NEW INFANT / CHILD REGISTRATION **MRN** _____

PATIENT INFORMATION

First Name	Preferred Name	Middle Name	Last Name

Date of Birth	Primary Language	Proficiency	Interpreter Required?
	☐ English ☐ Spanish	☐ Well ☐ Very Well	☐ Yes
Social Security #	☐ Other _____	☐ Not Well ☐ Not at all	☐ No

Birth Gender	Legal Gender	Pronoun	Gender Identity	Sexual Orientation
☐ Male ☐ Female	☐ Male ☐ Female	☐ Masculine ☐ Feminine ☐ Neutral	☐ Decline to answer ☐ Identifies as male ☐ Identifies as female ☐ Transgender male ☐ Transgender female	☐ Decline to answer ☐ Gay (lesbian/homosexual) ☐ Straight (heterosexual) ☐ Bisexual

Primary & Secondary Race	**Ethnicity**	**Tribal Affiliation**	**Tribe Quantum**	**Tribal Enrollment #**
☐ American Indian/AK Native ☐ White / Caucasian ☐ Black / African American ☐ Asian ☐ Other _____	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Answer			

Mailing Address	Physical Address

City	State	Zip Code

Primary Telephone	Secondary Telephone	Other Telephone

Relations to CDIB Holder: ☐ Natural Child ☐ Foster ☐ Spouse ☐ Self ☐ Stepchild ☐ Guardianship ☐ Other

Child's Place of Birth (city and state)	**Preferred Contact**
	☐ Letter ☐ Phone ☐ Email

PARENT / GUARDIAN INFORMATION

	FULL LEGAL NAME	**Previous Name(s) Used**	**Telephone**
MOTHER		☐ Maiden name _____ ☐ Former married name _____	
FATHER	**FULL LEGAL NAME**		**Telephone**

Emergency Contact:	**Relation:**	**Telephone:**

INSURANCE INFORMATION

Private Insurance: ☐ Medical ☐ Medicare ☐ Medicaid

Insurance Company:	**Member ID / Group #**
Policy Holder Name:	**Relationship to patient**
Policy Holder SSN:	**Policy Holder Birthdate:**

HOUSEHOLD INFORMATION

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

Printed Parent / Guardian Name _____ _____ _____
First Middle Last

Signature _____ Date _____

Received by _____ **REV: 07-12-2021**

Please list each member of your household below:

FIRST NAME	LAST NAME	RELATION	DATE OF BIRTH

*****I authorize assignment of benefits for all services to be paid to IHCRC.**

Printed Parent/Guardian Name: _____ _____ _____
First Middle Last

Signature: _____ Date: _____

INDIAN HEALTH CARE
RESOURCE CENTER OF TULSA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT

Indian Health Care Resource Center and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by Indian Health Care Resource Center and are accessible to its personnel and medical staff for use in my care. Indian Health Care Resource Center personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Indian Health Care Resource Center is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Indian Health Care Resource Center's charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to Indian Health Care Resource Center, except to the extent we have already acted in reliance on it.**

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for Indian Health Care Resource Center charges payable to the insured are to be made payable to Indian Health Care Resource Center and that insurance benefits for services provided by physicians in the practice setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care.

PRECERTIFICATION POLICY

You understand that Indian Health Care Resource Center will assist with insurance precertification requirements which are the responsibility of the policyholder and/or practice, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect has an original.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Indian Health Care Resource Center is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment. The Notice is posted throughout our office and you will be given a copy to read.

_____I have read the Indian Health Care Resource Center's Notice of Privacy Practices.
Initials

Basis of refusal, if refused: _____

_____

_____
Signature of Patient or Patient's Legally Authorized Representative **(Documentation Must Be Provided)**

_____ _____
Printed name of patient or representative Date

INDIAN HEALTH CARE RESOURCE CENTER OF TULSA, INC.
AUTHORIZATION / CONSENT FORM

PATIENT'S PLEDGE

I understand that as a patient of Indian Health Care Resource Center of Tulsa, my Medical Home, I have a right to expect competent professional care and to be treated with dignity and respect. I also understand that I have the responsibility to actively participate in my treatment.

I Pledge to:

- Attend all scheduled appointments.
- Call to cancel, or reschedule, in the event of an emergency.
- I understand that if I am late for my appointment it will be given to the next patient waiting to see the doctor. If this occurs I will have the option to reschedule or wait until the next available opening.
- I Pledge to follow through with my doctor's recommendations and referrals to ensure my proper care.
- I Pledge to be considerate and respectful of IHCRC staff, other patients and IHCRC property.

I understand that IHCRC is committed to teaching and offering learning experiences to individuals during the year. From time to time IHCRC will have Graduate, Doctoral and Medical Students as well as Medical Residents performing training and education which may involve the opportunity to observe patient or health care specific procedures and/or processes. This authorization will remain in effect until revoked in writing by the patient or guardian. **Submitting a new form will revoke the existing form.**

_____By checking this box and signature below, **I consent** to the admittance of observers during my health care visit for the purpose of medical and allied health education.

_____By checking this box and signature below, **I do not consent** to the admittance of observers during my health care visit for the purpose of medical and allied health education. My medical health record will acknowledge this by flagging my electronic medical record indicating my decision.

NO-SHOW POLICY

** The IHCRC NO SHOW POLICY (IHCRC.CLN.9035) states that 3 or more no-shows in six months' time is considered excessive. Patients who have no-showed 3 appointments within the preceding six months will be put on Limited Access. **Limited Access means that you will not be allowed to schedule an appointment for 6 months. You will, however, be able to obtain care by coming into the clinic as a Limited Access Status patient and wait for an opening in your primary care provider's schedule or other services that are needed.**

The definition of a no-show:

1. If you are late for your appointment.
2. Failing to call and cancel the appointment by 4:00 pm the day before.

ACKNOWLEDGEMENT OF RECEIPT OF ADVANCE DIRECTIVE

I have received a copy of the "What You Need To Know about Advance Directives for Health Care" booklet, which includes the Oklahoma Advance Directive for Health Care form. Pt. Initials_____

_____

Print Patient Name

_____ _____

Patient/Guardian Signature Date

INDIAN HEALTH CARE RESOURCE CENTER OF TULSA, INC.
AUTHORIZATION / CONSENT FORM

Patient's Full Legal Name: _____

Date of Birth: _____ **Medical Records #** _____

PHARMACY PICKUP AUTHORIZATION

I authorize IHCRC to allow the following individuals to obtain medication information and to pick up any and all medications for me. I understand that this authorization will remain in effect until revoked in writing by the patient or guardian. Submitting a new form will revoke the existing form.

Parents/Legal Guardians:

1. _____ 3. _____
2. _____ 4. _____

Others

1. _____ 3. _____
2. _____ 4. _____

AUTHORIZATION FOR PHI VERBAL COMMUNICATION

I authorize IHCRC to disclose my Protected Health Information (PHI) to the following person(s) or organization(s). This Authorization will remain in effect until revoked in writing by the patient or guardian. Submitting a new form will revoke the existing form.

I understand that the information provided based on the Authorization may be re-disclosed to another party by the authorized recipient, and that IHCRC has no control over that additional disclosure and cannot protect the information after it is released based on this authorization.

I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions taken or disclosures made while the authorization was in effect.

I understand that IHCRC may not condition my health care treatment, payment, enrollment or eligibility for services on my executing this Authorization.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of the executed Authorization is as effective as the original.

Name: _____ **Relationship/Organization**_____

Name: _____ **Relationship/Organization**_____

Name: _____ **Relationship/Organization**_____

Information to be provided: Verbal Communication Only.

Patient/Legal Guardian Signature: _____ **Date:** _____

Witness (IHCRC staff member): _____ **Date:** _____

Notary (If signed outside of IHCRC premises) _____ **Date:** _____

*****IHCRC staff explained to patient this update will replace old versions. Patient declined to complete all sections.** _____
Initials

DOB _____

Chart _____

Contract Health Services for Emergency and Referred Care

INDIAN HEALTH CARE RESOURCE CENTER IS NOT A CONTRACT HEALTH SERVICE DELIVERY LOCATION AND **DOES NOT PAY FOR SERVICES OBTAINED OUTSIDE OF OUR FACILITY.**

IF YOU SEEK EMERGENCY CARE OUTSIDE OF OUR FACILITY OR ANY IHS OR TRIBAL FACILITY, YOU MUST NOTIFY YOUR LOCAL CONTRACT HEALTH SERVICE LOCATION WITHIN 72 HOURS TO BE CONSIDERED FOR FUNDING (SEE BELOW).

CONTRACT HEALTH IS NOT AN ENTITLEMENT PROGRAM AND FUNDING IS NOT GUARANTEED.

Important information about Contract Health:

1. You must have an active and updated chart at your Contract Health service location.
2. You must reside in your Contract Health Service Delivery Area. (Must be able to provide proof of residency)
3. You must use all other resources to pay for your referred care and will be screened for alternative resources.
4. **A physician's referral or an ER call in does not constitute a commitment for payment by Contract Health. It is your responsibility to call your Contract Health Service Center to make sure the referral was approved.**
5. IHS is the "payer of last resort" for individuals determined as eligible for Contract Health Services.

CONTRACT HEALTH SERVICE LOCATIONS SURROUNDING THE TULSA COUNTY AREA:

Claremore Indian Hospital (CIH) Contract Health, Claremore, OK (918-342-6200)
Inpatient Services- Craig County, Delaware County, Mayes County, Nowata County, Rogers County, Tulsa County (Only if patient lives NORTH of Admiral Blvd inside Tulsa) and Washington County.
Outpatient Services-Rogers County, Tulsa County, Wagoner County

Cherokee Nation Contract Health, Tahlequah, OK (1-800-256-0671 – ask for Contract Health)
Outpatient Services: Craig County, Delaware County, Mayes County, Muskogee County, Nowata County, Washington County, Adair County, Cherokee County, Sequoyah County
Inpatient Services: Adair County, Cherokee County, Sequoyah County

Creek Nation Contract Health, Okmulgee, OK (918-758-2710)
Outpatient and Inpatient Services- Creek County, McIntosh County, Okfuskee County, Okmulgee County
Inpatient Services- Muskogee County, Wagoner County, Tulsa County (Inpatient if the patient lives SOUTH of Admiral Blvd in Tulsa), Creek County, McIntosh County, Okfuskee County, Okmulgee County

Miami Contract Health, Miami, OK (1-918-675-2019)
Outpatient and Inpatient Services- Ottawa County

Pawnee Contract Health Services, Pawnee, OK (918-762-6506)
These services are only available to patients who reside in the counties that have the Pawnee Benefit Package and who are enrolled in the Pawnee Benefit Package Program (PBPP 1-800-452-3588): Grant County, Garfield County, Kay County, Noble County, Osage County, Pawnee County and Payne County

Patient/Legal Guardian Signature: _____Date: _____

INDIAN HEALTH CARE
RESOURCE CENTER OF TULSA

REV: 01-04-2021

INDIAN HEALTH CARE
RESOURCE CENTER OF TULSA

IHCRC TELEHEALTH PATIENT CONSENT / REFUSAL FORM

PATIENT NAME: _____

DATE OF BIRTH: _____ IHCRC MR #_____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with medical and/or behavioral health services.
2. **NATURE OF TELEHEALTH CONSULT**: During the telehealth consultation:
    a. Details of your medical history, examinations, x-rays and test(s) may be discussed with other health professionals through the use of interactive video, audio and telecommunication technology.
    b. A physical examination of you may take place.
    c. We will be unable to provide technical support at your location.
    d. We will adhere to the IHCRC crisis response policy and procedures.
3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to the telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without consent.
4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Oklahoma state law apply to information disclosed during this telehealth consultation.
5. **RIGHTS**: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES**: You agree that any dispute arriving from the telehealth consult will be resolved in Oklahoma and that Oklahoma law shall apply to all disputes.
7. **RISKS, CONSEQUENCES, BENEFITS**: You have been advised of all the potential risks, consequences and benefits of telehealth. An IHCRC staff member has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above. We have taken good faith precautions to ensure your privacy and security. However, it is the patient's responsibility to ensure security on his or her internet connection.
8. **APPROPRIATENESS FOR TREATMENT**: The provider may determine that telehealth is not appropriate for treating you and/or your condition.
9. **CONSENT REPLACEMENT:** Submitting a new form will revoke the existing form.

DO YOU AGREE TO PARTICIPATE IN A TELEHEALTH CONSULTATION?

☐ **AGREE**: I agree to participate in a telehealth consultation for the procedure(s) described above.
☐ **REFUSE**: I refuse to participate in a telehealth consultation for the procedure(s) described above.

Signature _____ **Date:** _____

If signed by someone other than the patient, indicate relationship: _____