OKLAHOMA CITY INDIAN CLINIC
www.okcic.com

4913 W. Reno ◊ Oklahoma City, OK 73127

To establish a chart at Oklahoma City Indian Clinic, you must present this completed registration packet with all required documentation to the Registration Desk and schedule an appointment for a *New Patient Physical*. If you have any questions please contact a Registration Representative at: (405) 948-4900 ext. 221 or Pediatric Registration at ext. 633 or 635.

Patient Financial Responsibility:

Under the Indian Health Care Improvement Act Amendments, Public Law 100-713, Oklahoma City Indian Clinic is considered the "payer of last resort" and required by Federal law to seek and collect payment from any medical program that patients may be eligible to participate in such as SoonerCare. It is the financial responsibility of each patient to present all current or new insurance cards during check-in and apply for available medical programs with the assistance of a clinic Benefits Coordinator.

While this Clinic recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let Patient Registration staff know by completing a SOGI preferences questionnaire.

You must submit originals of the items listed below:

1. **Eligibility Documents:**
   - CDIB (Certificate of Degree of Indian Blood) card issued by the Bureau of Indian Affairs, or
   - Federally recognized tribal enrollment card, or
   - Letter of Descendancy from a federally recognized tribe

   Minor children may establish eligibility using their parent's documents, but must provide their own eligibility documents before their 19th birthday.

   Oklahoma City Indian Clinic reserves the right to make the final determination of eligibility.
2. **Social Security Card:** All persons must have a Social Security card within one year from date of birth.
3. **Photo Identification:** Current driver's license, State issued ID, passport, or government ID with photo for all persons aged 18 or older. Tribal enrollment card with a recent photo may be used until a current State ID can be obtained, but cannot be used for obtaining prescriptions for controlled substances.
4. **Medication List:** Needed for all applicants. Please provide a list of any prescriptions and over-the-counter medication you are taking (Including herbals/supplements, and vitamins/minerals).
5. **Medicaid, Medicare, private or tribal insurance card:** If you have Medicaid, Medicare, private, or tribal insurance, please provide a copy of your card(s) to the registration staff at each visit. The Clinic is required by **Federal law** to seek and collect payment from any insurance the patient may be eligible to participate in and patients are required to provide this information.
6. **Certified Birth Certificate:** Required for all applicants under 18 years of age. Appointed guardians **must** have court documentation for minor children.
7. **Immunization Record:** Required for persons under 16 years of age.

If the name (s) on your CDIB, identification and Social Security card do not match, you **must** provide legal verification of name change (marriage license, divorce decree, court papers, etc.)

If you have any questions, you may contact a Registration Representative at:
(405) 948-4900
Main Registration Desk at extension 221
Pediatric Registration Desk at extension 633 or 635

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CHART #_____

NEW PATIENT REGISTRATION

PATIENT INFORMATION

_____ _____ _____ _____ _____
LAST NAME **FIRST NAME** **MIDDLE NAME** **MAIDEN NAME** **PREFERRED NAME**

_____/_____/_____ _____/_____/_____ _____ _____
DATE OF BIRTH **SOCIAL SECURITY NUMBER** **CITY OF BIRTH** **STATE OF BIRTH**

☐MALE ☐FEMALE (On Birth Certificate)

RELATIONSHIP STATUS: ☐Divorced ☐Married ☐Never Married ☐Separated ☐Single ☐Widow(er) ☐Other_____

ETHNICITY: ☐Hispanic or Latino ☐Non-Hispanic OR Latino ☐Declined to Answer

RACE: ☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐ Native Hawaiian/Pacific Islander ☐White

ADDITIONAL RACE(S): ☐Duplicate AI/AN ☐Asian ☐Black/African-American ☐ Native Hawaiian/Pacific Islander ☐White

Our goal is to address you the way you want to be addressed, treat and acknowledge you in a way you are most comfortable. There is now a national requirement that **all** patients are given an opportunity to answer questions relating to sexual orientation and gender identity (SOGI). This information will ensure Two Spirit/LGBTQ patients are being provided with services and treatments that fit their health care needs. Participation is voluntary and all data collected is confidential.

PREFERRED LANGUAGE (including sign language) _____ **Interpreter Required? ☐ YES ☐ NO**

TRIBAL AFFILIATION:_____ **TRIBE QUANTUM:**_____ **OTHER TRIBE:**_____

_____ _____ _____
STREET ADDRESS (MAILING ADDRESS**)** **CITY** **STATE** **ZIP CODE**

_____ _____ _____
PHYSICAL LOCATION OF HOME (if different from mailing address) **CITY** **STATE** **ZIP CODE**

(_____)_____ (_____)_____ _____
HOME PHONE **CELL PHONE** **EMAIL ADDRESS**

PREFERRED METHOD OF CONTACT:
☐Cell Phone ☐Home Phone ☐Letter

Do you have Internet access?: ☐ Yes ☐ No
If Yes, where?_____

Do we have permission to send generic health information to the listed email address? ☐Yes ☐No

Are you a migrant worker? ☐ YES ☐ NO **Are you currently homeless? ☐ YES ☐ NO**

Did you serve in the military? ☐NO ☐YES BRANCH:_____**ENTRY DATE:**_____**DISCHARGE DATE:**_____

EMERGENCY CONTACT/NEXT OF KIN INFORMATION (Please list two different contacts here)

_____ _____ _____ _____ _____ _____ _____
EMERGENCY CONTACT NAME **PHONE NO.** **RELATIONSHIP** **STREET ADDRESS** **CITY** **STATE** **ZIP**

_____ _____ _____ _____ _____ _____ _____
NEXT OF KIN NAME **PHONE NO.** **RELATIONSHIP** **STREET ADDRESS** **CITY** **STATE** **ZIP**

EMPLOYMENT INFORMATION: COMPLETE IF YOU ARE CURRENTLY EMPLOYED

EMPLOYER NAME_____**PHONE NUMBER (**_____**)**_____
EMPLOYER ADDRESS_____ **Do you work ☐ Full Time or ☐ Part time**

RESPONSIBLE PARTY INFORMATION

Do you have **Medicare?**	☐ YES ☐ NO	Do you have **Dental** insurance?	☐ YES ☐ NO
Do you have **Medicaid/SoonerCare?**	☐ YES ☐ NO	Do you have **Vision** insurance?	☐ YES ☐ NO
Do you have **Private** or **Group** insurance**?**	☐ YES ☐ NO	Do you have **Insurance** through a **Tribe?**	☐ YES ☐ NO
Do you have **Prescription** or **Part D** insurance?	☐ YES ☐ NO	Do you have **VA (Military) Benefits**?	☐ YES ☐ NO

If you checked "Yes" to any of these questions, please complete the INSURANCE INFORMATION section on the next page.

I have requested Oklahoma City Indian Clinic to provide me and or my family with medical care. I authorize assignment of benefits for all services to be paid to Oklahoma City Indian Clinic.

_____ _____ _____
Responsible Party Signature **Printed Name** **Date**

CHART #_____

PARENT/LEGAL GUARDIAN INFORMATION: COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE

PARENTAL RELATIONSHIP: ☐Mother ☐Father ☐Guardian

_____
FULL LEGAL NAME

_____
STREET ADDRESS

_____ _____ _____
CITY **STATE** **ZIP**

(_____)_____ _____
PHONE NUMBER **EMAIL ADDRESS**

_____
EMPLOYER NAME

_____ (_____)_____
EMPLOYER CITY **EMPLOYER PHONE**

PARENTAL RELATIONSHIP: ☐Mother ☐Father ☐Guardian

_____
FULL LEGAL NAME

_____
STREET ADDRESS

_____ _____ _____
CITY **STATE** **ZIP**

(_____)_____ _____
PHONE NUMBER **EMAIL ADDRESS**

_____
EMPLOYER NAME

_____ (_____)_____
EMPLOYER CITY **EMPLOYER PHONE**

INSURANCE INFORMATION: COMPLETE IF YOU ANSWERED YES TO ANY TYPE OF INSURANCE COVERAGE

Please provide a copy of your insurance card(s) at the time you submit this form.

Primary Insurance:

_____ _____ (_____)_____
INSURANCE COMPANY NAME **ADDRESS** **PHONE NUMBER**

_____ _____ _____
POLICY NUMBER **GROUP NUMBER** **GROUP NAME**

_____ _____/____/_____ _____/_____/_____ _____
NAME OF POLICY HOLDER **POLICY HOLDER SSN** **DATE OF BIRTH** (Policy holder) **RELATIONSHIP TO PATIENT**

_____ _____ _____ _____
POLICY HOLDER ADDRESS **CITY** **STATE** **ZIP CODE**

Secondary Insurance:

_____ _____ (_____)_____
INSURANCE COMPANY NAME **ADDRESS** **PHONE NUMBER**

_____ _____ _____
POLICY NUMBER **GROUP NUMBER** **GROUP NAME**

_____ _____/____/_____ _____/_____/_____ _____
NAME OF POLICY HOLDER **POLICY HOLDER SSN** **DATE OF BIRTH** (Policy holder) **RELATIONSHIP TO PATIENT**

_____ _____ _____ _____
POLICY HOLDER ADDRESS **CITY** **STATE** **ZIP CODE**

Other Members on Policy:

Name	Relationship	Chart Number	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

****Oklahoma City Indian Clinic will NOT bill the patient for any services not covered by insurance.**

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PATIENT SERVICE AGREEMENT

RIGHT TO REFUSE SERVICES

Oklahoma City Indian Clinic reserves the right to refuse services to anyone for cause which includes, but is not limited to belligerent or abusive behavior; failure to comply with all third party payer processes (Indian Health Services is considered the payer of last resort); non-compliance with treatment; or any other violation of the Patient's Rights and Responsibilities.

PAYMENT FOR SERVICES AT AN OUTSIDE HEALTH CARE FACILITY

If you go to another health facility for services or receive a referral from an Oklahoma City Indian Clinic provider to go to another health facility, please be advised that YOU are responsible to pay for cost of this care. If you have an alternate resource such as Private Insurance, Medicare or Medicaid, you are responsible for providing this information. Purchased/Referred Care (PRC) will require application for Medicare and/or Medicaid benefits before considering payment for *services.*

CONSENT TO TREAT

The undersigned hereby gives consent to the staff of Oklahoma City Indian Clinic for medical examination, treatment, laboratory services and professional services including, but not limited to Behavioral Health Services, Dental, and Optometry to the undersigned and/or minor child listed below.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION FOR BILLING

I understand that under the Indian Health Care Improvement Act Amendments, Public Law 100-713, Oklahoma City Indian Clinic is the payer of last resort and required by Federal law to seek and collect payment from any medical program that my minor children or I may be eligible to participate in. I acknowledge that applying for benefits (i.e. SoonerCare) and providing my insurance information is my financial responsibility to Oklahoma City Indian Clinic and is required in order to receive services. I hereby assign all benefits for services rendered to Oklahoma City Indian Clinic and I understand that payments will be made directly to the clinic. I hereby authorize the release of any and all medical information necessary to process my claims. Fee information may be provided upon request.

_____
Initials

MAINTAINING "CURRENT MEDICAL PATIENT" STATUS

A "Current Medical Patient" is considered to be a patient who has been seen by a medical provider within the last year. By law, prescriptions *with refills* expire after one year (prescriptions for controlled substances expire sooner). In order to continue receiving medication you must follow the practitioner's treatment plan and keep your appointments. If you have not been seen in over one year you will not be able to receive prescriptions.

PATIENT INFORMATION BROCHURE

I hereby acknowledge receipt of the Oklahoma City Indian Clinic Patient Information brochure that outlines Patient Rights and Responsibilities, Generic Drug policy and additional departmental information.

AUTHORIZATION TO UTILIZE UNSECURE COMMUNICATIONS FOR APPOINTMENT REMINDERS

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Oklahoma City Indian Clinic to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending or missed appointment. I understand that notifications may use an autodialer and/or prerecorded or artificial voice and may be repeated multiple times per appointment and may exceed contacts more than three times per week.

NOTICE OF PRIVACY PRACTICES

- ☐ I have been offered and accept receipt of the Oklahoma City Indian Clinic Notice of Privacy Practices.
- ☐ I have been offered and decline receipt of the Oklahoma City Indian Clinic Notice of Privacy Practices.

PRIVACY ACT ACKNOWLEDGEMENT

I acknowledge that my record is maintained in the Health and Medical Records System at: **Oklahoma City Indian Clinic, 4913 W Reno, Oklahoma City, OK 73127**

I understand that the information given by me and/or collected and stored in my health record is necessary for Indian Health Service staff or Indian Health Service contractors and service units to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use (listed on the "Why We Ask Questions" notice), without my consent. This notice is available upon request.

_____ _____
Patient's Name (**PRINT**) Patient's Chart Number

_____ _____
Signature of Patient/Parent/Legal Guardian Date

Office Use Only

_____ _____
OKCIC Staff Signature/Title Date

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Broken Appointment Policy

Oklahoma City Indian Clinic works hard to meet and exceed the expectations of all our patients and as always, we are dedicated to providing you with the best care and service possible.

Time is specifically reserved for you on our schedule. When sufficient notice is not given to cancel or change an appointment, it does not give us enough time to contact another patient who could come to the Clinic during your assigned time.

Because of the great need for our services, we have created the following **Broken Appointment Policy:**

Failure to give a twenty-four (24) hour notice to cancel your appointment, or failing to appear for your appointment ("no-show") will count as a broken appointment. If you have three (3) broken appointments within a rolling one (1) year period your clinic privileges may be suspended for six (6) months. All pending appointments will be cancelled. No clinic services, including pharmacy, will be permitted during the suspension period.

If you have been suspended and feel you should have your clinic privileges reinstated, please contact in writing our Chief Operating Officer, Lysa Ross at lysa.r@okcic.com or mail your concerns to:

Lysa Ross, Chief Operating Officer
Oklahoma City Indian Clinic
4913 West Reno Avenue
Oklahoma City, OK 73127

I have read and fully understand Oklahoma City Indian Clinic's **Broken Appointment Policy**.

_____	_____	_____
Patient Signature / Parent or Guardian Signature	Chart Number	Date

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ADVANCE DIRECTIVE ACKNOWLEDGEMENT OF RIGHTS

Patient's Name: _____ Chart #: _____

1. You have the right to accept or refuse medical or surgical treatment.

2. You have the right to give written instructions, such as a living will or durable power of attorney for health care, about future treatment **before** you become seriously ill or unable to make health care decisions. This is called an Advance Directive. An Advance Directive typically takes effect when a patient becomes incompetent to make medical decisions.

3. You may consult your doctor, family, lawyer, or others before making a written Advance Directive.

4. You are not required to make any Advance Directive about your future medical treatment. It is entirely your choice.

5. If you decide to make an Advance Directive about future medical care it will become a part of your medical record at Oklahoma City Indian Clinic.

6. Photocopies of your fully executed and witnessed directive should be made for your personal records, your family members, and your proxy and alternate if you have chosen them. The original or a copy should be furnished to the hospital whenever you receive inpatient care.

7. Your directions will be followed unless they are considered by your doctor to be in violation of law or applicable ethics.

8. You may revoke your Advance Directive at any time, in writing or simply by telling your attending physician or other health care provider or a witness, regardless of your physical or mental condition.

9. The Behavioral Health department of the Oklahoma City Indian Clinic will provide you with information upon your request to help you develop an Advance Directive regarding your health care.

I understand my rights as set forth above.

Please check **one** of the following statements:

☐ I have an Advance Directive ☐ Attached ☐ Copy Requested
☐ I do not have an Advance Directive and I would like additional information
☐ I do not have an Advance Directive and I do not want any information at this time

Signature: _____ Date: _____

Witness: _____ Date: _____

Relationship to patient:_____ or ☐Oklahoma City Indian Clinic representative

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SOGI Preferences

Sexual Orientation / Gender Identity

Completion of this Form is Optional

You may choose to complete all or part of the form. You may choose to answer the questions at another time. You may give the form to Registration staff, your nurse, or provider.

Our goal is to address you the way you want to be addressed, treat and acknowledge you in a way you are most comfortable. There is a new national requirement that **all** patients are given an opportunity to answer the questions outlined below. This information will ensure our Two Spirit/LGBTQ patients are being provided with services and treatments that fit their health care needs. We value your privacy. Participation is voluntary and all data collected is confidential. This form will be shredded once your preferences are noted in the record.

LEGAL NAME:	**PREFERRED NAME:** _____ *(OPTIONAL)*
First: _____ Middle: _____ Last:_____	**DATE OF BIRTH:** _____/_____/_____ MM/DD/YYYY
	BIRTH SEX: *sex assigned at birth* O Female O Male O Other
	LEGAL SEX: *if different from birth sex - documentation required* O Female O Male O Other

GENDER IDENTITY *(OPTIONAL)*	**PERSONAL PRONOUN** *(OPTIONAL)*	**SEXUAL ORIENTATION** *(OPTIONAL)*
☐ Female	☐ He, Him, His, Himself	☐ Straight
☐ Male	☐ She, Her, Hers, Herself	☐ Gay, Lesbian
☐ Transgender male/man/female-to-male	☐ They, Them, Their, Theirs, Themselves	☐ Bisexual
☐ Transgender female/woman/male-to-female	☐ Ne, Nem, Nir, Nirs, Nemself	☐ Don't know
☐ Genderqueer, (neither)	☐ Ey, Em, Eir, Eirs, Emself	☐ Decline to answer
☐ Don't know	☐ Ve, Ver, Vis, Verself	☐ Other_____
☐ Decline to answer	☐ Xe, Xem, Xyr, Xyrs, Xemself	
☐ Other _____	☐ Ze, Hir, Hirs, Hirself	
	☐	
	☐ Ze, Zir, Zirs, Zirself	
	☐ Don't know	
	☐ Decline to answer	
	☐ Other _____	

» DO NOT SCAN INTO HEALTH RECORD «
Update in Patient Registration application and shred afterwards

Note: A court order is required to change the legal name and/or gender marker on a birth certificate in Oklahoma.

3/2022