Required Documents for Adults

- Required Documents to Establish Eligibility
- Valid Photo ID/Driver’s License
- Insurance Card: Medicare/Medicaid/Private Insurance

Required Documents for Children

- Required Documents to Establish Eligibility
- Shot Record
- Insurance Card: Medicaid/Private Insurance

Required Documents to Establish Eligibility

Proof of descendancy for persons of any age may be established by presenting any of the following:

- Certificate of Degree of Indian Blood (CDIB)
- Tribal enrollment or citizenship card issued by a federally recognized Indian tribe
- Document issued by a federally recognized tribe

Proof of descendancy may be established for a person who has not attained the age of 19, by presenting any of the following:

a. Any of the eligibility documents listed above
b. Adoption Decree, Marriage License, Custody Order from Child Welfare Agency, or Guardianship Order
c. Any of the eligibility documents listed above for the Indian parent plus one of the following:
   - Birth certificate
   - Notarized affidavit from eligible parent attesting to parentage

Options for Submitting Registration Documents

- Submit in-person to any health center Registration department.
  - Mail documents to any health center Registration department (addresses found on health.cherokee.org). Please include “Attention: Registration” to the envelope.
- Print, scan and e-mail documents to PatientAccess@cherokee.org

NOTE: Registration packets MUST include a notarized Consent to Treatment form and any required eligibility documents. All documents must be completed to establish a medical chart.
Name: Last ______________ First ______________ Middle ______ Other Names Used ______________

Sex: M  F  Date of Birth ______________ SSN: ______________ Marital Status (circle one) Single  Married  Divorced  Widowed

Preferred Language ______________ Mother’s Maiden Name ______________ Father’s Name ______________

Tribe ______________ Tribal Number ______________ Quantum ______ Race ______ Ethnic Group ______________

Home Phone ______________ Cell Phone ______________ Alternate Phone ______________ Email Address ______________

Current Mailing Address ______________

City: ______________ State: ______________ Zip: ______________ County ______________

Physical Address (if different than mailing) ______________

City: ______________ State: ______________ Zip: ______________ County ______________

Community ______________ Religion ______________ Do you have an advance directive on file?  ___YES  ___NO

Are you interested in completing an Advance Directive?  ______ YES   ______ NO

Veteran?  ____ YES  ____ NO  If yes, Military Branch ______  Military Status ______________

Employer Name ______________  Employer’s Address ______________

Employer’s Phone Number ______________  Hire Date ______________  Term Date ______________

If Minor (under the age of 18) please complete this section

Mother or Legal Guardian’s Name ______________  Father or Legal Guardian Name ______________

Address ______________  Address ______________

Phone ______________  Phone ______________

Patient Portal Registration:

____ Ages 0-12 (Parent/Guardian Full Access)  ____ Ages 13-17 (Requires Portal Proxy Form for Parent/Guardian Access)

____ YES, I would like to access my records online  If yes, Preferred email address ______________

____ NO, I am not interested.

Health Information Exchange:  We may share your PHI with external healthcare organizations through a secure health information exchange for the purpose of treatment and coordination of care.

_____ Please check here to opt-out of sharing your PHI via a health information exchange.

Emergency/Next of Kin Contacts

1. Emergency Contact Name ______________  Relationship ______________  Phone ______________

   Address ______________  City ______________  State ______________  Zip ______________

2. Emergency Contact Name ______________  Relationship ______________  Phone ______________

   Address ______________  City ______________  State ______________  Zip ______________
Insurance Information

Do you have any of the following type(s) of insurance coverage? (Please check all that apply)

_____ Medicare  _____ Medicare Supplement  _____ Medicaid/Soonercare
_____ Department of Veteran Affairs  _____ Private Insurance  _____ Other 3rd Party Payer
_____ No 3rd Party Payer

Policy Holder – Primary Insurance

Policyholder Name ___________________________ Policyholder’s Date of Birth ________ Policyholder SSN# ________________

Address __________________________________ City ________ State ________ Zip ________

Policy ID # ___________________________ Group # ___________________________ Effective/Beginning Date of Policy ________________

Name of Insurance Company ______________________________________________________

Insurance Address ___________________________________________ Insurance Phone # ___________________________

Employer Name ___________________________ Employer’s Telephone # ___________________________

Employer’s Address ______________________________________________________________

Dependents: List names of all persons covered by this insurance:

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<tr>
<th>Name</th>
<th>Relationship to Policyholder</th>
<th>Date of Birth</th>
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Policy Holder – Secondary Insurance

Policyholder Name ___________________________ Policyholder’s Date of Birth ________ Policyholder SSN# ________________

Address __________________________________ City ________ State ________ Zip ________

Policy ID # ___________________________ Group # ___________________________ Effective/Beginning Date of Policy ________________

Name of Insurance Company ______________________________________________________

Insurance Address ___________________________________________ Insurance Phone # ___________________________

Employer Name ___________________________ Employer’s Telephone # ___________________________

Employer’s Address ______________________________________________________________

Dependents: List names of all persons covered by this insurance:

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<tr>
<th>Name</th>
<th>Relationship to Policyholder</th>
<th>Date of Birth</th>
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I understand that the information given by me/or collected is necessary for the Cherokee Nation Health Services (CN Health) to provide for my health and wellbeing. I understand CN Health will seek payment from any medical program that I might be eligible to participate in or from any liable third party and I assign to CN Health all benefits for services rendered by CN Health Services. I understand that CN Health may verify the information necessary to process the claim. I certify that the information given by me is true and correct to the best of my knowledge and belief. All consents signed externally must be notarized.

Patient’s Signature ___________________________ Date ____________ Time ____________

Parent or Legal Guardian, if Minor

Page 2 of 2  CNH-REG-03-DC (2/25/2021)
Cherokee Nation Health Services
Consent for Treatment

I ____________________________ give permission for the Cherokee Nation Health Services to provide the following health services to me, or the minor (proof of legal guardianship is required if the undersigned is anyone other than a parent with legal custody) or incompetent adult. ____________________________, for whom I am legally responsible (proof of legal guardianship required):

- Health care including medical examinations, routine lab studies, routine x-rays; Injections and immunizations;
- Dental health services, including evaluation and treatment as necessary; Behavioral health services including evaluation and treatment as necessary; Emergency health services including evaluation and treatment as necessary; Transportation to and/or from another health care facility;
- WIC certification/recertification; Public Health services;
- HIV and Hepatitis C screening;
- Physical Therapy/Rehabilitation Services
- Optometry Services

I authorize the health care provider to call in any necessary consultants at their discretion. I further authorize the health care provider to exercise discretion in authorizing the disposal of any severed tissue or member. I understand that this consent is given in advance of any specific diagnosis or treatment and is given so the health care provider may use their best judgment as to the requirements for diagnosis and treatment.

I also authorize Cherokee Nation Health Services to provide the above healthcare services to the minor or incompetent patient when accompanied by the following:

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<th>Name</th>
<th>Relationship (if any)</th>
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As an eligible beneficiary of services funded through the Indian Health Service, services are provided at no out-of-pocket cost to you (except for some additional services that are provided by Cherokee Nation Health Services). However, Cherokee Nation Health Services is the payer of last resort. Federal law requires Cherokee Nation to seek payment from any third party resource which may be available to reimburse for the services provided to you, including Medicare, Medicaid, private insurance, disability plans, automobile insurance, or workers compensation. By signing this consent for treatment, I hereby authorize Cherokee Nation Health Services to bill any of the above listed resources that may be applicable to me.

I acknowledge that to provide the appropriate care for me, both mentally and physically, Cherokee Nation includes any behavioral health records I may have in the Electronic Health Record. These records are available to all members of my care team and any other Cherokee Nation employee who has a business reason for accessing these records.

This consent shall remain effective for one year from the date of my signature unless specifically revoked in writing and delivered to the Cherokee Nation Health Services. All consent forms signed externally must be notarized.

Signature: ____________________________ Date: _______ Time: _______
Witness: ____________________________ Date: _______ Time: _______

Subscribed and sworn to before me this ______ day of __________, ______.

_________________________ My commission expires: ___________ My Commission # ___________

Notary Signature

Patient Identification
The Cherokee Nation Health Services may disclose all or any part of the patient’s record to any person or corporation which is or may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital’s charge, including but not limited to, hospital or medical service companies, insurance companies, workmen’s compensation carriers, welfare funds or the patient’s employer.

I hereby assign to Cherokee Nation Health Services such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by Cherokee Nation Health Services. I authorize payment of such benefits directly to Cherokee Nation Health Services. I understand that this assignment applies only to medical services and supplies furnished to me for the period of one year from the date of my signature.

The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

Date

Patient’s Signature

Signature of Parent/Guardian (if minor)

Name:

DOB:

MRN:

CNH-REG-01-DC (07/24/2020)
NOTICE OF INFORMATION PRACTICES ACKNOWLEDGEMENT AND RECEIPT OF PATIENT HANDBOOK

____ I have been provided an opportunity to review and obtain a copy of the Notice of Information Practices of the Cherokee Nation Health Services.

____ I have been provided a copy of the Cherokee Nation Health Services Patient Handbook.

____ I have declined a copy of the Cherokee Nation Health Services Patient Handbook.

_____________________          _____________________      ______
Patient’s Printed Name                              Patient’s Signature                                            Date

___________________________________                    ___________________
Patient Representative’s Printed Name                                   Relationship to Patient

________________________________________
Patient Representative’s Signature                                   Date

For Office Use Only

□ Patient or Patient’s Representative declined to sign.

__________________________          __________________  __________________
Employee Signature                              Employee #                                Date