Check List of Documents Required for Registration

☐ Patient registration worksheets completed

☐ Signed Notice of Privacy Practices (can be completed by parent, legal guardian, state appointed guardian)

☐ Signed Consent to Treat and Bill (can be completed by parent, legal guardian, state appointed guardian)

☐ Copy of identification card (can be used for name change if current)

☐ Certificate of Indian Blood or Tribal Enrollment Card from Federally Recognized Tribe

☐ Copy of all/any insurance cards front and back

Chugachmiut Health Services
Anesia Anahonak Moonin Health Clinic
63998 Graham Road, Unit #3
Port Graham, Alaska 99603
Phone: 907-284-2241 Fax: 907-284-2277

PATIENT DEMOGRAPHICS

Last Name_____ **First Name** _____ **M.I.** _____

Suffix_____ **Preferred Name** _____ **Birth Sex** ☐ Female ☐ Male **Legal Sex** ☐ Female ☐ Male

Tribe _____ **Blood Quantum** _____ **Ethnicity** ☐Hispanic ☐Not Hispanic ☐Unknown

Race ☐Asian ☐African American ☐White ☐Native Hawaiian/Pacific Islander ☐Alaskan Native

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

Physical Address _____ **City** _____**State** _____ **Zip** _____

Country ☐ United States or ☐ Other _____

Date of Birth_____ **Social Security #**_____

Cell Phone # _____ **Home Phone #**_____

Alternate Phone # _____**Email Address**_____

Preferred Contact Method ☐ Home Phone ☐ Mobile Phone ☐ Letter ☐ Patient Portal-MyHealth ☐ Text SMS

GUARANTOR INFORMATION (guarantor is who is legally responsible for the patient)

Relationship to Patient _____

Last Name_____ **First Name** _____ **M.I.**_____

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

Physical Address _____ **City**_____**State** _____**Zip**_____

Home Phone_____**Cell Phone**_____ **Employer**_____

PATIENT PORTAL (provides access to records, results, appointments, secure messaging to your provider)

MyHealth Patient Portal Email Address _____

Challenge Question(s) Choose only one. ☐ Last 4 digits of your SSN _____ ☐ Year you got married_____

☐ Year you graduated high school _____ ☐ Year your father graduated high school _____

☐ Year your father was born_____ ☐ Year your mother graduated high school _____

☐ Year your mother was born_____ ☐ Your postal code _____

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PRIMARY INSURANCE

Insurance Company_____ **Policy Number** _____

Group Number_____ **Subscriber Employer** _____

Subscriber Employment Status ☐Active Duty Military ☐Declined ☐Disabled ☐Full Time ☐Minor Child ☐Part-Time ☐Retired ☐Self Employed ☐Part-Time Student ☐Part-Time Student ☐Unemployed

Employer Address _____ **Employer Phone Number** _____

Relationship to Patient ☐ **Self or Subscriber's Name**_____

Subscriber Phone# _____ **Subscriber Date of Birth** _____

SECONDARY INSURANCE

Insurance Company_____ **Policy Number** _____

Group Number _____ **Subscriber Employer** _____

Subscriber Employment Status ☐Active Duty Military ☐Declined ☐Disabled ☐Full Time ☐Minor Child ☐Part-Time ☐Retired ☐Self Employed ☐Part-Time Student ☐Part-Time Student ☐Unemployed

Employer Address _____ **Employer Phone Number** _____

Relationship to Patient ☐ **Self or Subscriber's Name** _____

Subscriber Phone# _____ **Subscriber Date of Birth** _____

TERTIARY INSURANCE

Insurance Company_____ **Policy Number** _____

Group Number _____ **Subscriber Employer** _____

Subscriber Employment Status ☐ Active Duty Military ☐ Declined ☐ Disabled ☐ Full Time ☐ Minor Child ☐ Part-Time ☐ Retired ☐ Self Employed ☐ Part-Time Student ☐ Part-Time Student ☐ Unemployed

Employer Address _____ **Employer Phone Number** _____

Relationship to Patient ☐ **Self or Subscriber's Name** _____

Subscriber Phone# _____ **Subscriber Date of Birth** _____

Chugachmiut Health Services
Anesia Anahonak Moonin Health Clinic
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PERSONAL INFORMATION

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner **Donor** ☐Yes ☐No

Advanced Directives or **Living Will** ☐Yes ☐No **Homeless** ☐Yes ☐No **Seasonal Migrant Worker** ☐Yes ☐No

EMERGENCY CONTACT

☐ Family Member ☐ Foster Parent ☐ Guardian ☐Next of Kin ☐Power of Attorney

Last Name _____ **First Name** _____ **M.I.** _____

Physical Address _____**City** _____ **State** _____ **Zip** _____

Home Phone _____**Cell Phone**_____

ADDITIONAL CONTACT

☐ Family Member ☐ Foster Parent ☐ Guardian ☐Next of Kin ☐Power of Attorney

Last Name _____ **First Name** _____ **M.I.** _____

Physical Address _____**City** _____ **State** _____ **Zip** _____

Home Phone _____**Cell Phone**_____

VERIFICATION OF INFORMATION

_____ _____
PATIENT OR GUARDIAN SIGNATURE **DATE**

_____ _____ _____
WITNESS SIGNATURE **WITNESS TITLE** **DATE**

**********STAFF USE ONLY**********

☐ Certificate of Indian Blood or Tribal Enrollment Card ☐ Notice of Privacy Practice ☐ Consent to Treat and Bill

☐ State Identification AVTEC Identification (if applicable) ☐ Completed Registration worksheet

☐ Signed ROI (if applicable) CommonWell ☐ YES ☐ NO ☐ CommonWell Opt Out Form (if applicable)

Legal Documents ☐ Guardianship documents ☐ Health Care Power of Attorney ☐ Living Will Advanced Directives

☐ Legal documents for name change ☐ Paternity Attestation

CHUGACHMIUT
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

This notice applies to records of services that are provided by Chugachmiut Health and Behavioral Health Services.

Chugachmiut respects your privacy and understands that your health information is a private and sensitive matter. We make a record of the care and services you receive at Chugachmiut which is called your protected health information (PHI). This information is needed to give you quality health care and comply with the law. For example, this information includes your symptoms, test results, diagnosis, treatment, health information from Chugachmiut and other health care providers, and billing and payment information related to those services. We will not disclose your information to others unless you authorize us to do so, or unless the law authorizes or requires us to do so.

This privacy notice will tell you about: (1) the way that we may use and disclose PHI about you; (2) your privacy rights; and (3) special rules for patients of Chugachmiut's substance use disorder (SUD) treatment programs; and (4) Chugachmiut's responsibilities in using and disclosing your PHI.

WHO WILL FOLLOW THIS NOTICE:

- Any staff or other individuals authorized by Chugachmiut to access, handle, or enter information into your health record; or
- Any member of a volunteer group we allow to help you while you are receiving services at Chugachmiut;

CHUGACHMIUT'S RESPONSIBILITIES:

We are required by law to:

- Keep your PHI private;
- Provide you with this Notice of our legal duties and privacy practices with respect to PHI;
- Notify you of your specific rights as to PHI which includes substance use disorder records and is subject to 42 C.F.R. Part 2;
- Notify affected individuals following a breach of unsecured PHI;
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the PHI we create or maintain. If we make changes, we will update this Notice. You may obtain the most recent copy of this Notice by

calling, visiting any of our Chugachmiut programs and asking for it, or by visiting our website: www.Chugachmiut.org.

HOW CHUGACHMIUT MAY USE & DISCLOSE YOUR PHI:

The following is an explanation of some of the ways your PHI may be used and disclosed:

Treatment: We use your PHI for treatment purposes. Information obtained by our health care staff will be recorded in your health record and used to help decide appropriate care. We may also provide information to other individuals or entities providing your care. For example, Chugachmiut may share your medication information with a specialist that we refer you to in order to avoid treatment that might cause a negative reaction with your medication.

Payment: We use your PHI for payment purposes. "Payment" includes the activities of Chugachmiut to obtain payment or be reimbursed for the services we provide to you. For example, insurance companies may need information about services you received at a Chugachmiut clinic in order to authorize payment. In addition, if someone else is responsible for your health care costs, we may disclose information to that person about services we provided to you when we seek payment.

Health Care Operations: We use your PHI for health care operations. "Health care operations" are certain administrative, financial, legal and quality improvement activities necessary to run Chugachmiut's clinics and programs and make sure all patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff, or to evaluate services provided at Chugachmiut.

Electronic Health Information Systems: We utilize electronic health information systems, including an integrated multi-facility electronic health information systems with a patient service communications network that permits providers involved in your care at other tribal health care facilities, and the Indian Health Service, to access health information accumulated about you at our facilities. Once information is entered into many of these systems, it can be amended, but it cannot be removed. Once a user is authorized to have access to your information contained in some of these systems, the user will continue to have such access until determined otherwise. We may make your protected health information available electronically through an electronic health information exchange to other health care providers and health plans that request your information for their treatment and payment purposes. Participation in an electronic health information exchange also lets us see their information about you for our treatment and payment and healthcare operation purposes. You are permitted to request and review documentation regarding who has accessed your information through the electronic health information exchange. You also may "opt out" of including some or all of your health information in the exchange. If you opt out, then your information will only be available to providers who use the Alaska Tribal Health System's shared electronic health record. Your provider will have information on how to make this request, or you may find the information on our website, once we begin participating in the exchange.

Appointment Reminders: We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or health care at Chugachmiut. We may use and disclose health care information during the reminder call, but the information disclosed will be kept to what is necessary to remind you of the appointment.

Interpreters: In order to provide you proper care and services, we may use the services of an interpreter. This may require the use or disclosures of your PHI to the interpreter or others facilitating the provision of interpreter services.

Other Treatments and/or Health Products: We may use and disclose your PHI to tell you about treatment options or alternatives or about health-related products or services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose PHI about you for research purposes, both with and without your permission. Before we disclose your PHI without your permission, we verify that researchers meet specific requirements under HIPAA to protect your PHI, and if appropriate, obtain approval from authorized body that ensure the protection of human research subjects. .

Funeral Directors/Coroners/State Medical Examiner: We will disclose PHI about you to funeral directors, coroners and the state medical examiner, consistent with applicable law to allow them to carry out their duties.

Public Health Risks**:** We may disclose your PHI for public health activities that can include the following:

- Prevention or control of disease, injury or disability;
- Reports of births and deaths;
- Reports of abuse or neglect of children, elders and dependent adults;
- Reports of reactions or problems with medications or health products;
- Notifying people of product recalls related to their health care;
- Notifying a person that they may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

Workers' Compensation Laws: We will disclose your PHI when required by state law and/or when you have made a workers' compensation claim that provides benefits for work-related injuries or illness.

Correctional Institutions: If you are in jail or prison, we may disclose your PHI to the Department of Corrections for your health and the health and safety of others.

Law Enforcement: We may disclose PHI about you to law enforcement for certain purposes, such as to report criminal conduct that occurred on our premises, to locate you when you are the suspect of a crime, to avert a serious and imminent threat to health or safety, or when

required by law such as to report certain injuries caused by guns or knives, or by a subpoena, court order or other legal process.

Tissue Donation, Organ Procurement and Transplant: We may disclose your PHI to organizations that handle organ procurement or tissue transplantation or to an organ donation bank, to help with organ or tissue donation and transplant, if you or your family members agree.

***Health and Safety Oversight*:** We will disclose your PHI to a health oversight agency when required by law. These oversight activities include audits, investigations and medical licensure.

Preventing a Serious and Imminent Threat: We may use or disclose your PHI if we believe in good faith that it is necessary to prevent or lesson a serious and imminent threat to the health and safety of a person or of the public. Disclosure may be to a person reasonably able to prevent or lessen the threat, including a friend, family member, employer, provider, or law enforcement.

Disaster Relief Purposes: We may disclose your PHI to disaster relief agencies or law enforcement to assist in notification of your condition to family or others in case of a disaster.

Military and Veterans: If you are a member of the armed forces, Chugachmiut may release your PHI as required by military command authorities.

Court Orders, Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a warrant, subpoena, court or administrative order in accordance with applicable law.

National Security and Intelligence Activities: We may release your PHI to authorized federal officials for intelligence, counter intelligence and other national security activities authorized by law.

Business Associate Agreements: We may disclose your PHI to individuals and organizations that assist Chugachmiut with treatment, health care operations or payment purposes. For example, Chugachmiut may disclose PHI to consultants or attorneys who assist us in complying with our legal obligations. These business associates must agree to protect the confidentiality of PHI.

- ***Other Uses and Disclosures:*** We may also use and disclose your PHI as specifically required or authorized by applicable laws for other reasons not specifically listed here.

Notification of Family and Others: Unless you object, we may release PHI about you to a friend or family member who is involved in your health care, or payment for care, while you are receiving services, if determined appropriate under the circumstances. In emergency cases where you are unavailable or incapacitated, or do not otherwise object, we may also tell your family or friends your location and general condition. If you would like to restrict the PHI

provided to family or friends involved in your care or payment for care, please contact the Privacy Officer at number at the end of this notice.

If you want a family member or friend to be able to access information about you or assist in arranging your health care, such as scheduling or checking on appointment times, please make sure that an authorization is on file for that person to access your records. This will be required for individuals to assist you in this manner.

Uses and Disclosures That Require Your Authorization: Other than the uses and disclosures described above, PHI will be used or disclosed only as allowed or required by law, or with your written authorization. For example, uses or disclosures made for the purpose of marketing or the sale of PHI require your authorization. You have the right to revoke an authorization at any time, except where we have otherwise relied on the authorization or the law prohibits revocation.

SPECIAL RULES FOR SUBSTANCE USE DISORDER PATIENT RECORDS

If you receive substance use disorder (SUD) treatment services, whether at Chugachmiut or another facility, PHI that identifies you as receiving SUD services may be protected not only by HIPAA, but also by federal confidentiality regulations at 42 C.F.R. Part 2 ("Part 2"). Part 2 provides additional safeguards to protect the privacy of your PHI. Not all PHI discussing an SUD or SUD services is protected by Part 2. Chugachmiut will determine whether Part 2 applies to your PHI.

In general, Chugachmiut must obtain your written consent before disclosing PHI protected by Part 2 outside of Chugachmiut or to providers that are not part of your SUD treatment team. Chugachmiut may condition SUD treatment on receiving your consent to disclosure for payment purposes. However, Part 2 permits Chugachmiut to release your PHI subject to Part 2 without your consent in certain circumstances, including:

- Pursuant to an agreement between Chugachmiut and a qualified service organization or business associate which provides health care operational services to Chugachmiut;
- For research, audit or evaluation purposes:
- To report a crime against Chugachmiut personnel or on Chugachmiut property;
- To medical personnel in a medical emergency;
- To report suspected child abuse or neglect to appropriate authorities; and
- Pursuant to a court order.

In other situations not listed here, we will obtain your consent before disclosure.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR PHI

The health and billing records we make and store belong to Chugachmiut. The PHI in the records, however, generally belongs to you. You have specific individual rights as to the uses and disclosures of your protected health information, as follows:

***Notice*:** You have the right to receive a copy of this Notice.

***Questions*:** You have the right to ask questions about any information contained in this Notice.

***Right to Request Restrictions on Use*:** You have the right to ask Chugachmiut to limit certain uses and disclosures of your PHI. If you want to limit a use and disclosure, you must submit the request in writing. We are not required to grant the request except under special circumstances, such as a restriction on information provided to an insurer for services paid for out-of-pocket. If we grant your request, we will inform you and comply with it unless the PHI is needed to provide emergency services.

***Right to Request Confidential Communications*:** You may request that Chugachmiut communicate with or contact you by a particular means (mail, e-mail, fax, etc.) or at a particular location. These requests must be made in writing and we have a form available for this type of request. Chugachmiut will accommodate reasonable requests.

***Right to Request An Inspection and Receive Copies*:** You may request to see and/or get a copy of your PHI. If your PHI is in electronic format, you may request that your copy also be in electronic format, and Chugachmiut will comply if the requested electronic format is reasonably available.

***Right to Request An Amendment to Your Record*:** You have the right to request amendment to your PHI, which must be submitted to us in writing. The right to request amendment of your record does not include the right to have your records destroyed. If we agree to your request, we will amend your record. If we deny your request, we will inform you in writing, and you may submit a statement of disagreement that will be stored in your health record. Please note that we may add our own statement disagreeing with your proposed changes. All statements regarding amendments to your PHI will be included with any release of your PHI.

***Revoke or Cancel Prior Authorizations*:** If you provided us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. Once revoked, we will no longer use or disclose your PHI for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission, and if the authorization was obtained as a condition of obtaining insurance coverage, applicable law may prohibit you from revoking your authorization.

***Right to Know About Disclosures*:** You have the right to request a list (an "accounting") of certain disclosures of your PHI made by Chugachmiut, for up to a period of six years following disclosures of hard copy PHI, and for a period of three years following disclosures of electronic PHI. This list will not include disclosures to third party payers, or disclosures for treatment or health care operations purposes. Other exceptions to the accounting requirement include, but are not limited to, disclosures made subject to your right of access, to individuals involved in your care, for national security purposes, and for the health and safety of inmates or detainees.

You may request an accounting at any time. Chugachmiut is only required by law to provide one accounting without charge during any 12-month period. We will notify you of the cost involved if you request this information more than once in a 12-month period.

***Right to be Notified of a Breach*:** In the event of a breach of the privacy or security of your PHI, Chugachmiut will notify you of regarding the circumstances of the breach, efforts that Chugachmiut has taken to correct or mitigate the breach, and steps you can take to protect yourself from potential harm.

***No Right to Certain Information*:** There is certain information to which you do not have a right to access. Specifically, you do not have a right to access psychotherapy notes regarding your care, any information prepared for a legal proceeding, or any information that might have other legal restrictions against disclosure. If Chugachmiut refuses to give you access to certain information, you may request that Chugachmiut provide you with information on your appeal rights, if any.

TO ASK FOR HELP, EXPRESS A CONCERN OR COMPLAINT

If you have questions, want more information or want to report a problem about the handling of your PHI, or file a written complaint because you believe your privacy rights have been violated, you may contact:

Privacy Officer
c/o Chugachmiut Health Services
201 3rd Avenue, Suite 201
Seward, AK 99664
1-800-224-3076

For general PHI, you may also file a written complaint with the Office of Civil Rights online at hhs.gov/hipaa or at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue. S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Violation of the protections established by 42 C.F.R. Part 2 for substance use disorder patient records is a crime. You may file a complaint regarding a violation with the U.S. Attorney's Office in Anchorage, reachable by mail at 222 West 7th Ave., Room 253 #9, Anchorage, AK 99513, or by phone at (907) 271-5071.

Chugachmiut will not, and is prohibited from, retaliating or discriminating against you due to reports you've made to us or the federal government regarding your privacy rights.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Effective Date April 14, 2003, Revised November 8, 2021

Chugachmiut's Notice of Privacy Practices provides information about how Chugachmiut may use and disclose protected your PHI. You have the right to review the Notice before signing this acknowledgement. As stated in the Notice, the terms of the notice may change. If the Notice is changed, you may obtain a revised copy by contacting the Privacy Officer or asking any Chugachmiut health service team member.

By signing this form, you acknowledge receipt of Chugachmiut's Notice of Privacy Practices, and have had sufficient opportunity to review its contents and ask any questions of Chugachmiut.

_____

Date

_____ _____

Printed Name of Patient Printed Name of Authorized Representative

_____

Signature of Patient or Authorized Representative

MY CONSENT FOR MEDICAL TREATMENT AND BILLING

I consent to medical treatment which may be performed during the visit and for ongoing medical care as a patient of Chugachmiut, including emergency treatment of services, which may include, but are not limited to: laboratory procedures, x-ray examinations, medical and/or surgical treatment and/or procedures, anesthesia and/or medical services rendered under the general and special instructions of the patient's physician, healthcare provider or surgeon.

I understand that:

A) It is customary, except in emergencies or unusual circumstance, that major procedures are not carried out until the patient has discussed them with the physician or other health professionals and has agreed to the procedure(s);
B) Each patient has the right to refuse any proposed procedure(s) and/or treatment(s);
C) No patient will be involved in any research or experimental procedure(s) without his/her full knowledge and consent; and
D) I understand that no guarantee has been made to me as to the result or cures that may obtained from examination or treatment.
E) I understand that Chugachmiut is a teaching facility and that resident physicians "physician in training", medical students, nursing students and other health professional students may be involved in my care. I recognize that these residents and students are supervised by experienced staff. My primary physician and/or healthcare provider have full authority and responsibility for my care. I understand I may refuse care by any resident or students at any time, and that such refusal will not result in any reduction of the quality of care provided.

In the event that a healthcare worker has an exposure to my blood or body fluids during the course of my care at Chugachmiut, I hereby give my consent to be tested for the presence of communicable diseases that may cause risk to the healthcare worker. The results of these tests will be retained with my confidential medical information. I will not be charges for the testing, and the results will be sent to my primary healthcare provider. I understand that testing will be done through Chugachmiut and that I may contact them with any questions or concerns regarding this issue.

FINANCIAL MATTERS

My Financial Obligation for Services Provided to Me

I understand payment in full is required within thirty (30) days of service. I may be asked to remit in full if my insurance has not paid within the time frame. I may make special payment arrangements if this creates a financial hardship by talking to a billing representative at the clinic or contacting the billing department at 907-334-0106. Should the account be referred to a collection agency or an attorney for collections, I understand I shall pay actual attorney fees and collection expenses.

Upon request, Chugachmiut will make a good faith effort to give the patient, guarantor, resident or client, an estimate of charges using the most current pricing for the same or similar services.

These estimates provide no guarantees or limitation to a person's actual billed charges due to the inability to predict all the services and equipment that may be required to comply with the individual plan of care.

My Authorization for Direct Payment of Insurance Benefits to Chugachmiut

I authorize, whether I sign as an agent or as a patient, direct payment to Chugachmiut any insurance benefits otherwise payable for services related to the visit and ongoing medical care. It is understood that I am financially responsible for all charges not covered by this assignment including those that are excluded from coverage by my insurance carrier.

My Consent to Chugachmiut to Release Information

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Chugachmiut to disclose portions of my record, including medical records, to any person and/or corporation which may be liable to pay for my clinic(s) services.

GENERAL INFORMATION

Safe Environment for Health Care

Weapons or other dangerous objects, illegal drugs, and drugs not prescribed to the patient, by the patient's physician or healthcare provider are not permitted at the clinic(s). The clinic's obligation to provide a safe environment for care must override the individual's right to privacy. Chugachmiut reserves the right to search the patient, guarantor, resident or clients and to confiscate such objects upon reasonable probable cause.

Personal Valuables

I understand that the clinic(s) have advised that I should leave my personal property, money, and valuables at home or with family/friends. I agree that the clinic(s) shall not be liable for any loss or damage to said personal property, money, or valuables and waive all such claims. I understand that the clinic(s) is not responsible for the safekeeping of my personal property, money, or valuables left by me in the clinic(s) public areas or in patient, resident or clients rooms.

By signing my signature, I acknowledge that I have read and understand MY CONSENT FOR MEDICAL TREATMENT AND BILLING regarding treatment for myself or if signing as a parent or guardian, for my minor child or the person for whom I am responsible.

Current Phone Number(s) Printed Patient Name Date of Birth

Signature of Patient Date

Signature of Guardian, Relative or Responsible Party Date