CHART #-_____

WAH-ZHA-ZHI HEALTH CENTER
HEALTH RECORD APPLICATION

WAH-ZHA-ZHI HEALTH CENTER
715 GRANDVIEW
PAWHUSKA, OK 74056
918 287-9300

Please submit the requested documents with your completed application

----Incomplete applications will not be considered----

- **Tribal Membership Card (Osage Members Only)**
- **Certificate Degree of Indian Blood (CDIB) or proof of Native American Descent from a federally recognized tribe of the U.S.**
  NOTE: Children under 18 years of age, using their parent's CDIB, A state issued birth certificate will be needed.
- **Valid Picture ID or driver's license**
- **Health Insurance Cards** *(Examples include: Blue Cross/Blue Shield, Medicare A & B, Part D-Drug Plan, Medicare Replacement/Advantage Plan, Tricare, VA health card, or any other third party coverage.)*
- **Utility Bill-** *(Examples: Gas, Water, Rent Receipt. No cut-off notices.)*

Attention Expectant Mothers: Along with the above information, submit your marriage license or notarized paternity affidavit, husband/boyfriend's picture ID, proof of pregnancy like the blood serum HCG test or ultra sound, and a signed Non-Beneficiary Acknowledgement form.

As part of this registration, a Patient Benefits Coordinators will screen those patients who do not have insurance or any kind of third party coverage

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WAH-ZHA-ZHI HEALTH CENTER
HEALTH RECORD INFORMATION

(Please do not leave any blanks)

Legal Last Name **First Name** **Full Middle Name**

Date of Birth **Social Security #** **Gender**

List other names and aliases used (if any): _____

Tribal Membership or Descendancy: _____ **Blood Quantum:** _____

Please list other Tribe(s): _____ **Blood Quantum:** _____

Marital status: Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Separated ☐

Birthplace of Patient: _____ **Religious Preference:** _____
(City and State) (Optional)

MAILING ADDRESS: _____ **Primary Phone #:** _____

PHYSICAL ADDRESS

For PO Boxes: _____ **Alternate Phone #:** _____

City & State: _____ **Work #:** _____

Zip Code: _____

Patient's FATHER: _____

LAST NAME, FIRST NAME, and BIRTHPLACE (City and State)

Patient's MOTHER: _____

MAIDEN NAME, FIRST NAME, and BIRTHPLACE (City and State)

Company Name: _____ **Company Name:** _____

Address: _____ **Address:** _____

City, State, Zip Code: _____ **City, State, Zip Code:** _____

Phone: _____ **Phone:** _____

Full Time: ☐ **Part Time:** ☐ **Self Employed:** ☐ **Full Time:** ☐ **Part Time:** ☐ **Self Employed:** ☐

****** For Children under 18, please list the parents' or legal guardians' employers ******

Do you have Internet access? **Yes** □ **No** □ **E-mail address:** _____

Internet access locations: (*Check all that apply*): **Home** □ **Work** □ **Cell** □ **School** □ **Library** □ **other** □

Do we have permission to send generic health information to your E-mail address? **Yes** □ **No** □

What is your preferred method to receive appointment reminders? (*Check one*): **Phone** □ **E-mail** □ **Letter** □

What is your primary language of communication? **English** □ **Tribal Language** □_____**Spanish** □

Sign Language □ **If other than English, would you need an interpreter?** **Yes** □ **No** □

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Name of Emergency Contact: _____	**Name of Next of Kin:** _____
Phone: _____	**Phone:** _____
Relationship: _____	**Relationship:** _____
Address: _____	**Address:** _____
City & State: _____	**City & State:** _____
Zip Code: _____	**Zip Code:** _____

MILITARY SERVICE INFORMATION

Branch of Service: _____ **Vietnam Service indicated? Yes No Service Connected? Yes No Claim Number:** _____

Entry Date: _____

Separation Date: _____

Do you have a valid VA card? Yes_____No _____

Brief description of VA disability: _____

ADVANCE DIRECTIVE/LIVING WILL

(For our patients who are 18 years or older)

Do you have an Advance Directive (Living Will) in place? YES_____NO_____

If you answered NO, would you like some information on the subject? YES_____NO _____

Please tell patient registration, your physician or nurse if you would like to know more about the Advance Directive (Living Will), and they will arrange for the Patient Benefits Coordinator to meet with you and answer your questions.

INSURANCE COVERAGE

If you answer YES to any of the following, please show card/cards to Patient Registration clerk

Private Insurance: YES____NO_____ **Medicare A and/or B:** YES____NO_____

Affordable Care Act: YES____NO____ **Medicare Replacement/Advantage:** YES____NO_____

Oklahoma SoonerCare: YES____NO_____ **Part D (Rx Plan):** YES____NO_____

The Wah-Zha-Zhi Health Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charges, including but not limited to: hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer. The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I hereby assign to the clinic such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the clinic. I understand that this assignment applies only to medical services and supplies furnished to me during the time period indicated below.

By signing below, ***I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO WHA-ZHA-ZHI HEALTH CENTER.***

Patient Signature here **Date**

Parent/Legal Guardian or Proxy signature here on behalf of the patient **Date**

CHART #-_____

Notice of Privacy Practices for HIPAA

(Health Insurance Portability and Accountability Act)
Privacy Rule

I hereby acknowledge receipt of the Wah-Zha-Zhi Notice of Privacy Practices at:

WAH-ZHA-ZHI HEALTH CENTER
715 GRANDVIEW
PAWHUSKA, OK 74056

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Legal Guardian or Patient Representative Date
(State Relationship to Patient)

_____ _____
Signature & title of Business Office/Patient Registrar Date

For patients unable to acknowledge receipt

I hereby certify that the patient was unable to acknowledge receipt of the Wah-Zha-Zhi Notice of Privacy Practices because of reason stated below:

_____

_____ _____
Signature & title of Business Office employee Date

For Office use only:

Patient Name	**Chart Number**

CHART #-_____

ASSIGNMENT OF BENEFITS
AND
AUTHORIZATION TO FURNISH INFORMATION

WAH-ZHA-ZHI HEALTH CENTER
715 GRANDVIEW
PAWHUSKA, OK 74056

The Wah-Zha-Zhi Health Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charges, including but not limited to: hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer.

The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immune deficiency virus, also known as acquired immune deficiency syndrome (AIDS).

I hereby assign to the Wah-Zha-Zhi Health Center such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the Wah-Zha-Zhi Health Center. I understand that this assignment applies only to medical services and supplies furnished to me during the time period indicated below.

I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO WAH-ZHA-ZHI HEALTH CENTER.

Patient or Proxy Signature: _____
(IF OTHER THAN PATIENT SIGNATURE, PLEASE SPECIFY RELATIONSHIP TO PATIENT)

Date(s) of Service: _____

For Office Use Only:

Patient Name	Chart Number

CHART #-_____

WAH-ZHA-ZHI HEALTH CENTER
715 GRANDVIEW
PAWHUSKA, OK 74056

PRIVATE INSURANCE
POLICY HOLDER INFORMATION

Private Insurance: □YES □NO **AFFORDABLE CARE ACT INSURANCE: □YES □NO**

Policy Holder NAME: _____
Last *First* *Middle*

Policy Holder's DOB: _____ **SSN:** _____

Mailing Address: _____
City, *State* *Zip Code*

Phone Number: _____

EMPLOYER INFORMATION FOR POLICY HOLDER

Name of Employer: _____
Full Time □ **Part Time □** **Self Employed □**

Employer's Address: _____

City, State, Zip Code: _____

Employer's Phone Number: _____

Please list by DOB or CHART NUMBER of any covered family members:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

OFFICE USE ONLY:

NAME OF INSURANCE COMPANY: _____

CLAIMS MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

EFFECTIVE DATE: _____

COVERAGE: MEDICAL DENTAL VISION

GROUP NAME:_____GROUP # _____
POS BIN#:_____GROUP # _____

CHART #-_____

WHA-ZHA-ZHI HEALTH CENTER
715 GRANDVIEW
PAWHUSKA, OK 74065
918-287-9300

PRIVACY OF CONSENT
AUTHORIZATION OF MINORS

I/We the undersigned, parent, or legal guardians of the following minor(s):

1. _____ DATE OF BIRTH: _____
2. _____ DATE OF BIRTH: _____
3. _____ DATE OF BIRTH: _____
4. _____ DATE OF BIRTH: _____
5. _____ DATE OF BIRTH: _____
6. _____ DATE OF BIRTH: _____

I/We authorize any x-ray examination, anesthetic, dental, mental health, medical or surgical diagnosis or treatment by any member of the medical or nursing staff at Wah-Zha-Zhi Health Center that may be rendered to said minor under the general, specific, or special consent of

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

The temporary custodian of the minor(s). I/We authorize the medical or nursing staff of Wah-Zha-Zhi Health Center to call if any necessary consultation in his/her discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourage those persons who have temporary custody of the minor(s), and nursing and /or medical staff to exercise their vest judgement as the requirements of such diagnosis, medical or dental treatment.

This consent shall remain effective at any time they have him/her in their care unless revoked in writing and delivered to the Wah-Zha-Zhi Health Records Department.

_____ _____
Parent/Guardian Date

_____ _____
Parent/Guardian Date

CHART #-_____

Osage Nation Purchase Referred Care

Wah-Zha-Zhi
Health Center
715 Grandview
Pawhuska, OK 74056

The Osage Nation Purchase Referred Care Provides emergency care in hospitals, emergency rooms, surgery centers and may provide other services for Osage Tribal Members who reside in the Oklahoma counties of Pawnee, Payne, Kay, Garfield, Osage, Noble and Grant, and Non-Osage Indians living in Osage County. ***This does not include members of the Iowa Tribe of Oklahoma, Kaw Nation, Otoe-Missouria, Pawnee Nation, Ponca Tribe of Oklahoma, Sac and Fox Nation and Tonkawa Tribe. Living in Osage County, as your referrals will continue to be forwarded and managed through the Indian Health Service Pawnee Indian Clinic.***

THE FOLLOWING ITEMS ARE REQUIRED TO DETERMINE ELIGIBILTY FOR THE OSAGE NATION PURCHASE REFERRED CARE

MEDICAL CHART- Must be established and active at the Wah-zha-zhi Health Center before purchase referred care can be approved.

PROOF OF RESIDENCE- Acceptable proof must be one of the following:

- CURRENT rent receipt or lease agreement with complete physical address, business name or landlord name, and name of occupant
- CURRENT utility bill as, such as cable, gas, electric, water, or residential landline. We must receive a full copy of your bill that shows your name, physical address, name of township or business letterhead on bill/receipt.

  >>The utility bill or rent receipt must be for the CURRENT month/year. We will not accept cut-off notices<<

NOTARIZED STATEMENT- If the proof of residence in not in your name, please provide a Notarized Statement (form attached) from the name of the person appearing on the bill confirming your residence. Children under age 18 will use their parent's proof of residence accompanied with a Notarized Statement. (For use only if no other proof of residence.)

OSAGE SERVICE AREA- If your address is outside of the service area, but your residence is within the service area boundaries, you will need to provide a current County Tax Receipt verifying your county residence.

To complete the enrollment, please submit the completed bottom portion of this page along with a copy of:
1)Proof of residence document and 2)Notarized Statement (if necessary), and mail to address or fax to the number listed above, on this page.

_____

Current physical address (No P.O. Box) City State Zip Code

PRINT Name of Applicant _____ Date of Birth _____

Signature of Applicant _____ Date _____

_____

Print Name of Guardian for Minor or Court Appointed Guardian

_____ _____

Signature of Guardian for Minor or Court Appointed Guardian Date

****

_____ _____

Signature of Enrollment Employee Date

☐ APPROVED ☐ NOT APPROVED

CHART #-_____

NOTORIZED CERTIFICATION

(For use if no other proof of residence)

Fill out top portion of form. If the proof of residency is in another name, please have this statement notarized by person listed on utility bill.

Applicant Information:

Name:_____
LAST FIRST MIDDLE

Address:_____
PHYSICAL ADDRESS

_____
CITY STATE ZIP CODE

Telephone:_____

I certify that all of the answers to the questions above are true, complete and correct and are in good faith.

I also fully understand that any FALSIFICATION of this form is punishable by law.

****

(Signature of PERSON listed on utility bill, SIGNED IN FRONT OF A NOTARY)

Signature:_____ Date:_____

STATE OF OKLAHOMA)

Subscribed and sworn to before me this _____day of_____, _____.

_____

Notary Public

COMMISSION EXPIRES:_____

COMMISSION NUMBER:_____