

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----

-
- **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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HEALTH SYSTEM

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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: _____

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

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 Homeless? ☐ Yes ☐ No

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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Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

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

Next of Kin:

Name: _____ Phone: _____ Relationship: _____

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

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: _____

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 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.**

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



**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. **This document shall remain in effect for one (1) year from the date of my signature and must be reviewed and renewed annually.**

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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Wahzhazhe Health Center

316 E. Main St

Pawhuska, OK 74056

**PRIVATE INSURANCE
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:

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#: _____

Wahzhazhe Health Center

Osage Nation Health Systems: Wahzhazhe Health Center

316 E. Main St., Pawhuska, OK 74056 | Office: 918.287.9300 | registration@osagehealth.org



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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 for one year from the date of my signature unless specifically revoked in writing or delivered to the Osage Nation Health System.**

Parent/Legal Guardian _____ Date _____



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PERSONAL REPRESENTATIVE FORM

Patient Information:			
Last Name	First Name	Middle Initial	Sex:
			☐ Male ☐ Female
Address		City	State / Zip
Date of Birth	Chart #	Phone Number	

I authorize Wahzhazhe Health Center to relay and/or disclose information regarding any radiological exams, physical examinations, laboratory results, medications, dental, mental health, medical, surgical, or treatment information provided by members of the WZZHC medical, nursing, dental, optometry, behavioral health, or pharmacy staff to the individuals listed below. This authorization also includes permission for the listed individuals to make appointments on my behalf.

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

This consent shall remain effective for one year from the date of my signature unless specifically revoked in writing or delivered to the Osage Nation Health System.

Print Patient or Legal Guardian _____ Date _____

Signature of Patient or Legal Guardian _____ Relationship _____



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 ELIGIBILITY 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.

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 OKLAHOMA

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

Notary Public: _____

Commission expires: _____

Commission Number: _____

T19 SCREENING INFORMATION FORM



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Patient Information:

Patient Name: _____ DOB: _____ Chart#: _____

What is your age? _____ Gender: M F

Marital Status? S M D W

Tax Filing:

Are you Pregnant? _____ Est. Due Date _____

Eligible for Breast & Cervical Program? _____

Employment Status: _____ Spouse Employment Status: _____

Total Household Gross Monthly Income: _____

Are you employed? _____ Gross Monthly income: \$ _____

Do you receive Unemployment Benefits? _____ Weekly Amount: \$ _____

Do you have minor children in your custody? _____ + Adults _____ = _____ in Household

Are you disabled? _____ Elig/Receiving Social Security? _____ Mo. Income \$ _____

Do you have Private Insurance? _____

Medicare? A _____ A/B _____ A/B/D _____

Replacement Plan? _____ Supplemental Plan? _____

Do you receive Veterans Benefits? _____ Insurance Info:

Is referral related to a Crime? _____ MVA? _____ Workman's Comp? _____

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

T19 Application Status:

Ineligible _____ Denied _____

Commnet: _____

Patient/Guardian Signature: _____ Date: _____

PBC Staff Signature: _____ Date: _____

Osage Nation Health Services (ONHS)



HIPAA Electronic Communications Consent and Acknowledgement

Osage Nation Health Services (ONHS) may communicate with patients regarding Protected Health Information (PHI) through electronic means, including but not limited to:

- MyChart patient portal
- Telephone calls
- Voicemail/Text messages
- Telemedicine/video visits

ONHS will use reasonable safeguards to protect the privacy and security of your Protected Health Information when using electronic communications.

Messages containing important health information may become part of your permanent medical record. Electronic communications sent by ONHS that contain sensitive information will be encrypted whenever possible unless you specifically request otherwise.

Patient Responsibilities

By signing this form, I understand and agree that I am responsible for:

1. Not using electronic communications for medical emergencies. In an emergency, call 911 or go to the nearest emergency room.
2. Keeping ONHS informed of any changes to my electronic contact information, including email addresses and telephone numbers.
3. Notifying ONHS immediately if I receive a communication in error or believe a message was sent to the wrong recipient.
4. Understanding that this consent does not authorize the release of medical records and is not a request for copies of medical records.

Acknowledgement and Authorization

I acknowledge that I have read and understand this Electronic Communications Consent Form. I understand the potential risks associated with electronic communications and voluntarily accept those risks.

I understand that my Protected Health Information may include sensitive information, including but not limited to medical diagnoses, treatment information, laboratory results, behavioral health information, and other confidential healthcare information.

By signing below, I authorize Osage Nation Health Services (ONHS) to communicate with me regarding my healthcare and Protected Health Information through electronic means, including those described above. I understand that I may revoke this consent at any time by submitting a written request to any Osage Nation Health Services facility.

Parent/Legal Guardian _____ DATE _____