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 _____

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:

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. **All consents signed externally must be notarized.**

_____ _____ _____

Patient's Signature Date Time

_____

Parent or Legal Guardian, if Minor

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:

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 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

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

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	Relationship to Patient

Patient Representative's Signature	Date

For Office Use Only

☐ Patient or Patient's Representative declined to sign.

Employee Signature	Employee #	Date

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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

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.