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.
Cherokee Nation Health Services
Registration Form

Please fill out completely

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.

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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<th>Name</th>
<th>Relationship to Policyholder</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

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**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>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:
CHEROKEE NATION HEALTH SERVICES

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

_____________________________
Patient Representative’s Signature                                   Date

For Office Use Only

☐ Patient or Patient’s Representative declined to sign.

__________________________
Employee Signature                           Employee #                                Date