keep a scheduled appointment time and/or need to reschedule.
- Patients are responsible for alerting staff if they do not understand what they are being told and if they feel they will not be able to do what is being asked of them during their care.
- Patients are responsible for following their provider's instructions and treatment plan and accepting the medical consequences if they fail to do so.
- Patients are responsible for reporting safety concerns immediately to their provider or support staff.
- Patients are responsible for authorizing members of their family or appropriate designee to review their treatment if they are unable to communicate with staff.
- Patients are responsible for respecting the privacy, property, and rights of other patients.
- Patients are responsible for respecting all KCHC staff.
- Patients are responsible for observing NO SMOKING rules of the health center.
- Patients are responsible for signing a written acknowledgement that they have received and understand KCHC's Notice of Privacy Practices.

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Patient Acknowledgment of Understanding

CONSENT TO TREAT

- I consent to the plan of care proposed by KCHC providers.
- I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I understand it is my responsibility to ask questions, voice concerns, and understand my care.
- I am aware that during my treatment I may interact with a medical student or trainee, and I will be informed when such persons are taking part in my care.

NOTIFICATION OF RELEASE FOR PAYMENT

- I understand that KCHC will disclose any diagnoses and pertinent information to the extent required to assure payment from insurance companies and any applicable third-party payers.
- I understand diagnosis release for payment may include Substance Use Disorder (SUD) treatment protected under 42CFR part 2 and I consent to this disclosure.
- I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical and behavioral health.

FINANCIAL AGREEMENT

- I understand that any applicable co-payments, sliding fee discounts, and/or other associated charges are due at time of service.
- I authorize payment from my insurance directly to KCHC and will updated KCHC staff of changes to my insurance. I understand I am financially responsible to KCHC for charges not paid by insurance and that payment for those charges is due within 30 days of receiving my bill. I
- understand that in addition to the bill from my provider, I may also receive separate bills from laboratory, radiology, and other specialized services.

SLIDING FEE DISCOUNT PROGRAM

- I understand that KCHC offers a sliding fee discount program for eligible individuals.
- The discount categories have been explained to me and I have been given the opportunity to apply for this program.

NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have been offered and have reviewed KCHC's Notice of Privacy Practices and that I may request a copy of this notice at any time.

____ ________________________________

Signature Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to services that are provided and the related records. Kodiak Community Health Center (KCHC) takes the privacy of your protected health information seriously and follows state and federal guidelines of disclosure. We will not release your information to others unless you authorize us to do so; unless the law authorizes or requires us to do so.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, healthcare operations, electronic health information systems, interpretation services, and special situations allowed or required by law.

Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. This includes but is not limited to coordination of care for referrals and between other providers for coordination of care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review and patient satisfaction surveys.

Electronic Health Information Exchange and Business Associate agreements KCHC is part of an organized health care arrangement including participants in OCHIN[1]. As a business associate of KCHC, OCHIN supplies information technology and related services. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. KCHC utilizes electronic health information systems through the electronic health record which include your protected health information. This electronic health information exchange is a collaboration with other health care providers and health plans to ensure swift coordination of care with KCHC for their treatment, payment and healthcare operation purposes. Participation in an electronic health information exchange also lets us see the other user's information about you for your healthcare at KCHC for treatment, quality, and payment purposes. We may use your health care information and disclose it to individuals or organizations that assist KCHC with treatment, health care operations/payments, or with complying with legal obligations. These business associates must agree to protect the confidentiality of the protect health information. The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information to the extent disclosed, will be consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Special Situations Other situations in which PHI may lawfully be disclosed may occur. This can include, but is not limited to, legal subpoena, workers'

compensation claims, law enforcement requests, coroners' reports, health oversight activities, or situations to prevent a serious threat to public health or safety. Other examples of special circumstances can include language interpretation services, after hours care provided by business associate, and appointment reminder services. We may use your PHI to contact you regarding your care or upcoming appointments.

[1] A current list of OCHIN participants is available at www.ochin.org

Substance Use Disorder Treatment If you receive alcohol and/or drug treatment services, your medical records that identify you as receiving those services are protected not only by HIPAA, but also by the 42 CFR Part 2 confidentiality law. This law provides additional safeguards to protect the privacy of these records.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than that allowed by law[2] requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.
- *We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.*
- *We are also required to abide by the privacy policies and practices that are outlined in this notice.*

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: compliance@kodiakchc.org or

Kodiak Community Health Center Attn: Compliance Officer
1911 E. Rezanof Dr. Kodiak, AK 99615

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address above. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date of this Notice

This Notice is effective on or after June 10th, 20

[2] Health Information Privacy https://www.hhs.gov/hipaa/index.html