

KODIAK COMMUNITY HEALTH CENTER

Registration Packet

KODIAK COMMUNITY HEALTH CENTER 1911 E Rezanof Dr. Kodiak, AK 99615



PATIENT DEMOGRAPHICS				
Patient's First name:		Middle:		Last Name:
Preferred Name:	Social Security Number:	Date of Birth:	Age:	
Mailing Address:		City and State:	Zip:	
Email Address:	Home Phone Number:	Work Phone Number:	Mobile Phone Number	
Preferred Primary Care Provider:	Free interpreter services available. Do you need interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language?	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Significant Other <input type="checkbox"/> Other		
Veteran status: <input type="checkbox"/> Active duty <input type="checkbox"/> Inactive Duty <input type="checkbox"/> No previous Experience <input type="checkbox"/> Reservist <input type="checkbox"/> Yes- Separated/Combat Veteran <input type="checkbox"/> Uncollected		Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/ African American <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Patient Refused <input type="checkbox"/> Unknown		Ethnic Group: <input type="checkbox"/> Hispanic or Latino/a <input type="checkbox"/> Non-Hispanic or Latino/a <input type="checkbox"/> Patient Refused <input type="checkbox"/> Unknown
ADDITIONAL DEMOGRAPHICS				
<p>Please note: It is important we collect the Sexual Orientation and Gender Identity (SOGI) information below. This is used in the health care setting to improve culturally sensitive care, reduce health disparities, and allow for more patient-centered care. SOGI is widely considered crucial to providing adequate care to the LGBTQ community</p>				
Sexual Orientation <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else <input type="checkbox"/> Don't Know <input type="checkbox"/> Queer <input type="checkbox"/> Asexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Omnisexual <input type="checkbox"/> Choose Not to Disclose			Patient's Sex Assigned at Birth <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary/genderqueer <input type="checkbox"/> Questioning <input type="checkbox"/> Two Spirit <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose	
Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Two Spirit <input type="checkbox"/> Questioning <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary/Genderqueer <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other			Preferred Pronoun: <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Patient's Name <input type="checkbox"/> Ze/Hir/Hirs <input type="checkbox"/> Ey/Em/Eirs <input type="checkbox"/> Xe/Xem/Xyrs <input type="checkbox"/> Ve/Vir/Vis <input type="checkbox"/> Other <input type="checkbox"/> Declines to answer <input type="checkbox"/> Unknown	



Emergency Contact			
Name of Emergency Contact:	Phone number:	Relationship to Patient:	Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
PATIENT'S EMPLOYMENT INFORMATION			
Employment Status: (full/part time etc.)	Employer:	Address:	Work Status: <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Neither
FINANCIALLY RESPONSIBLE PARTY			
Financially Responsible (who's paying)	Relationship to Patient:	Subscriber DOB	Subscriber Social Security Number
INSURANCE INFORMATION			
Living in Public Housing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline	Do you have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Interested in Sliding Fee Discount Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Please see front desk staff for an application			
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			
Annual Income: Please let us know the number of people living in your household and estimated household income in the slots provided below. This information is NOT associated with the Sliding Fee Discount Program and does not affect your care or billing. 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.			
Estimated yearly household income: \$ _____		Number of people (including children) living in your household? _____	
Housing Status:			
<input type="checkbox"/> At risk for Homeless <input type="checkbox"/> Currently not Homeless, was in the last 12 months <input type="checkbox"/> Homeless unknown Shelter <input type="checkbox"/> Living in shelter <input type="checkbox"/> Living with others <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Single Occupancy Hotel <input type="checkbox"/> Not homeless <input type="checkbox"/> Street, Camp, Bridge <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Child at Risk for Homeless <input type="checkbox"/> Veteran at risk for homeless			
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:



Patient Rights and Responsibilities

Patient's Rights:

All patients of Kodiak Community Health Center have the following rights:

- Patients have the right to receive health care services regardless of age, race, creed, color, sex, sexual orientation, religion, national origin, geographic residency, or the ability of an individual or family to pay or their insurance status.
- Patients have the right to be treated in a caring, polite, and professional way.
- Patients have the right to the facts about their diagnosis, treatments, and possible outcomes and be an active participant in decision making.
- Patients have the right to refuse treatment.
- Patients have the right to review their medical records and obtain a copy for a reasonable fee, if applicable.
 - Medical records are available digitally via MyChart free of charge.
 - Patients also have the right to request a review to amend their health care information.
- The patient, family, or guardian has the right to inform us when something is seriously wrong by presenting a complaint.
 - KCHC has a policy of non-retaliation. If a complaint is given, it will not affect patient's care. If the patient has a complaint or issue that cannot be resolved by the provider, caregiver or other staff, patients may contact the KCHC Quality team.

Patient's Responsibilities

Prior to receiving care at Kodiak Community Health Center patients are informed of the following responsibilities:

- Patients are responsible for being honest and informing their provider about their present and past diagnosis, illnesses, hospitalizations, medications, and other matters relating to health history that would assist in their treatment.
- Patients should provide accurate and complete information for:
 - Advance directives
 - Insurance coverage and/or alternative payment arrangements
 - Authorization of family members and/or appointees with whom their treatment can be reviewed
- Patients are responsible to contact KCHC immediately with any questions regarding a bill or if they need to discuss alternative payment options in the case of financial hardship.
- Patients are required to provide full information about availability of any health insurance coverage.
 - By receiving services patients authorize KCHC to release information only as required to process claims and will provide all documentation to bill insurance company effectively.
- Patients are financially responsible for any balance. Failure to pay account balance can result in the account being referred to a collection agency
- Patients are responsible for respecting provider time and schedules by stating their most pressing complaint first while understanding that other complaints may be addressed only if time allows.
- Patients are responsible for notifying the KCHC front desk staff if they are unable to keep a scheduled appointment time and/or need to reschedule.
- Patients are responsible for alerting staff if they do not understand what they are being told and if they feel they will not be able to do what is being asked of them during their care.
- Patients are responsible for following their provider's instructions and treatment plan and accepting the medical consequences if they fail to do so.
- Patients are responsible for reporting safety concerns immediately to their provider or support staff.



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- Patients are responsible for authorizing members of their family or appropriate designee to review their treatment if they are unable to communicate with staff.
- Patients are responsible for respecting the privacy, property, and rights of other patients.
- Patients are responsible for respecting all KCHC staff.
- Patients are responsible for observing NO SMOKING rules of the health center.
- Patients are responsible for signing a written acknowledgement that they have received and understand KCHC's Notice of Privacy Practices.



Patient Acknowledgment of Understanding

CONSENT TO TREAT

- I consent to the plan of care proposed by KCHC providers.
- I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I understand it is my responsibility to ask questions, voice concerns, and understand my care.
- I am aware that during my treatment I may interact with a medical student or trainee, and I will be informed when such persons are taking part in my care.

NOTIFICATION OF RELEASE FOR PAYMENT

- I understand that KCHC will disclose any diagnoses and pertinent information to the extent required to assure payment from insurance companies and any applicable third-party payers.
- I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical and behavioral health.

FINANCIAL AGREEMENT

- I understand that any applicable co-payments, sliding fee discounts, and/or other associated charges are due at time of service.
- I authorize payment from my insurance directly to KCHC and will updated KCHC staff of changes to my insurance. I understand I am financially responsible to KCHC for charges not paid by insurance and that payment for those charges is due within 30 days of receiving my bill. I
- I understand that in addition to the bill from my provider, I may also receive separate bills from laboratory, radiology, and other specialized services.

SLIDING FEE DISCOUNT PROGRAM

- I understand that KCHC offers a sliding fee discount program for eligible individuals.
- The discount categories have been explained to me and I have been given the opportunity to apply for this program.

NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have been offered (next page) and have reviewed KCHC’s **Notice of Privacy Practices** and that I may request a copy of this notice at any time.

Signature

Date

Witness

Date



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.

Organized Health Care Arrangement Terms KCHC is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business associate of KCHC, OCHIN supplies information technology and related services. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by KCHC with other OCHIN participants, or a health information exchanges only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operations can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

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 this 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 March 25, 2021



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