An Independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
PH: (828) 497-9163
FAX: (828) 497-3355

Required Information For New Chart Packets

- **New Chart Packet**
- **Driver's License or State ID with current 911 Address**
- **Enrollment Card/CDIB Card/EBCI First Descendant Letter**
- **Certified Birth Certificate**
- **Social Security Card/Number**

If a Driver's License or State ID cannot be provided then Proof of Residency can be established by showing documentation or two (2) of the following (Post Office Boxes are not accepted as proof):

- Utility Bill (power, gas, telephone, etc. with physical location of home)
- Payroll/Check stub from current employer or Per Capita showing the 911 address
- Voter Registration Card
- Bank Statement showing 911 address
- Tax Return showing 911 address
- Newborns (parents need to complete a New Chart Packet and provide the required documentation listed above to Patient Registration)

Note: Parents have 180 days to submit newborns enrollment card or chart will be changed to Direct Care Only or Ineligible depending on parent enrollment and eligibility

Cherokee Indian Hospital Authority

Non-Established Patient/Newborn

Registration Form

Health Record Number: _______________ Received by: ____________ Date: _____________

Last Name	First Name	Middle	Date of Birth
Social Security Number		Primary Language	
Sex	Marital Status	Hispanic or Non-Hispanic (Circle One)	
Race	Place of Birth (State)	Place of Birth (City)	
911 Address		Tribal or Deeded Land (Please Circle)	
Indian Blood Quantum	Tribal Membership	Tribal Quantum	Tribal Enrollment Number
Mailing Address (If different from above)	City		State
Zip Code		Present Community	
Home Phone	Work Phone	Other Phone	

Employer Information

Employer Name	Employer Phone	Employer Address

Communication Information

Internet Access? ☐ Yes ☐ No	Email Address
Internet Access Locations (Check all that apply) ○ Healthcare Facility ○ Home ○ Library ○ Mobile Device ○ School ○ Tribe/Community Center ○ Work	Generic Health Information ☐ Do we have permission to send generic health information to your email? (Check for YES) Preferred Method of Communication (Choose One) ☐ Email ☐ Letter ☐ Phone

Emergency Contact: Person to notify in case of Emergency

Name		Relationship
Address	City	State
Zip Code	Phone Number	Other Phone

Family Information

Father's Name	Father's Birth City	Birth State	Father's Date of Birth
Father's Phone	Other Phone	Father's Employer	
Mother's Maiden Name	Mother's Birth City	Birth State	Mother's Date of Birth
Mother's Phone	Other Phone	Mother's Employer	
Spouse's Name	Spouse's Date of Birth	Spouse's Employer	
Spouse's Employer Address	Employer Phone		
Number in Household	Monthly Income		

Next of Kin

A legal Representative, over the age of 18, in the event there must be authorization given for treatment

Name	Relationship	
Address	City	State
Zip Code	Phone Number	Other Phone

Veteran Information

Service Branch	Service Entry Date	Service Separation Date
Did you serve in Vietnam?	Are you Disabled?	

Insurance Information

Please provide information if you have Health Insurance, Medicare, NC Medicaid or other private insurance & **PRESENT YOUR INSURANCE ID CARD**

Insurance Company Name	Identification Number

Do you have custody (51% of the time) of minor children (under 18) living in your home? ☐Yes ☐No
Are you over the age of 65, blind or disabled? ☐ Yes ☐ No
Are you a minor (under the age of 18)? ☐Yes ☐No
Is this visit pregnancy related? ☐ Yes ☐No
Does your employer offer Health Insurance? ☐Yes ☐ No
Do you have coverage through your spouse? ☐Yes ☐ No
Is this visit related to a car accident? ☐ Yes ☐ No
Is this visit a Workmen's Comp? ☐Yes ☐No

Financial Policy: If you have insurance coverage, it is your responsibility to notify the Business Office, otherwise you will be considered SELF PAY. In the event you are determined not to be eligible for service at CIHA/EBCI Programs or your health determines a service to be non-covered, or any balance remains after the insurance payment is made, you will be responsible for the complete charge remaining. IF NO OTHER ARRANGEMENTS RE MADE FOR PAYMENT, FULL PAYMENT IS DUE UPON RECEIPT OF A STATEMENT FROM OUR OFFICE.

I have read and understand the financial policy of the Cherokee Indian Hospital as stated on this form and I agree to be bound by its terms, I also understand and agree that such terms may be amended from time to time by CIH. If I am covered by a Health Insurance Plan, I hereby authorize that my Insurance Benefits be paid directly to the CIH or EBCI Compound units, and I authorize the facility to release any information required. I certify that this information is accurate and acknowledgeable that I am financially responsible for any non-covered services, including and self-pay services.

Patient/Guardian Signature:	**Date:**

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Summary of Notice of Privacy Practice

Each time you go to a doctor, hospital, or other healthcare provider, a record of that visit is made. Usually, this record contains your symptoms, the examination, test results, diagnosis, treatment given, and a plan for further care or treatment. The information which we call your medical record, is an important part of healthcare we provide for you. Although this record belongs to the facility that treated you. The information in the notes is yours and you have the right to this information. These notes are called “protected health information”. (PHI)

Psychotherapy notes will only be used by the person generating the notes and kept separately from the medical record, unless you sign a separate authorization to release this information.

The following is our Notice of Privacy Practice that explains your rights and the steps we take to protect your health information. This notice tells you in detail how we will use your health information.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge the receipt of the Eastern Band of Cherokee Notice of Privacy Practices at Cherokee Indian Hospital.

X______________________________ ______________________

Signature of Patient or Guardian for Minor Date

______________________________ ______________________

Signature & Title of Employee (CIHA/EBCI) Date

For Patients Unable to Acknowledge Receipt:
I hereby certify that the patient was unable to acknowledge receipt of Notice of Privacy Practice due to the following reason(s):

____

______________________________ ______________________

Signature of CIHA staff Date

______________________________ ______________________

Signature & Title of Employee (CIHA/EBCI) Date

For Patients Refusing to Acknowledge Receipt:
I hereby certify that the patient is refusing to acknowledge receipt of the Notice of Privacy Practices.

______________________________ ______________________

Signature of CIHA staff Date

______________________________ ______________________

Signature & Title of Employee (CIHA/EBCI) Date

Patient Name:________________________________ **HRN:**__________________

Cherokee Indian Hospital or EBCI components
HOSPITAL ROAD, CHEROKEE, NC 28719
MAIL: CALLER BOX C-268, CHEROKEE, NC 28719
PHONE: 828-497-9163 FAX: 828-497-5343

Service Agreement

1. **AUTHORIZATION FOR CLINICAL CARE, HOSPITAL CARE AND EMERGENCY ROOM TREATMENT**:
The undersigned voluntarily agrees to treatment and services that his/her physician deems necessary.

2. **RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW**:
Cherokee Indian Hospital or EBCI component units may disclose all or any reasonable part of the patient's record to include information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the hospital's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any other purposes reasonably related to these activities. The undersigned understands that this authorization will remain in effect, until revoked in writing.

3. **ASSIGNMENT OF INSURANCE BENEFITS**:
I hereby authorize payment directly to the Cherokee Indian Hospital or EBCI component units of the benefits otherwise payable to me but not to exceed the regular charges for this period of services or hospitalization. Should any insurance benefit be paid to me, I understand that it is my responsibility to forward that benefit to the Cherokee Indian Hospital or EBCI component units. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, liability claims and/or reimbursements for any services I receive.

3.**5. MVA LIEN**:
In accordance with Public Law 87-693 (42 U.S.C. - 2652-2653) and recognizing that Cherokee Indian Hospital Authority & The Eastern Band of Cherokee is the payer of last resort, I hereby agree to assign to the CIHA /EBCI, upon request, any claim I have against a third person of reasonable value for hospital, medical, surgical or dental care and treatment furnished or to be furnished to me by or at the expense of the EBCI/ CIHA as the result of any injury or disease suffered by me under circumstances creating a tort liability upon such third person to pay damages to me.

4. **MEDICAID**:
State regulations require you to present a current identification card every time you are admitted or receive service. Every patient is required to submit an application for Medicaid if referred by a Physician, Benefits Coordinator, Contract Health Service or other provider. Lack of compliance with the Medicaid application process may result in a denial for Contract Health Service until an application is completed. If you do not identify yourself as a NC Medicaid recipient, you will be responsible for this bill. Services not paid or covered under the NC Medicaid program will be billed to the patient or Guardian.

5. **MEDICARE:**
This program covers hospital and other services if it is determined that it is medically necessary for the patient to be admitted or receive health care. By signing this agreement I have given this facility a "Statement of Permit for Payment of Medicare Benefits to this Provider". It is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable. You are expected to pay the Medicare deductible and co-insurance. If for some reason your care does not meet the requirements of your insurance, you will be responsible for the entire bill.

6. **NON-BENEFICIARY FINANCIAL AGREEMENT**:
The undersigned agrees individually as follows: That in consideration for the services rendered to the patient, he/she obligates himself/herself and the patient to pay the account in accordance with the regular rates and terms. Any cost denied by an insurance agent or other responsible party, including co-payment and deductibles would be the responsibility of the parent, patient or guardian

7. **PATIENT RIGHTS AND RESPONSIBILITIES**:
Patient Rights and Responsibilities have been explained to me and I understand my Rights and Responsibilities as a patient or guardian. Advance Directives has been explained to me and if I should have any questions, I must speak with my Physician or other designated Advance Directives liaison. Privacy Act: I have been given notice and read the Privacy Act Notice and the laws which govern my rights as a patient.

8. **CONTRACT HEALTH SERVICES**:
I have received notice of my Contract Health Service (CHS) eligibility. I fully understand my responsibility under the CHS regulations. I understand the CHS is not an insurance program or an entitlement program. I understand that I must comply eligibility guidelines established in 42CFR Part 136 Sub Part C.

9. **AGREEMENT:**
By signing this form I understand the contents of the service agreement and have received a copy. I understand the interpretation of this agreement, which was explained to me in English and/or in a common language.

X ______________________________ - ____________ ______________________________ - ____________
Patient/Guarantor Signature Date Interviewer Signature Date

Patient Name HRN:

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ONLY FILL OUT IF YOU HAVE MEDICARE

Medicare Secondary Payer Questionnaire

We need the following information to determine which health insurance is the Primary

1. Are you presently working? ☐ Yes ☐ No **Retired**? ☐ Yes ☐ No
   Date of Retirement: ________________________

2. If you are currently working and covered by a health insurance plan or (HMO) please provide the name of the plan:__________________________________

3. Are you covered by a health insurance plan of your working spouse? ☐Yes ☐No
   If yes, please provide the name of the insurance plan (HMO):
   ____

4. You are eligible for Medicare based on which of the following: (Check One)

   - ☐ Age
   - ☐ Disability
   - ☐ End Stage Renal
   - ☐ Black Lung
   - ☐ Work related illness or injury

5. Do you have:

   - ◊ Worker's Compensation ☐ Yes ☐ No
   - ◊ Veteran's Benefits ☐ Yes ☐ No

6. Are the services to be paid by a government program such as a research grant? ☐ Yes ☐ No

7. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility? ☐ Yes ☐ No
   ____

8. Have you had Home Health in the last 30 days? ☐ Yes ☐ No

9. Are you currently a Hospice Patient? ☐Yes ☐No

Signature: ____________________________________ Date: ________________

Print Name: ___________________________________ HRN: ________________

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Patient Confidential Communications

Individuals have a right to request confidential communications regarding their Protected Health Information (PHI). These requests could require that communication be directed to alternative locations; such as different mailing address or phone number.

Patient Name ______________________________________ DOB: ________________

Record Number: __________________

Home Phone _____________________ Other Phone ____________________

_______ OK to leave a detailed message ______OK to leave a detailed message

_______ Leave callback name and number ONLY ______ Leave callback name and number ONLY

______ Text messages for appt. reminders and callback name and number ONLY

Written Communication

Address: ____

_______ OK to mail to the above address any medical information regarding labs, billing, etc.

Other: ____
Please list any information you DO NOT want to be mailed to the address you listed above.

The privacy rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual or for uses and disclosures for Treatment, Payment and healthcare Operations (PTO),

Please list below Individuals we may communicate with regarding your PHI without written authorization. This may include diagnoses, test results and treatment plans.

◊ Name: ________________________________ Relationship to you: ____________________

Address: __________________________________ Phone Number: _________________________

◊ Name: ________________________________ Relationship to you: _____________________

Address: __________________________________ Phone Number: _________________________

◊ Name: _______________________________ Relationship to you: _____________________

Address: __________________________________ Phone Number: _________________________

Patient Signature: ____ Date: _______________________

Relationship if other than Self: _________________________________ Date: ______________________
** This document will be scanned into the patient record and remain in effect until revoked by the patient**