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
- Enrollment Card or EBCI Descendant Letter showing 911 address
- Lease or Rental agreement 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 Name
Date of Birth:	Social Security Number:	Race:
Primary Language:	Legal Sex: ☐ Male ☐ Female	☐Hispanic ☐Non-Hispanic
Marital Status: Place of Birth (City, State):	Gender Identity: ☐ Prefer not to answer ☐ Non-binary ☐ Male ☐ Transgender ☐ Female ☐ Other: _____	
Sexual Orientation: ☐Straight, Heterosexual ☐Bisexual ☐Lesbian, Gay, Homosexual ☐Questioning, Unsure ☐Queer ☐Other: _____	Preferred Pronouns (may choose multiple): ☐She/Her ☐He/Him ☐They/Them ☐Other: _____	
Physical (911) Address:		
City:	State:	Zip Code:
Mailing Address (if different from above):	Present Community:	
City:	State:	Zip Code:
Residence Phone:	Cell Phone:	
Work Phone:	Other Phone:	
Tribal Membership:	Indian Blood Quantum:	
Tribal Enrollment Number:	Tribal Blood Quantum:	

Employer Information

Employer Name:	Employer Phone:	
Employer Address:		
City:	State:	Zip Code:

Communication Information

Internet Access? ☐Yes ☐No	Email Address:
Internet Access Locations (Check all that apply) ☐Healthcare Facility ☐Work ☐Home ☐School ☐Library ☐Tribe/Community Center ☐Mobile Device	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 Full Name	Place of Birth (City, State):
Father's Phone	Other Phone:
Father's E-mail:	Father's Employer:
Mother's Full Maiden Name	Place of Birth (City, State):
Mother's Phone:	Other Phone:
Mother's E-mail:	Mother's Employer:
Spouse's Full Name:	Spouse's Date of Birth:
Spouse's Employer:	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-I.e., Medicare, Medicaid or other private insurances & **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 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:**

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 apply 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: _____

Acknowledgement of Receipt of IHS Notice of Privacy Practices

By Signing this form, you acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by logging onto: https://www.ihs.gov/sites/hipaa/themes/responsive2017/display_objects/documents/NoticePrivacyPracticePamphlet.pdf or by contacting the IHS Privacy Officer at (240) 479-8521.

If you have any questions about our Notice of Privacy Practices, please contact the IHS Privacy Officer at (240) 479-8521.

_____

Name of Patient

_____ _____

Signature of Patient Date

If patient is unable to sign:

_____

Name of Legal Representative and state relationship to patient

_____ _____

Signature of Patient Representative Date

_____ _____

Signature and Title of CSU Staff Date

Staff Only: For Patient unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the IHS Notice of Privacy Practices Because:

_____

_____ _____

Signature of IHS Staff Date

IHS Staff Use Only:
Health Record Number: _____ D.O.B. _____

OMB STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

An Independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719

ONLY FILL OUT IF YOU HAVE MEDICARE

Medicare Secondary Payer Questionnaire

The following information is needed to determine which health insurance is the Primary.

1. Are you receiving Black Lung Benefits? ☐ Yes ☐ No
2. Are the services to be paid by a government research grant? ☐ Yes ☐ No
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ☐ Yes ☐ No
4. Was the illness/injury due to a work-related accident/condition? ☐ Yes ☐ No
5. Was illness due to a non-work-related accident/condition? ☐ Yes ☐ No
6. Are you entitled to Medicare based on?
   ☐ Age
   ☐ Disability
   ☐ End Stage Renal Disease (ESRD) - Please complete section on back of the form.
7. Are you currently employed?
   ☐ Yes Name of Employer: _____
   ☐ No Date of Retirement: _____/_____/_____
8. Do you have a spouse who is currently employed?
   ☐ Yes Name of Employer: _____
   ☐ No Date of Retirement: _____/_____/_____
9. Do you have group health plan (GHP) coverage based on your own or spouse's current employment?
   ☐ Yes - ☐ Self ☐ Both ☐ Spouse
   ☐ No
10. Are you covered under the group health plan of a family member other than your spouse?
    ☐ Yes Name of Employer: _____
    ☐ No
11. If you have GHP coverage based on your own or spouse's current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?
    ☐ Yes - ☐ Self ☐ Spouse
    Name of group health plan: _____
    ☐ No

An Independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719

THIS SECTION IS ONLY REQUIRED IF YOU HAVE END-STAGE RENAL DISEASE (ESRD)

1. Have you received a kidney transplant?
   - ☐ Yes - Date of transplant: _____/_____/_____
   - ☐ No
2. Have you received maintenance dialysis treatments?
   - ☐ Yes - Date dialysis began: _____/_____/_____
     If you participated in a self-dialysis training program, provide training start date:
     _____/_____/_____
   - ☐ No
3. Are you within the 30-month coordination period?
   - ☐ Yes
   - ☐ No
4. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   - ☐ Yes
   - ☐ No
5. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
   - ☐ Yes
   - ☐ No
6. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?
   - ☐ Yes
   - ☐ No

Signature: _____ Date: _____

Print Name: _____ HRN: _____

Confidential Communications Request Form

This form helps us understand how you want us to communicate with you, or others, about the care we provide you. You can choose what modes of communication you would like us to use, what information is shared and who we can share that information with. We may need to communicate test results, prescription information, or respond to a message you left for us.

Patient Information

Patient Name: _____ Date of Birth: ____ / ____ / ____Chart Number _____

1. Confidentiality Statement

I understand that:

- This form gives Cherokee Indian Hospital (CIHA) permission to communicate with me or those that I choose in the manner I choose.
- I can change my decisions on this form at any time by completing a new form. The information on this form cannot be changed over the phone. If I want anything changed on this form it is my responsibility to contact CIHA to complete a new form.
- This form does not authorize the release of my complete medical record; it only permits CIHA to communicate in the ways I have indicated.
- If I give permission to communicate my health information to someone else, I understand that this could include any information in my medical record including test results, medications, diagnosis, procedures, etc.
- Decisions on this form apply to CIHA locations and outlying clinics.
- Communications by text or email may not be fully secure, and I accept the risks associated with these communication methods. Text messaging will only be used for appointment reminders, or general messages from my care manager, or primary care team to contact them.

2. Preferred Method(s) of Communication

I request that Cherokee Indian Hospital communicate with me about my health care and related matters in the following ways (check all that apply):

☐ Mail ☐ Alternate mailing address: _____☐ Phone ☐ Text message ☐ Email

3. Authorized Persons to Communicate on My Behalf - I authorize CIHA to communicate with the following person(s) about my appointments, treatment, and other necessary information:

Name and Phone Number	Relationship	Information that we can share (check box)
		☐ Appointment Information ☐ Medical Information
		☐ Appointment Information ☐ Medical Information
		☐ Appointment Information ☐ Medical Information

This form is Valid: ☐ Until revoked or ☐ From ____ / ____ / _____ Until____ / ____ / _____

_____ _____

Patient/Legal Representative Signature **Date**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)*_____
☐ Personal Use ☐ Disability ☐ Research ☐ Health Information Exchange *(IHS/Other)* _____

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐Only information related to *(specify)* _____

☐Only the period of events from _____ to _____

☐Other *(specify((CHS, Billing, etc.)* _____

☐Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐Substance Use Disorder Treatment/Referral ☐HIV/AIDS-related Treatment ☐Mental Health *(Other than Psychotherapy Notes)*

☐Sexually Transmitted Diseases ☐Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date (mm/dd/yyyy) or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	
ADDRESS	
CITY/STATE	
DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

PSC Publishing Services (301) 443-6740 EF

Instructions for Completing IHS Form 810 AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Section III, provide the name of the person, facility, and address that will receive the information.

    a. If the information is being disclosed to prevent multiple enrollments in a withdrawal management or maintenance treatment program, please provide the name of each central registry, withdrawal management, and maintenance treatment program to which disclosure may be made OR state "any withdrawal management or maintenance treatment program within 200 miles of [IHS Facility permitted to make the disclosure]".

4. Section IV, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE, as well as the name or general designation of the HIE participants who may access your records (e.g., a specific provider(s) or "my current and future treating providers").
5. Section V, check the appropriate box as applicable.

    a. Only information related to – specify diagnosis, injury, operations, special therapies, etc.

    b. Only the period of events from – specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

    c. Other (specify) – e.g., Purchased Referred Care (PRC), Billing, Employee Health.

    d. Entire Record – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

    e. IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/ AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES *MUST* BE CHECKED BY THE PATIENT.

    f. Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES (which are separate from progress notes and contain the therapist's impressions and the content of psychotherapy conversations), ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.

    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

6. Section VI, if a different expiration date or event is desired, please specify. When you opt-in to share information through the HIE, an expiration date must be entered; it is recommended that a date five (5) years into the future be entered to provide for continuity of care.

    a. If authorizing the release of records for court-ordered substance use disorder treatment, the expiration date/event must be no later than the final disposition of the criminal proceeding.

7. Section VI, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

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Choice of Provider

7 Clans Pediatrics	*Eagle* Adults	Snowbird
Dr. Bram Pinkley, MD	**Dr. Blythe Winchester, MD**	**Mary Postell-Jones, FNP**
Dr. Kathleen Foote, MD	*(Only accepts patients who are 65 and older)*	
Adults	**Quana Winstead, PA-C**	
Kelsey Two Bears, PA-C	*(Only Accepts Diabetes Patients)*	
Trudy Crowe, FNP	**Dr. Matthew Mahar, MD**	**Cherokee County**
Dr. Tony Jones, MD	**Dr. Winona Houser, MD**	**June Hensley, FNP**
	Jennifer Peterson, FNP	

***We will try to accommodate all requests but cannot guarantee everyone will be given their first choice. ***

*** Please allow up to 30 days to complete this process. If you need something urgently, please let your current team know of the need, so we may address it in a timely manner. ***

First and Last Name: _____

Date of Birth: _____ Chart Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

1st Choice: _____

2nd Choice: _____

3rd Choice: _____

If not choosing a provider for the first time, please include the reason for requesting a change of provider:

Patient Signature: _____ Date: _____