"To Elevate the Quality of Life of the People We Serve"

KODIAK AREA NATIVE ASSOCIATION

New Patient Registration Packet

Things to bring with you to your first appointment:

- ☐State ID or Driver's License
- ☐Certificate of Indian Blood *(If Applicable)*
- ☐Federally Recognized Tribal Enrollment Card *(If Applicable)*
- ☐Insurance Card
- ☐Birth Certificate
- ☐DD214 to enroll in Veterans Administration *(If Applicable)*
- ☐Medical Records *(Optional)*

Return completed application; in person, by mail, or email at registration@kodiakhealthcare.org

KANA Main Clinic
3449 Rezanof Drive East
907-486-9800

Mill Bay Health Center
2414 Mill Bay Road
907-486-7300

IF YOU ARE EXPERIENCING SYMPTOMS OF A LIFE THREATENING EMERGENCY, CALL 911 OR PROCEED TO THE EMERGENCY ROOM

Providence Kodiak Island Medical Center
Emergency Room
1915 Rezanof Drive

Kodiak Area Native Association
KANA Main Clinic | Mill Bay Health Center
Registration Form

Section 1: Patient Information

☐New Patient ☐ Update | **Veteran**: ☐ Yes ☐ No

Last Name	First Name	Middle Initial	Suffix

Gender ☐Male ☐Female ☐Other **If you selected other go to Section 2.*	Social Security #	Birth Date

Ethnicity		Race	
☐Choose not to disclose	☐Unable to Provide Information	☐American Indian or Alaska Native	☐Native Hawaiian or Pacific Islander
☐Hispanic or Latino	☐Unknown	☐Asian	☐Other
☐Not Hispanic or Latino		☐Black or African American	☐White

Mailing Address	City	State	Zip Code	Home Phone	Preferred Phone

Homeless ☐Yes ☐No	Public Housing ☐Yes ☐No	Language(s)	Interpreter Required? ☐Yes ☐No	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Employment Status
☐Active Military Duty ☐Decline ☐Disabled ☐Full Time ☐Minor Child ☐Part-Time ☐Reserve National Assignment
☐Retired – Date: _____ ☐Self Employed ☐Student Full-Time ☐Student Part-Time ☐Unemployed ☐Unknown

Employer Name	Street Address	Zip Code	City	State

Phone Number	☐Monthly or ☐Annual Household Income	Total in Household

Emergency Contact Name	Emergency Contact Number	Relationship

Section 2: *Since KANA accepts Federal funding we are required to gather information for reporting purposes. Your name will **NOT** be associated with the report and all information is kept confidential.*

Sexual Orientation	Gender Identity
☐Heterosexual (Straight)	☐Transgender Female/Male-to-Female
☐Homosexual (Gay/Lesbian)	☐Transgender Male/Female-to-Male
☐Bisexual	☐Gender Queer
☐Something else	☐Other
☐Don't know	☐Choose not to disclose
☐Other	☐Not applicable
☐Choose not to disclose	
☐Not applicable	

Section 3: Guarantor/Legal Guardian *(if different from above)*

Relationship to Patient
☐Self (skip) ☐Spouse ☐Parent ☐Child ☐ Other

Last Name	First Name	Birth Date	Gender ☐Male ☐Female	Social Security #

Mailing Address	City	State	Zip Code	Phone

Section 4a: Primary Insurance

Insurance Company Name	Group Number	Subscriber ID Number

Subscribers Full Name	Co-payment

Section 4b: Secondary Insurance

Insurance Company Name	Group Number	Subscriber ID Number

Subscribers Full Name	Co-payment

Section 5: Acknowledgement

CONSENT TO CARE: Initial_____

I consent to the plan of care proposed by the providers in this clinic. 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 medical care and will make my wishes known. I understand that KANA 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 Initial: _____

I understand that KANA will disclose any diagnoses and pertinent information to the extent required to 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 Initial:_____

I understand co-payments are due at the time of service. I assign payment from my insurance directly to KANA. I understand I am financially responsible to KANA for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from laboratory, radiology and other specialized services.

NOTICE OF PRIVACY PRACTICES Initial:_____

I acknowledge and agree that I have reviewed a copy of KANA's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

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

Date:_____ **Patient Signature:_____**

Parent/Guardian Signature:_____