COPPER RIVER
NATIVE ASSOCIATION

Please return this completed form prior to your visit with a provider

☐ New Patient ☐ Update

Section 1: Patient Information

Last Name	**First Name**	**Middle Initial**
Gender ☐ Male ☐ Female ☐ Other	**Social Security Number**	**Birth Date**
Mailing Address	**City, State**	**Zip**
Home Phone	**Cell Phone**	**Message Phone**
Marital Status	**Homeless**	**Public Housing**
Ethnicity	**Race**	
Languages	**Interpreter Required**	**Chaperone**
Employment Status		
Employer Name	**Employer Address**	**Employer Phone**
Monthly Income	**Household Income**	**Total People in Household**
Emergency Contact Name	**Emergency Contact Number**	**Emergency Contact Relationship**
	Section 2: Guarantor/Legal Guardian	
Relationship to Patient		**Gender**
Last Name	**First Name**	**Birthdate**
Mailing Address	**City State**	**Zip**
	Section 3: Primary and Secondary Insurance	
Insurance Company Name	**Group Number**	**Subscriber ID Number**
Subscribers Full Name	**Employers Name**	**Co-Payment**
Insurance Company Name	**Group Number**	**Subscriber ID Number**
Subscribers Full Name	**Employers Name**	**Co-Payment**

Section 4: Acknowledgment

Please Initial

_____ **CONSENT TO CARE**
I consent to the plan of care proposed by the providers in the Primary Care Clinic at CRNA. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my health care and will make my wishes known. I understand that CRNA participates in the training of physicians and other healthcare providers and will be told when trainees take part in my care.

_____ **NOTIFICATION OF RELEASE FOR PAYMENT**
I understand that CRNA will disclose any diagnoses and pertinent information to the extent required at assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical, dental and behavioral health.

_____ **FINANCIAL AGREEMENT**
I understand that any applicable co-payments, discounts and prompt pay charges are due at time of service, including fees for services not covered by the I H S, if I am an eligible beneficiary. I assign payment from my insurance directly to CRNA. I understand I am financially responsible to CRNA for charges not paid by my insurance and that payment for those charges is due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills for laboratory, radiology, and other specialized services.

_____ **PAYMENT AGREEMENT**
I understand that CRNA, under certain circumstances, may offer me the opportunity to repay my portion of services provided under a payment agreement. I understand that this is a legally binding agreement and I am responsible to meet the terms of the agreement.

_____ **NOTICE OF PRIVACY PRACTICES**
I acknowledge and agree that I have received a copy of CRNA's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of this notice at any time.

I have read the above and initialed my consent and financial responsibility for services at CRNA. If I have a question about my visits or any fanatical liability I will contact kana registration prior to my appointment.

Date: _____ Patient Signature _____

Guardian Signature_____

OFFICE USE ONLY

Staff Initials:_____

Patient MRN #:_____

Date Entered In CERNER: _____

☐ Patient refused to sign

☐ Communication barriers prohibited obtaining acknowledgment

☐ An emergency situation prohibited obtaining acknowledgment

☐ Other: _____