KODIAK COMMUNITY HEALTH CENTER

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

CONSENT TO TREAT & PATIENT RESPONSIBILITIES

Patients have responsibilities, and we ask that you make every effort to:

1. Follow all Kodiak Community Health Center rules and policies.
2. Attend appointments on time.
3. Call to reschedule or cancel appointments within 24 hours **prior** to your scheduled appointment time.
4. Consider the rights of others and treat them with respect, including other patients and KCHC staff.
5. Conduct yourself appropriately to all KCHC staff.
6. Using profanity, raising your voice, or making threats are grounds for immediate discharge of your patient care and you will no longer be eligible to be seen at KCHC.
7. The services provided at the KCHC are a privilege and we reserve the right to refuse service to anyone.
8. Make a good faith effort to meet all financial obligations and to provide all documentation necessary to apply for our Sliding Fee Discount Program if applying.
9. Follow the recommended treatment plan.
10. Provide KCHC with full information about your medical/dental history and health care.
11. Know what medications that you are taking, why you are taking them and the proper way to take them.
12. Inform KCHC of the effectiveness of the treatment that you are receiving.
13. Inform your health care provider of any changes in your health.
14. Contact us immediately if you have any questions about your bill or you have financial problems.
15. Provide us with full information about availability of any health insurance coverage. I authorize KCHC or insurance company to release any information required to process claims, and I will provide all documentation to bill my insurance company effectively.
16. I authorize my insurance benefits be paid directly to the physician.
17. I understand that I am financially responsible for any balance. Should the account be referred to a collection agency I shall pay all delinquent accounts and bear the payment of accrued interest and fees.
18. I agree to notify KCHC immediately of any changes to my address, telephone number and/or insurance eligibility status.
19. **I AUTHORIZE TREATMENT AT KCHC. I have read and understand the Patient Responsibilities:**

_____ _____

Signature of Patient/Guardian **Date**

_____

Printed Name of Patient

_____ _____

Witness **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician credentialing.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Kodiak Community Health Center has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Signature:

I have received a copy of the Notice of Privacy Practices for Kodiak Community Health Center and understand the above information.

_____

Name of Patient (Print)

_____

Patient's Date of Birth

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

KODIAK COMMUNITY HEALTH CENTER

MRN_____

PATIENT REGISTRATION FORM

PLEASE GIVE YOUR INSURANCE CARD AND PICTURE ID TO THE FRONT DESK

PATIENT DEMOGRAPHICS

Patient's First name:	**Middle:**	**Last Name:**	
Social Security Number:	**Gender:** ☐ Female ☐ Male	**Date of Birth:**	**Age:**
Mailing Address:		**City and State:**	**Zip:**
Home Phone Number: ( )	**Work Phone Number:** ( )	**Mobile Phone Number:** ( )	**Veteran status:** ☐ Yes ☐ No
E-mail:	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Preferred Primary Care Provider:	**Ethnic Group:** ☐ Hispanic ☐ Non-Hispanic ☐ Patient Refused ☐ Unknown	**Race:** ☐ Asian ☐ White/Caucasian ☐ Black/ African American ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian ☐ Alaskan Native ☐ Patient Refused ☐ Unknown	

EMERGENCY CONTACT

Name of Emergency Contact:	**Legal Guardian:** ☐ Yes ☐ No	**Relationship to Patient:**	**Home Phone Number:**	**Cell Phone Number:**

PATIENT'S EMPLOYMENT INFORMATION		**Language**
Employment Status: (full/part time etc.)	**Employer:**	**Preferred Language:**

FINANCIALLY RESPONSIBLE PARTY

Financial Responsible Name: (who's paying)	**Relationship to Patient:**	**Social Security Number:**	**Date of Birth:**

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No	**Interested in Sliding Fee Discount Program:** ☐ Yes ☐ No	**Living in Public Housing:** ☐ 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

Please fill out the information below as accurately as possible. The information that you provide below is NOT associated with the Sliding Fee Discount Program.

Number of people (including children) living in your household? _____	Estimated yearly household income? _____

ADDITIONAL DEMOGRAPHICS

Please note: 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. Thank you!

Sexual Orientation	**Gender Identity**
☐ Straight ☐ Lesbian or Gay ☐ Bisexual	☐ Female ☐ Male ☐ Other
☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose	☐ Transgender Female ☐ Transgender Male ☐ Choose not to disclose

Preferred Pronoun: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Patient's Name ☐ Declines to answer ☐ Unknown

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

Patient/Guardian Signature: **Date:**

Rev 4/5/19

Our federal grant requires us to collect and report on this information, in an effort to provide culturally competent healthcare services. The information is reported on the population as a whole, not by specific individual.

Kodiak Community Health Center

"TO PROVIDE HIGH QUALITY COMPREHENSIVE PRIMARY & PREVENTIVE HEALTH CARE SERVICES."

1911 E Rezanof Dr. Kodiak, AK 99615
Phone (907) 481-5000 / Fax (907) 481-5030
http://www.Kodiakchc.org / http:facebook.com/KodiakCHC

Welcome to Your Patient Centered Medical Home!

Patient centered is a way of saying that you, the patient are the most important person in the health care system. You are the center of your health care.

A medical home is an approach to providing total health care. With your medical home, you will join a team that includes health care professionals, trusted friends, or family members & most importantly you.

Here at KCHC we provide high quality affortable primary care & preventative care services to everyone in the community. **No one will be denied services based on inability to pay.**

Affordable Care

All KCHC patients can apply for the Sliding Fee Discount Program. Discount eligibility is based on household size and income. Women can enroll in the state funded Breast & Cervical Health Check (BCHC) Program. BCHC can assist with the cost of breast and cervical health screening for eligible patients.

Our Medical Services

- Full Service Primary Care
- Health Coach/Behavioral Health
- Registered Dietician Service
- Chronic Pain Management
- Pre-Employment, School, Sports & CDL/DOT Physicals
- Family Planning
- Prenatal Care & Deliveries
- Well Child Checks
- Immunizations
- On-Site Laboratory Services

My Chart

MyChart powered by Epic

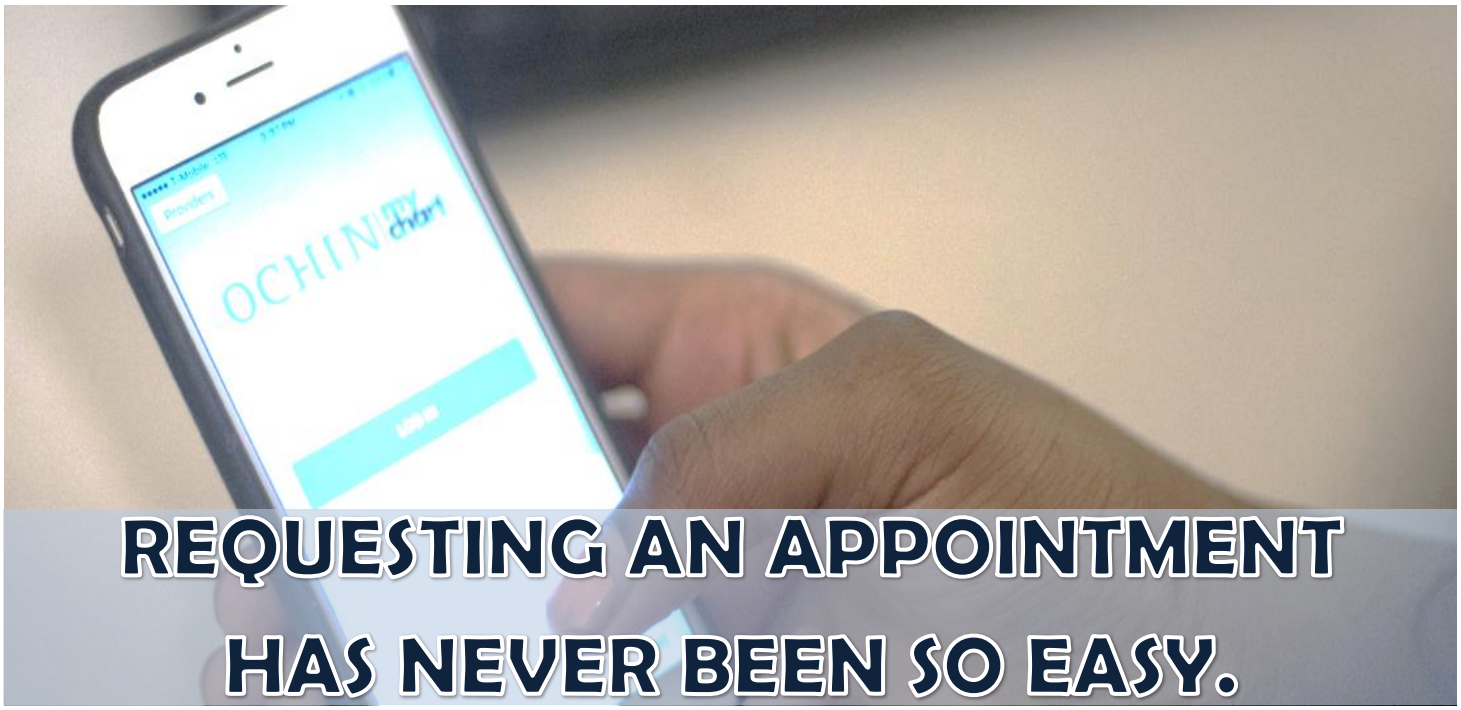
Use the electronic portal "My Chart" to communicate with your provider, view your medical records, request refills, receive lab results & more!

Ask about sign up at our front desk & download the free app on your smart phone.

got transition

For more information in learning about Pediatric to Adult Care Transition, please visit their website at **www.gottransition.org**

We accept all insurances, offer a Sliding Fee Discount Program & have payment plan options.



REQUESTING AN APPOINTMENT HAS NEVER BEEN SO EASY.

Sign up for *MyChart*, our *FREE* patient website to access your KCHC health records. Sign up is fast, easy, and you never have to listen to on-hold music again!

- **Request or change an appointment**
- **Securely e-mail your KCHC Provider**
- **View lab results**
- **Request prescription refills**
- **View your medical records**
- **Use the search engine to find current healthcare information.**

Sign up for MyChart today!

For more information ask at the Front Desk or visit our website at **www.kodiakchc.org**

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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 the information and records we have about your health, health status and the healthcare and service you receive at this office. This notice describes information about the privacy practices that are followed by our employees. We are required by law to give you this notice. It will tell you about the ways in which we may disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, healthcare operations 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. Some examples of this would include a physical examination, or a referral to a specialist.

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.

Special Situations may include subpoena, workers' compensation, law enforcement, coroners, health oversight activities, situations to avert a serious threat to health or safety, or other situations allowed or required by law. An example would be a subpoena received from a court of law requesting health information.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above 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.

We may use your health information to contact you to confirm your appointments.

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 the 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:

Kodiak Community Health Center
Attn: Director of Operations
1911 E. Rezanof Dr.
Kodiak, AK 99615
(907) 481-5000

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 January 6, 2004.

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All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*						
DOB:						
Marital Status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Sex: ☐ M ☐ F						

PERSONAL HEALTH HISTORY

Childhood illness: ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Chickenpox** ☐ **Rheumatic Fever** ☐ **Polio**

List any medical problems other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Hospitalization

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs (such as vitamins, inhalers, antacids)

Name of Drug	Strength	Frequency Taken

Allergies to medications

Name of Drug	Reaction you experienced

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind of alcohol?		
	How many alcoholic beverages do you drink per week?		
	Are you concerned about the amount of alcohol you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Do you experience any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you now have, or previously have experienced, any symptoms in the following areas to a significant degree; briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	