OSAGE NATION HEALTH SYSTEM
A Culture of Caring

# *New Patient Application*

*Wahzhazhe Health Center*
*316 E. Main St*
*Pawhuska, OK 74056*
*918 287-9300*

Please submit the requested documents with your completed application
Fax: 539-257-0717
or
**registration@osagehealth.org**

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

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- **Tribal Membership Card (Osage Members Only) OR**
- **Certificate Degree of Indian Blood (CDIB) OR**
- **Proof of Native American Descent from a federally recognized tribe of the U.S.**
- **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, and Vote Registration Card. 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 ultrasound, and a signed Non-Beneficiary Acknowledgement form.

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

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***Wahzhazhe Health Center New Patient Application***

*(Please do not leave any blanks)*

Legal Last Name: _____First Name: _____ 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 ☐ Widowed ☐ Divorced ☐ Separated
Birthplace of Patient: _____ Religious Preference: _____

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Mailing Address: _____City: _____State: _____Zip: _____
Physical Address: _____City: _____State: _____Zip: _____
Primary Phone #: _____ Alternate Phone#: _____
Work phone #: _____Cell Phone#: _____
Patient's Father: _____
Last Name, First Name, City and State of Birth
Patient's Mother: _____
Maiden Last Name, First Name, City and State of Birth

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Employment information:

Name of Employee: _____Company Name: _____

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

Phone#: _____ Employment status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired

**** **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 □ 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 ☐ Cell ☐ Letter
Would you be interested in Communicating via text? ☐ Yes ☐ NO
Are you a Migrant Worker? ☐ Yes ☐ No Are you Homeless? ☐ Yes ☐ No

What is your primary language of communication?
☐ English ☐ Tribal Language ☐ Spanish ☐ Sign Language

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If other than English, would you need an interpreter? ☐ Yes ☐ No

**Emergency Contact:**

Name: _____ Phone: _____ Relationship: _____

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

**Next of Kin:**

Name: _____ Phone: _____ Relationship: _____

Address: _____ City_____ State: _____ Zip: _____

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MILITARY SERVICE INFORMATION

Branch of Service: _____ Vietnam Service indicated? ☐ Yes ☐ No Service

Entry Date: _____ Separation Date: _____ Connected? ☐ Yes ☐ No claim

Do you have a valid VA card? ☐ Yes ☐ NO Number: _____

Brief description of VA disability: _____

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*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.

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***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 Sooner Care: ☐ Yes ☐ No Part D (Rx Plans): ☐ Yes ☐ No

The Wahzhazhe 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 indicated below.

By signing below, ***I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO WAHZHAZHE HEALTH CENTER.***

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**Patient Signature**_____ **Date**_____

**Parent or Legal Guardian**_____ **Date**_____

# Notice of Privacy Practices for HIPAA

## (Health Insurance Portability and Accountability Act) Privacy Rule

***I hereby acknowledge receipt of the Wahzhazhe Notice of Privacy Practices at:***

**Wahzhazhe Health Center**
**316 E. Main St**
**Pawhuska, OK 74056**

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Date

_____ _____
Signature of Patient Registrar Date

## For patients unable to acknowledge receipt

***I hereby certify that the patient was unable to acknowledge receipt of the WZZHC Notice of Privacy Practices because of reason stated below:***

Signature & title of Registrar _____ Date_____

## For Office use only:

| Patient Name | Chart Number |
|---|---|
| | |

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# Assignment of Benefits
# &
# Authorization to Furnish Information
# Wahzhazhe Health Center
# 316 E. Main St
# Pawhuska, OK 74056

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

I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY
TO Wahzhazhe 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 |
|---|---|

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**316 E. Main St**
**Pawhuska, OK 74056**

**P R I V A T E  I N S U R A N C E**
**POLICY HOLDER INFORMATION**

Private Insurance: ☐ YES ☐ NO  AFFORDABLE CARE ACT INSURANCE: ☐ YES ☐ NO

Policy Holder Information:
Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ SSN #: _____ Phone #: _____
Mailing Address: _____City: _____State: _____Zip: _____

*EMPLOYER INFORMATION FOR POLICY HOLDER*

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

**Employer's Address: _____City: _____ State: _____ Zip: _____**

**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 MIN#: _____ GROUP#: _____

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# Wahzhazhe Health Center
# 316 E. Main St
# Pawhuska, OK 74056

## PRIVACY OF CONSENT AUTHORIZATION OF MINORS

I/We the undersigned, parent, or legal guardians of the following minor:
Name_____ 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 Wahzhazhe Health Center that may be rendered to said minor under the general, specific, or special consent of

Name_____Relationship: _____
Name_____Relationship: _____
Name_____Relationship: _____
Name_____Relationship: _____

The temporary custodian of the minor(s). I/We authorize the medical or nursing staff of Wahzhazhe Health Center to call if any necessary consultation is at 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 best judgment 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 Wahzhazhe Health Registration Department.

Parent/Legal Guardian_____ Date_____

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# Osage Nation Purchase Referred Care

Wahzhazhe Health Center
316 E. Main St., 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-Zhe Health Center before purchased-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 bills 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 is 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 parents' proof of residence accompanied with a Notarized Statement. (For use only if there is 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.

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**To complete the enrollment, please submit the completed bottom portion of this page along with a copy of:**

1)Proof of residence document
2)Notarized Statement (if necessary) and mail to address or fax to the number listed above, on this page.

Current Physical Address: _____

City: _____ State: _____Zip: _____

PRINT Name of Applicant: _____ Date of Birth: _____

Applicant signature: _____ Date: _____

Name of Guardian for Minor or Court Appointed Guardian: _____

Signature of Guardian: _____ Date: _____

---

Signature of Enrollment Staff: _____ Date: _____

☐ APPROVED ☐ NOT APPROVED Chart # _____

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# NOTORIZED CERTIFICATION

**(For use if there is no other proof of residence)**

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

**Applicant Information:**

Last Name: _____ First Name; _____ Middle: _____

Address (physical): _____

City: _____ State: _____ Zip; _____

Telephone number: _____

I certify that all of the answers to the question above are true, complete and correct and are in good faith.
***I also understand that any FALSIFICATION of this form is punishable by law***.

(signature of the **PERSON** listed on utility bill, ***SIGNED IN FRONT OF A NOTARY!)***

Signature; _____ Date; _____

NOTARY from STATE OF OKLHAOMA

Subscribed and sworn to before me this _____ day of, _____, _____.

Notary Public: _____

Commission expires: _____

Commission Number: _____

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# T19 Screening **INFORMATION FORM**

**Patient Name**: _____ ___**DOB**:_____**Chart#**:_____

**PRC Referral#:**_____

**Patient Information:**

1.) **What is your age?**_____**Gender:** M F

2.) **Marital Status?** S M D W **Are you Pregnant?** _____

3.) **Eligible for Breast & Cervical Program?** _____

4.) **Are you employed?** _____ **Gross Monthly income:** $_____

5.) **Do you receive Unemployment Benefits?**_____ **Weekly Amount:** $_____

6.) **Do you have minor children in your custody?**_____**+ Adults**_____**=**_____ **in Household**

7.) **Are you disabled?** _____**Elig/Receiving Social Security?** _____**Mo. Income** $_____ 8.)

**Do you have Private Insurance?**_____**Medicare?** A_____ A/B ____ A/B/D_____

Replacement Plan?_____ Supplemental Plan? _____

10.)**Do you receive Veterans Benefits?**_____ **Insurance Info:**_____

11.)**Is referral related to a Crime?**_____**MVA?**_____**Workman's Comp?** _____

12.)**Has patient applied for Affordable Care Act (ACA)?** _____

**Patient Directed To Go To: PRC Medical Assistance Screening Results:**

PRC Approved

DHS Office Denied

Other_____Pending

Results/Comments _____

_____

Patient/Guardian Signature:_____ Date: _____

PBC Staff Signature: _____Date: _____

PRC Staff Signature: _____ Date: _____