ITEMS NEEDED TO ESTABLISH A NEW CHART

CHILDREN:

1. Certificate Degree of Indian Blood/Self or Parents
2. State Birth Certificate
3. Social Security Card
4. Any Insurance Cards (Private or Soonercare)

ADULTS:

1. Drivers License
2. Social Security Card
3. Certificate of Indian Blood
4. Insurance Cards (Medicare, Medicaid, Medicare D Plan, Private)

EXPECTANT NON-INDIAN MOTHERS

1. Spouse/Boyfriends Certificate Degree of Indian Blood
2. Marriage Certificate OR Notarized Statement By Father Acknowledging Paternity
3. Drivers License
4. Social Security Card
5. Insurance Cards (Private, Medicare, Medicaid/Soonercare)

WHITE EAGLE HEALTH CENTER

Medical Chart Information

LEGAL LAST NAME_____FIRST NAME_____MIDDLE NAME_____

DATE OF BIRTH_____SOCIAL SECURITY NUMBER_____ MALE OR FEMALE (circle)

TRIBAL MEMBERSHIP_____BLOOD QUANTUM_____RELIGIOUS PREFERENCE:_____

PATIENTS MARITAL STATUS: SINGLE_____MARRIED_____WIDOWED_____ DIVORCED_____

PATIENTS PLACE OF BIRTH: (CITY)_____ (STATE) _____

FATHERS LAST NAME_____FIRST NAME_____PLACE OF BIRTH_____

MOTHERS MAIDEN NAME_____FIRST NAME_____PLACE OF BIRTH_____

PATIENTS MAILING ADDRESS

MAILING ADDRESS:_____CITY:_____STATE:_____ZIP CODE_____

TELEPHONE NUMBER:_____CELL:_____WORK:_____MSG:_____

DO YOU HAVE ACCESS TO THE INTERNET? ☐ YES ☐ NO

IF YES, CHECK ONE OF THE FOLLOWING: ☐ HOME ☐ WORK ☐ SCHOOL ☐ LIBRARY ☐ TRIBAL CENTER

PATIENTS EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

RELATIONSHIP TO PATIENT: _____

TELEPHONE NUMBER: ( )_____

PATIENTS NEXT OF KIN INFORMATION

NAME OF NEXT OF KIN:_____

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

RELATIONSHIP TO PATIENT:_____

TELEPHONE NUMBER: ( )_____

PATIENTS PLACE OF EMPLOYMENT INFORMATION

PATIENTS PLACE OF EMPLOYMENT:_____

ADDRESS OF EMPLOYER:_____CITY:_____STATE:_____

IF MARRIED? NAME OF SPOUSE'S EMPLOYER:_____

FOR CHILDREN UNDER 18, PARENTS PLACE OF EMPLOYMENT

FATHERS PLACE OF EMPLOYMENT:_____TELEPHONE NUMBER:_____

MOTHERS PLACE OF EMPLOYMENT: _____TELEPHONE NUMBER:_____

VETERAN INFORMATION

VETERAN ☐ YES ☐ NO BRANCH OF SERVICE_____

ENTRY DATE:_____ SEPERATION DATE:_____

VIETNAM SERVICE INDICATED ☐ YES ☐ NO SERVICE CONNECTED ☐ YES ☐ NO

VALID VA CARD ? ☐ YES ☐ NO CLAIM NUMBER:_____

BRIEF DESCRIPTION OF VA DISABILITY:_____

PROVIDE CARD INFORMATION TO THE REGISTRATION CLERKS

SOONERCARE OR MEDICAID: ☐ YES ☐ NO MEDICARE A AND/OR B ☐ YES ☐ NO

MEDICARE D (RX CARD) ☐ YES ☐ NO PRIVATE INSURANCE: ☐ YES ☐ NO

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand the information given by me and /or collected is necessary for the White Eagle Health Center to provide Services for my health and well being. Furthermore , I understand that the White Eagle health Center will seek payment from any Medical Program that I might be eligible in and I assign the Clinic benefits for services rendered. The information given by me is true and correct to the best of my knowledge. I authorize the release of any and all medical information necessary to process my claims.

_____ _____

Patient signature Date

Refer To: Patient Registration

Business Office

White Eagle Health Center

200 White Eagle Drive

Ponca City, Ok 74601

RE: Certificate of Degree of Indian Blood (CDIB)

Date: _____

On this date, I have been given a one time visit for direct care, excluding any Contract Health Services. Also , I have been informed this date and fully understand that I must furnish a Certificate of Degree of Indian Blood before I receive any further medical and / or dental care.

I understand that I will be billed for any emergency care received until this proof is furnished . I have 30 days to comply

For a child with no CDIB , a copy of the parent's CDIB and the child's State Birth Certificate must be provided. This information is retained until the child turns 18 years of age.

_____

Date

Patient Acknowledgment_____

Date_____

Effective Date : January 20, 2010

White Eagle Health Center
200 WHITE EAGLE DRIVE PONCA CITY, OK 74601
PHONE (580) 765-2501 FAX (580) 765-6348

HIPPA

ACKNOWLEDGEMENT FORM

I have been given HIPPA Privacy Practices for the White Eagle Health Center. I understand it is my responsibility to read the HIPPA Privacy Practices or ask a staff member to read the form to me.

_____ _____

Patient's Signature Date

_____

Patient's Name (print)

Ponca Tribe of Oklahoma
200 White Eagle Drive
Ponca City Ok 74601
580-762-8104 Fax 580-765-0984

PATIENT SELF – DETERMINATION AND ADVANCE DIRECTIVE FOR HEALTH CARE

Every competent person has the right to make decisions about his or her Medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive (living will) . This means putting into writing before you are seriously ill the kind of health care measures you do or do not or naming so someone to make those choices if you become unable to make them for yourself

If you would like more information about Advance Directive (living will) please tell Patient Registration. Physician or nurse and they will arrange for the Patient Benefits Coordinator to meet with you and answer your questions

White Eagle Health Center Director

I have read this Patient Self- Determination form and Advance Directive for Health care (Living Will)

☐ I do wish to complete the Advance Directive form at this time.
☐ I DO NOT wish to complete the Advance Directive form at this time.

_____ _____

Print Name Date

_____

Signature

WHITE EAGLE HEALTH CENTER
200 WHITE EAGLE DRIVE
PONCA CITY, OK 74601
(580) 765-2501

Assignment of Benefits/Release of Information

I hereby give lifetime authorization for payment of Insurance benefits is made directly to White Eagle Health Center and any assisting physicians, for services rendered. I understand that this assignment applies to medical services, prescriptions, and supplies furnished to me by the White Eagle Health Center. I hereby authorize this healthcare provide to release of All Information necessary to secure the payment of benefits.

_____ _____

Date Patient Name

_____

Parent/Guardian Signature

WHITE EAGLE HEALTH CENTER

PATIENT SERVICE AGREEMENT

RIGHT TO REFUSE SERVICES

The White Eagle Health Center reserves the right to refuse services to anyone for cause, which includes, but is not limited to, belligerent or abusive behavior; non-compliance with treatment; or any other violation of the Patient's Rights and Responsibilities.

CONSENT TO TREAT

The undersigned hereby gives consent to the staff of the White Eagle Health Center for medical examination, treatment, laboratory services and professional services including but not limited to, Behavioral health Services, Dental and Optometry to the undersigned and/or minor child listed below.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION FOR BILLING

I understand that the Indian Health Amendments of 1988, Public Law 100-713, allows the White Eagle Health Center to seek and collect payment from any medical program that my minor children or I may be eligible to participate in and I assign benefits to the White Eagle Health Center for services rendered.

MAINTAINING "CURRENT MEDICAL PATIENT" STATUS

A "Current Medical Patient" is considered to be a patient who has been seen by a medical provider within the last year. By law, prescriptions with refills expire after one year. (Prescriptions for pain medication expire sooner.) In order to continue receiving medication, you must follow the provider's treatment plan and keep your appointments. If you have not been seen in over one year you will not be able to receive prescriptions.

PATIENT HANDBOOK

I hereby acknowledge the receipt of the White Eagle Health Center's Patient Handbook that outlines Patient Rights and Responsibilities, Generic Drug policy and additional departmental information.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the White Eagle Health Center's Notice of Privacy Practices at the White Eagle Health Center, 200 White Eagle Drive, Ponca City, OK 74601.

PRIVACY ACT ACKNOWLEDGEMENT

I have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical Records system at the White Eagle Health Center, 200 White Eagle Drive, Ponca City, OK 74601.

I understand that the information given by me and/or collected and stored in my health record is necessary for the White Eagle Health Center staff or contractors to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use without my consent.

Patient's Name (PRINT) Patient's Chart Number

Signature of Patient (or Parent/Legal Guardian for Minor) Date

Signature and Title of WEHC Staff Member or Contract Employee Date