Sokaogon Chippewa Health Clinic
3144 VanZile Road
Crandon, WI 54520

Patient Registration

Please complete all sections. Please provide us with your Insurance Card, Tribal ID Card and Picture ID. Please print clearly.

Last Name: _____ **First:** _____ **Middle:** _____
Nick/Maiden Name: _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Other**
Sex: M F Date of Birth: _____ **Place of Birth (City/State):** _____
Social Security #: _____ **Religion Preference:** _____

Federal Recognized Tribe Name: _____ **Enrolled: Y N**
Enrollment #: _____ **Indian Blood Quantum:** _____
Present Community: _____ **Date moved to community:** _____

Mailing Address: _____
_____
City **State** **Zip**

REMINDER CALL PREFERENCE: ☐ **Home#** ☐ **Cell #** ☐ **Text Messaging/Messenger**
Home Phone #: _____ **Cell #:** _____ **Other #:** _____
Employment: _____ **Work #:** _____
Spouse Employment: _____ **Work #:** _____

Father's Name: _____ **City of Birth:** _____ **State:** _____
Living, Deceased, Retired **Employed by whom:** _____
Mother's Maiden Name: _____ **City of Birth:** _____ **State:** _____
Living, Deceased, Retired **Employed by whom:** _____

Emergency Contact: _____
Name **Phone Number** **Relationship**
Address: _____
Box/Street **City** **State** **Zip**
Next of Kin: _____
Name **Phone Number** **Relationship**
Address: _____
Box/Street **City** **State** **Zip**

MILITARY SERVICE

Veteran: YES OR NO **Entry Date (last):** _____ **Date of discharge:** _____ **Claim Number:** _____
Vietnam Duty: YES OR NO **Service Connected:** YES OR NO

PRIVACY ACT OF 1974, P.L. 93-579. I understand that the information given by me and/or collected is necessary for the Indian Health Service staff or IHS contractors to provide services for my health and well being. Furthermore, I have been informed that my health record or any portion of the record shall not be disclosed to another agency or person, unless specified as routine use **(listed on the "Why We Ask Questiou" notice)**, or without my signed consent. I certify that the information given is true and correct.

SIGNATURE: _____ **DATE:** _____
(Signature of Patient / Parent / or Legal Guardian)

Authorization To Release And Assign Benefits

Insurance Co. Name _____ **Effective Date** _____

Subscriber Name _____ **Subscriber SS #** _____ **D.O.B.** _____

I hereby assign **SOKAOGON CHIPPEWA HEALTH CLINIC** to receive payment of authorized Medicare/Medical Assistance benefits on my behalf for any services furnished to me by that provider.

I hereby assign benefits from my insurance carrier listed to **SOKAOGON CHIPPEWA HEALTH CLINIC** on my behalf for any services furnished to me by that provider.

I authorize release of information to **SOKAOGON CHIPPEWA HEALTH CLINIC**, Health Care Financing Administration, and its agents from any provider relating to medical care. I permit a photographic or other facsimile of this authorization to be used in place of the original.

This authorization shall remain in force and effective until revoked by me in writing.

INITIALS _____

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts for any visit you have received at Sokaogon Chippewa Health Clinic. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these services. In addition, if your insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered. Only exception to this is eligible individuals for direct service coverage, but doesn't include non-covered services under that program.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

Patient/Guardian Signature _____ **Date** _____

Acknowledgement of Receipt of SCHC Notice of Privacy Act

I hereby acknowledge receipt of the Sokaogon Chippewa Health Clinic Notice of Privacy Practices at:

Sokaogon Chippewa Health Clinic
3144 VanZile Road
Crandon, WI 54520

SIGNATURE OF PATIENT _____ **DATE** _____

SIGNATURE OF PARENT / LEGAL GUARDIAN _____ **DATE** _____

SIGNATURE OF SCHC EMPLOYEE _____ **DATE** _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION UTILIZED BY AUTHORIZED PERSON(S)

Complete all sections, date, and sign

I. **I, _____, hereby voluntarily authorize the disclosure of**
(Name of Patient) information during any clinical visit.

II. ***The information is to be disclosed by:***

Name of Facility: *Sokaogon Chippewa Health Clinic 3144 VanZile Rd, Crandon, WI 54520 715-478-5180*

And is to be provided to:

Name of Person: _____
Relationship to Patient: _____

Name of Person: _____
Relationship to Patient: _____

Name of Person: _____
Relationship to Patient: _____

III. **The information to be disclosed during my Date of Visit, via phone or verbally is:**
(Check appropriate box(es)

- ☐ **Appointment Time**
- ☐ **Appointment Date**
- ☐ **Transportation Arrangements**
- ☐ **Other**
  (Specify): _____

IV. **I understand that I may revoke this authorization at any time to the Health Records Department. If this authorization has not been revoked, it will terminate one year from the date of my signature.**

SIGNATURE: _____ **DATE:** _____
(Signature of Patient / Parent / or Legal Guardian)

The information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a (1) (3).	
NAME: (Last, First MI)	**RECORD NUMBER:**
DATE OF BIRTH:	**SCHC(1/17)**