CANONCITO BAND OF NAVAJOS
HEALTH CENTER INC.
129 Medicine Horse Drive – To'Hajiilee, New Mexico 87026
Phone: (505) 908-2307 / Fax: (505) 908-2310

APPLICATION FOR HEALTHCARE SERVICES

(Please complete one form for every new patient. Present this form along with required documents to establish your patient record).

Health Record Number: _____ Date: _____

_____ _____ _____
First Name: Middle: Last Name:

Other Names Used: _____ Social Security #: _____

Date of Birth: _____ Place of Birth: _____

Marital Status: _____ Sex: _____ Religious Preference: _____

Physical Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Current Community: _____ Date Moved to Community: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Internet Access? **YES** or **NO** Email Address: _____

Ethnicity: Hispanic or Latino **YES / NO** Migrant Worker: **YES / NO** Homeless: **YES / NO**

Tribal Affiliation: _____ Tribal Census: _____ Degree of Indian Blood: _____

Other Tribal Affiliation: _____ Blood Quantum: _____

Employer: _____Address: _____

City: _____ State: _____ Zip: _____ Employer Phone: ( ) _____

To provide better service for you please list information requested below:

_____ _____ _____
Father's Last Name Father's First Name City/State of Birth

_____ _____ _____
Mother's (Maiden) Last Name Mother's First Name City/State of Birth

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(*If registering a minor patient, please list parent's employer information below)*

Mother's
Employer:_____Address:_____

City: _____ State: _____ Zip: _____Employer Phone: ( ) _____

Father's
Employer:_____Address:_____

City: _____ State: _____ Zip: _____Employer Phone: ( ) _____

Emergency Contact: _____ _____ _____
First Name Last Name Relationship to Patient

Emergency Contact Address: _____ City: _____

State: _____ Zip: _____ Phone: ( ) _____

Note: A legal representative in the event that there must be authorization given for treatment, i.e., legal spouse, mother, father, son/daughter over the age of 18 or someone designated by Power of Attorney.

Next of Kin Contact: _____ _____ _____
First Name Last Name Relationship to Patient

Next of Kin Address: _____ City: _____

State: _____ Zip: _____ Phone: ( ) _____

Veteran: **YES** or **NO** Retiree (20 Years or Service?) _____

Branch: _____ Entry on Duty: _____ Date of Discharge: _____

ALTERNATE RESOURCE INFORMATION:

*This information is necessary in order for the CBN Health Center, Inc. to **bill** and **receive reimbursement** for all types of insurance plans such as the Medicare Program, the State of New Mexico Medicaid Program, Tricare, and other Commercial Insurance Plans.*

Monies reimbursed to the CBN Health Center, Inc. are used to fund, support, and increase services here at CBN Health Center. Your insurance is billed directly to the insurance carrier. YOU WILL NOT BE BILLED, OR REQUIRED TO PAY ANY KIND OUT-OF-POCKET EXPENSES. The CBN Health Center does not require you to pay for a copayment or deductible.

*Any questions, please feel free to call **Cornelia Garcia** in Billing at (505) 908-2571 x 302*
***Wendi Abeita** in PRC at (505) 908-2307 x 108*

Please Complete the Following:

Policy Holder Information:

Policy Holders Name: _____ Soc.Sec.# _____ DOB: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone#: (Home)_____ (Cell)_____

Policy Holder Employer Information:

Employer Name: _____ Address: _____

City: _____ State:_____ Zip: _____ Employer Ph#:_____

Insurance Information:

Coverage: **DENTAL**: **YES or NO** Policy# _____

Coverage: **MEDICAL**: **YES or NO** Policy# _____

Coverage: **VISION**: **YES or NO** Policy# _____

If Family or Dependent Coverage, please provide the following information:

NAME	RELATIONSHIP	DATE OF BIRTH	HEALTH RECORD#

I understand an Electronic Health Record will be created at the CBN Health Center, Inc. I certify that the information provided above is true to the best to my knowledge and no information is deliberately falsified.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
CBNHC Staff Print Name	CBNHC Staff Signature	Date

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Date: _____

Dear Patient (HRN) #: _____

In order to adhere to Public Health Service statutory requirements, Native Americans who are served in Canoncito Band of Navajos Health Center (CBHC), Inc. must present a Certificate of Indian Blood (CIB) or Tribal enrollment card from your enrollment office. This is required in order to continue to receive care. Please bring your tribal CIB or Tribal enrollment card with your enrollment number within the next thirty (30) days. This is in accordance with the Indian Health Care Improvement Act.

Your cooperation is appreciated. Thank You.

I ACKNOWLEDGE PROVIDING THIS DOCUMENTATION TO CBNHC, INC. WITHIN 30 DAYS.

_____ _____
Patient Signature Date Cindy Browning, CBNHC CEO

_____
Authorized Official Date

WHAT YOU STILL **NEED** TO PROVIDE TO COMPLETE YOUR MEDICAL RECORD.

_____ Tribal Enrollment/Certificate of Indian Blood (CIB)

_____ Social Security Card

_____ State Driver's License (DL)/State identification Card (ID)

_____ Health Insurance Card (Medicare, Medicaid, or Private Insurance)

_____ State Birth Certificate

_____ Proof of Residency

_____ Marriage Certificate

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CONSENT FOR TREATMENT

Receipt of Service is also approval of the terms of this agreement and the conditions of service. It is specifically agreed as follows:

1. **Authorization for Treatment**: The undersigned voluntarily agrees to treatment and service that his/her physician deems necessary.
2. **Release of Information for Billing Services and Review**: Canoncito Band of Navajos Health Center, Inc. (CBNHC, Inc.) may disclose all or any reasonable part of the patient's medical record to include information pertaining to the 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 health center's charges to include but not limited to any person, insurance companies, employer, preadmission review, evaluation, financial audit for any other purpose reasonable related to these activities. The undersigned understands that this authorization will remain in effect for as long as outpatient services are rendered unless revoked in writing before that date.
3. **Assignment of Insurance Benefits**: Private Health Insurance – 1 hereby authorize payment directly to the CBNHC, Inc. of the health center benefits otherwise payable to me but not to exceed the health center's regular charges for this period of services. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, liability claims and/or reimbursable insurance for any services that I receive.
4. **Medicaid**: State regulations require you to present a current identification card every time you receive services. Every patient is required to submit an application for Medicaid of referred by a Physician, Benefits Coordinator, Purchased and Referred Care, or other provider. Lack of compliance with the Medicaid application process may result in a denial for Purchased and Referred Care until an application is completed.
5. **Medicare**: This program covers hospital services if it is determined that it is medically necessary of the patient to receive health care. By signing this agreement, I have given CBNHC, Inc. a "Statement of Permit for Payment of Medicare Benefits to this Provider," it is my understanding that the Professional Review Organization and its agent may receive information needed to determine benefits payable.
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 of the health center in accordance with the regular rates and terms of the health center. Any cost denied by an insurance agent or other responsible part, including co-payments and deductibles will be the responsible for this bill. Services not paid or cover under the Medicaid program will be billed to the patient or guardian. Medicare: You are expected to pay the requirements of your insurance agency; you will be responsible for the entire bill.

Patient Rights and Responsibilities: Patient Rights and Responsibilities have been explained to me, and I understand my rights as a patient or guardian. Advance Directives have been briefly 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 and have read the Privacy Act Notice and laws which govern any rights as a patient.

Purchased and Referred Care: I have received notice of my Purchased and Referred Care (PRC) eligibility. I fully understand my responsibility under the PRC regulations. I understand that PRC is neither insurance nor entitlement program. I understand that I must comply with the regulations outlined under the alternate resource notice.

_____	_____	_____
Date:	Patient's Signature	Guardian/Guarantor Signature
_____	_____	_____
Date:	Interviewer's Signature	Patient's Name and MR#

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Acknowledgment of Receipt of the Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practice

_____	_____	_____
Print Name of Patient	Signature of Patient	Date
_____	_____	_____
Print Name of Patient Representative	Signature of Patient Representative	Date
_____	_____	_____
Print Name of Staff and Title	Staff Signature	Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of Notice of Practice because:

_____

_____

_____	_____	_____
Print Name of Staff and Title	Staff Signature	Date