american indian
health service of chicago

4326 W. Montrose Ave. Chicago, IL 60641
Phone: 773-883-9100 Fax: 773-883-0005

MRN# _____

AIHSC PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ Maiden Name _____

Date of Birth __/__/__ Social Security Number ___-___-___ Gender _____ Preferred Name _____

Address (Mailing Address) _____ City _____ State _____ Zip Code _____

Address (If Different From Mailing Address) _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email Address _____

Preferred Method Of Contact: ☐Phone ☐Letter ☐Do Not Notify

Marital Status: ☐Divorced ☐Married ☐Never Married ☐Separated ☐Single ☐Widow(ed) ☐Other

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Declined to Answer

Race: ☐American Indian/Alaska ☐Asian ☐Black/African ☐Native Hawaiian/Pacific ☐White

Preferred Language: _____ **Interpreter Required:** ☐ Yes ☐ No
(Including sign Language)

Tribal Affiliation: _____ Tribe Quantum: _____ Other Tribe: _____

Are you a migrant worker? ☐Yes ☐ No Are you currently homeless? ☐ Yes ☐ No

Did you serve in the military? ☐Yes ☐ No

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

MOTHER INFORMATION:

Full Legal Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number ( ) _____ Email Address _____

Employer Name _____

Employer City _____ Employer Phone ( ) _____

FATHER INFORMATION:

Full Legal Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number ( ) _____ Email Address _____

Employer Name _____

Employer City _____ Employer Phone ( ) _____

american indian
health service of chicago

4326 W. Montrose Ave Chicago, IL 60641 • www.aihschgo.org • phone: 773-883-9100 • fax: 773-883-0005

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE NUMBER	ADDRESS

ADVANCE CARE DIRECTIVE

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

If **NO** *would you like more info.* ☐ Yes ☐ No

Have you designated a Durable Power of Attorney? ☐ Yes ☐ No **If yes please enter information below**

NAME	RELATIONSHIP	PHONE NUMBER	DATE

INSURANCE INFORMATION

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

Primary Insurance: ☐ Medicare ☐ Medicaid ☐ Other

INSURANCE COMPANY NAME _____ POLICY HOLDER NAME _____ PHONE NUMBER _____

POLICY NUMBER _____ GROUP NUMBER _____ GROUP NAME _____

Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ Other

INSURANCE COMPANY NAME _____ POLICY HOLDER NAME _____ PHONE NUMBER _____

POLICY NUMBER _____ GROUP NUMBER _____ GROUP NAME _____

Other Members on Policy:

NAME	*RELATIONSHIP*	*CHART NUMBER*	*DATE OF BIRTH*

I, THE UNDERSIGNED CERTIRY THAT THE INFORMATION CONTAINED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE. FUTHERMORE, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM FOR TREATMENT, PAYMENT, OR OPERATION.

PATIENT SIGNATURE X_____ DATE_____

RESPONSIBLE PARTY'S SIGNATURE X_____ DATE_____

american indian
health service of chicago

4326 W. Montrose Ave. Chicago, IL 60641
Phone: 773-883-9100 Fax: 773-883-0005

MRN# _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please complete all sections, date and sign.

Name:_____ DOB:_____

I voluntarily authorize the disclosure of information from my health record.

Other names medical record may be located under:_____

The information/communication is to be disclosed by:

Name of Facility:_____ Phone:_____

Address of Facility:_____

To be provide to/communicated with:

Name of Facility/Person:_____ Phone:_____

Address of Facility:_____

FOR THE PURPOSE OF PROVIDING THE FOLLOWING SERVICES FOR ME:

◯ Further Medical Care ◯ Personal Use ◯ Insurance ◯ Attorney Other:_____

The information to be disclosed from my health record: Check appropriate box(es)

◯ All Medical Records ◯ All Dental Records ◯ Radiology Reports ◯ Immunizations

◯ Clinic Visit Notes last____ years ◯ Lab Reports _____ ◯ Consultation Reports

◯ Admit H&Ps, DC Summaries, ER Reports ◯ Other (specify) _____

Only information related to (specify):_____

Only the period of events from:_____ to:_____

CHECK AND INITIAL the appropriate item(s) below to authorize the following sensitive information to be disclosed.

____ ◯ Alcohol/Drug ____ ◯ Abuse Treatment/Referral ____ ◯ HIV/Tests/Treatment

____ ◯ Sexually Transmitted Infections ____ ◯ Mental Health/Behavior Health Notes

I understand that I may revoke this authorizaton 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 was obtained as condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy If this authorization has not been revoked, it will terminate one year from date of my signature unless a different expiration date or expiration event is stated. **This consent will expire:**_____.
I understand that AIHSC will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) Research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CRF Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Portability ad Accountability Act Privacy Rule (45 CRF Part 164) and the Privacy Act of 1974 (5 USC 552a)

Patient's Signature:_____ Date:_____

Authorized Representative Signature:_____ Date:_____

(state relationship to patient) or Witness (if signature is by thumb print or mark)

american indian
health service of chicago

4326 W. Montrose Ave. Chicago, IL 60641
Phone: 773-883-9100 Fax: 773-883-0005

MRN _____

PATIENT SERVICE AGREEMENT

RIGHT TO REFUSE SERVICES

American Indian Health Service of Chicago 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 American Indian Health Service of Chicago 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.

CONSENT TO TREAT

The undersigned hereby gives consent to the staff of American Indian Health Service of Chicago for medical examination, treatment, laboratory services and professional services including, but not limited to Behavioral Health Services 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, American Indian Health Service of Chicago 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. Medicaid) and providing my insurance information is my financial responsibility to American Indian Health Service of Chicago and is required in order to receive services. I hereby assign all benefits for services rendered to American Indian Health Service of Chicago 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 pain medication 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 HANDBOOK

I hereby acknowledge receipt of the AIHSC Patient handbook that outlines Patient Rights and Responsibilities and additional departmental information.

NOTICE OF PRIVACY PRACTICES

☐ **I have been offered and accept receipt of the AIHSC Notice of Privacy Practices.**

☐ **I have been offered and decline receipt of the AIHSC Notice of Privacy Practices.**

PRIVACY ACT ACKNOWLEDGEMENT

I have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical Records System at:

American Indian Health Service of Chicago, 4326 West Montrose, Chicago, Il 60641

I understand that the information given by me and/or collected and stored in my health record is necessary for AIHSC staff 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 "operations use", without my consent.

Patient Name (**Print**) _____ Signature of Patient(or Parent/ Legal Guardian for Minor) _____ Date _____

american indian
health service of chicago

4326 W. Montrose Ave. Chicago, IL 60641
Phone: 773-883-9100 Fax: 773-883-0005

Release of Information

Patient's Name: _____ MRN #: _____

In general, the HIPPA privacy rule gives individuals the right to request the restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please check all that apply

- ☐ Home Telephone: _____
  - ☐ Leave voice message with detailed information
  - ☐ Leave voice message with call back number only
- ☐ Cell/ Smartphone _____
  - ☐ Leave voice message with detailed information
  - ☐ Leave voice message with call back number only
- ☐ **Mail to home address**
- ☐ Work Telephone: _____
  - ☐ Work/Leave message with detailed information
  - ☐ Work/Leave message with call back number only

The Patient Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for the PHI to the minimum, necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures information provided below.

Please indicate to whom American Indian Health Service of Chicago may release information to other than billing persons or Healthcare professionals.

Name:	Telephone Number:	Relationship:

This agreement will remain In effect until notification, of any changes or corrections, is received by American Indian Health Service of Chicago from the patient or guardian

Patient/Parent Guardian Signature

Print Name **Date**