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CHEROKEE NATION®
Health Services

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
- Court Issued Custody Order, if applicable

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 ***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 _____ 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 _____

Parent Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married

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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 _____

_____ _____ _____

Patient's Signature Date Time

_____

Parent or Legal Guardian, if Minor

CNH-REG-03-DC (12/2023)

Cherokee Nation Health Services
Insurance Information Form
(Please fill out completely)

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:

Name	Relationship to Policyholder	Date of Birth

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:

Name	Relationship to Policyholder	Date of Birth

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.

_____ _____ _____

Patient's Signature Date Time

_____

Parent or Legal Guardian, if Minor

Cherokee Nation Health Services
Authorization to Furnish Information
and Assignment of Benefits
Private Insurance – Medicare – Medicaid

As an eligible beneficiary of services funded through 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 allows Cherokee Nation Health Services 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.

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 Cherokee Nation Health Services, the patient, a family member and/or employer of the patient for all or part of Cherokee Nation Health Services' charges, including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer in relation to payment purposes.

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
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;
Behavioral Health Services, including evaluations and treatment, as necessary;
Dental health services, including evaluation and treatment, as necessary,
Diagnostic Services, (x-ray; CT scan; lab, injections, etc.)
Emergency health services, including evaluations and treatment; transportation to and from another health care facility;
Community Health Nursing Services;
WIC certification/re-certifications/Lactation Services;
Public Health Services;
HIV, Hepatitis C, Syphilis and other sexually transmitted infection screenings
Physical Therapy/Rehabilitation Services
Optometry Services

I understand that I may decline any of the above services at any time by notifying my healthcare team.

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:***

Name	Relationship (if any)

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 allows 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.

Signature: _____ Date: _____ Time: _____

Patient Identification

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	Relationship to Patient

_____	_____
Patient Representative's Signature	Date

For Office Use Only

☐ Patient or Patient's Representative declined to sign.

_____	_____	_____
Employee Signature	Employee #	Date

CHEROKEE NATION HEALTH SERVICES
Electronic Communication Authorization

Cherokee Nation Health Services (CNHS) may communicate with patients regarding protected health information (PHI) via electronic communications (email, text messaging, telephone, voicemail, patient portal, telemedicine/video communications). CNHS will use reasonable means to protect the security and confidentiality of protected health information via electronic communications.

Your email address or phone number(s) that you have provided to us will only be used for important communications related to our services. We will not give your email address or phone number to anyone who is not authorized. Messages with important content may be saved as part of your medical record. Outgoing messages from CNHS that contain sensitive information will be encrypted, unless you specifically ask us not. CNHS is not responsible for information loss due to technical failures associated with your software or internet provider.

Patient Responsibilities:

1. DO NOT USE ELECTRONIC COMMUNICATIONS FOR EMERGENCIES. PLEASE CALL 911!
2. Notifying CNHS when my electronic contact information (email address, phone number, etc.) changes.
3. Notify CNHS, if you believe you have received or sent a message by mistake, or one that contains errors and delete any messages that are not intended for you.
4. Notify CNHS immediately of a possible privacy or security event that affects your devices.
5. Ensure that your own device is secure and private before sending and receiving messages.
6. This consent is not a "request" or "authorization" to obtain medical records.

I understand that transmitting protected health information via electronic communications may not be 100% secure and there are risks associated with these forms of communications. These risks include but are not limited to: (1) being forwarded, intercepted, stored, or even changed without the knowledge or permission of the patient or CNHS; (2) misdirected to unintended and unknown recipients resulting in sensitive information being disclosed; (3) difficult to verify the true identity of the sender, or to ensure that only recipient can read the message once it has been sent; (4) be used to introduce malware and viruses into computer systems and potentially damage or disrupt the computer, networks, and security settings; and (5) backup copies may exist even after the sender of the recipient has deleted his or her copy.

Acknowledgement and Agreement:
I acknowledge that I have read and fully understand that electronic communications have risks and agree to accept these risks. I further acknowledge and understand that my protected health information may contain sensitive information, for example, test results, mental health, etc. I am authorizing CNHS to communicate my health information via electronic communications. I may revoke this authorization at any time by contacting any Cherokee Nation Health Services Facility.

Patient Portal Registration:

☐ 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

Data Exchange: We may share your PHI with external healthcare organizations through a secure health data exchange for the purpose of treatment and coordination of care. The health data exchange is electronic platform for participating providers to access and/or share your health information for the purposes of coordinating your care amongst your care teams.
☐ ***Please check here to opt out of sharing your health information via health data exchange.***

We may use electronic messaging to inform you about things related to our services, such as appointment reminders, patient satisfaction surveys, facility closings, etc. that we believe would interest you.
☐ ***Please check here to opt out of receiving these types of electronic messages***.

_____
Patient or Legal Authorized Representative Printed Name

Signature:_____ Date: _____