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 |
| Veteran □ Yes □ No | | Social Security Number | | Birth Date |
| Mailing Address | | City, State | | Zip |
| Home Phone | Cell Phone | Work Phone | Message Phone | Email |
| How would you prefer to be contacted by Copper River native association? □ Home Phone □ Cell Phone □ Work Phone □ Message phone □ Email □ Other_____ | | | | |
| Marital Status □ Single □ Married □ Other_____ | | Homeless □ Yes □ No | | Public Housing □ Yes □ No |
| Employer Name | | Employer Address | | Employer Phone |
| Monthly Income | | Household Income | | Total People in Household |
| Emergency Contact Name | | Emergency Contact Number | | Emergency Contact Relationship |
| Languages | | Interpreter Required | | Chaperone |

*CRNA Community Medical Center is required to ask for the following Demographic Data. This data is used strictly for statistical purposes, and no Personnel Health Information is released.*

| | | |
|---|---|---|
| Ethnicity<br>□ Not Hispanic or Latino □ Chicano<br>□ Hispanic or Latino □ Cuban<br>□ Mexican American □ Puerto Rican<br>□ Unknown □ I do not wish to disclose | Race (Check all that apply):<br>□ American Indian □ Asian<br>□ Black/African American<br>□ Caucasian □ Native Hawaiian<br>□ Other Pacific Islander □ Two or more races<br>□ I do not wish to disclose | Alaska Native:<br>□ Aleut □ Athabascan □ Haida<br>□ Inupiat □ Tlingit □ Yupik<br>□ Tsimshian<br>□ Other Alaska Native |
| Employment Status<br>□ Employed Full Time □ Employed P/T<br>□ Self Employed □ Retired □ Unemployed | Gender<br>□ Male □ Female<br>□ Transgender Male/Female to Male<br>□ Transgender Female/Male to Female<br>□ Other -<br>□ I do not wish to disclose | Orientation<br>□ Lesbian/Gay □ Straight<br>□ Don't Know<br>□ Bisexual □ Something Else<br>□ I do not wish to disclose |

## 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 financial liability, I will contact CRNA 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: _____