SILETZ COMMUNITY HEALTH CLINIC

PO Box 320, Siletz, OR 97380 (541) 444-1030

ANNUAL UPDATE

PATIENT LEGAL NAME:____
Last First Middle Maiden/Other

LAST 4 SS#: XXX-XX-________ DOB:____________ Marital Status: Single/Married/Divorced/Widow(er)

ADDRESS(es):
Mailing:______________________________City:____________State:__________Zip__________

Physical:_____________________________City:____________State:__________Zip__________

Date Last Moved:____________ Email Address:______________________________

Cell#:__________________ Home#:__________________ Message#:__________________

PREFERRED order for REMINDER CALLS (rank 1-4): ___ Email ___ Text ___ Cell ___ Home

EMERGENCY CONTACT:__________________________________ Phone#:________________
Name/Relationship

Patient Employer:____

How Many In Your Household: ________ Annual Household Income:________________

ARE YOU A VETERAN? ❑ Yes ❑ No

ARE YOU A FULL-TIME COLLEGE STUDENT? ❑ Yes ❑ No IF YES, must provide proof of enrollment.

ARE YOU HOMELESS? ❑ Yes ❑ No IF YES, (CIRCLE ONE): Shelter/Transitional/Doubling Up

PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS

"Primary" = your insurance **"Secondary"** = you are on your spouse's or partner's plan

Primary Medical Insurance: ❑ Yes ❑ No If yes, Insurance Name:______________________

Policy Holder's Name & DOB:______________________________

Secondary Medical Insurance: ❑ Yes ❑ No If yes, Insurance Name:______________________

Policy Holder's Name & DOB:______________________________

Optometry Primary Insurance: ❑ Yes ❑ No If yes, Insurance Name:______________________

Dental Primary Insurance: ❑ Yes ❑ No If yes, Insurance Name:______________________

Pharmacy Primary Insurance: ❑ Yes ❑ No If yes, Insurance Name:______________________

****FOR OFFICIAL USE ONLY****

PRC / Direct / Siletz Direct / OOA / Ineligible

MRN#__________ Roll#__________

OHP Status____________ Signature__________________

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICIES

All professional services rendered are charged to the patient. All necessary forms will be completed to expedite insurance carrier payments. Please understand that insurance coverage is an agreement between you and your insurance company to pay certain amounts for your medical care. Our office will not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Any monies received from an insurance company for services provided by the SCHC are owed to the clinic.

All patients are required to utilize any alternate resources available to them. Alternate resources (including IHS facilities) are any that are available and accessible to an individual. They would include but not be limited to such sources as Medicare, Medicaid, Vocational Rehabilitation, Veterans administration, Crippled Children, Private Insurance, Workers Compensation, Motor Vehicle Insurance, and other programs. Congress passed a law that allows us to bill health insurance carriers for care provided to Native American patients who use IHS facilities. Federal Regulations waive the Native American patient's responsibility to pay co-pays or deductibles for office visits. All patients are screened for Medicaid/OHP prior to receiving services and ARE REQUIRED to apply if eligible.

I hereby authorize Siletz Community Health Clinic to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the SCHC all payments for services rendered to my dependents or myself. I understand that patients are financially responsible for the cost of their health care services. This cost will normally be reimbursed (or covered) by my insurance or by the Indian Health Service. To the extent it is not covered by other legally responsible sources, however, I understand I remain liable for reimbursing the Clinic for the cost of care. I will be informed of any amounts for which I am financially responsible.

RESPONSIBILITIES OF PATIENTS

You are responsible for making and keeping appointments. If you are not able to keep an appointment, it is your responsibility to call the clinic to cancel or reschedule at least 24 hours prior to your cancellation so that someone else has the opportunity to be seen. You are responsible for informing the clinic of any changes in your personal status, including changes in your address or phone number, legal name changes, and changes in eligibility or health insurance coverage.

I understand that my signature authorizes treatment at the Siletz Community Health Clinic for the duration of one year from the date of my signature. I have read and understand the above information and hereby give authorization for payment of insurance benefits to be made directly to the SCHC for services rendered. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby acknowledge receipt/offer of the Siletz Community Health Clinic's Benefits and Financial Policies AND Notice of Privacy Practices form.

______________________________ Date: ______________

Patient/Parent or Guardian Signature

______________________________ Date: ______________

Representative OR Witness Signature (if signature is thumb print or mark)

Your relationship to the Patient: ______________________

______________________________ Date: ______________

SCHC Staff Signature