



Ninilchik Traditional Council Community Clinic

 P.O. Box 39368, Ninilchik, AK 99639
 15765 Kingsley Rd.
 (907)567-3970
 (907)567-3902
 www.ninilchiktribe-nsn.gov

Ninilchik Traditional Council Community Clinic 2020 Health Information Consent

I understand that as part of my healthcare the NTC Community Clinic originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment.

I understand that the NTC Community Clinic uses and discloses protected patient health information to provide treatment, to obtain payment, and for healthcare operations, including electronic access to medication history. This disclosure of protected patient information includes administrative purposes. I further understand that the NTC Community Clinic complies with federal and Alaska state law, regarding privacy protection and/or disclosure of the patient's protected health information. By signing below, I consent to such use and disclosure of the protected health information. I also consent to the use and disclosure of health information from which all identifying information has been removed.

Today, I have received, or declined to receive, a copy of the NTC Community Clinic's Notice of Information Practices as to how my protected health information may be used and disclosed. I understand that the NTC Community Clinic may change its information practices. I further understand that before changing information practices a notice will be posted in the waiting area and in each examination room. I may contact the NTC Community Clinic Tribal Health Director at (907)567-3370, ext. 2301, at any time, to request a copy of the notice.

I understand that I have the right to revoke this consent, in writing, except where the NTC Community Clinic has already made disclosures in reliance on my prior consent.

Print Name of Patient, Authorized Representative, or Responsible Party

Relationship to Patient

Signature of Patient, Authorized Representative, or Responsible Party

Date Signed

Ninilchik Traditional Council Community Clinic 2020 Patient Registration

Patient Demographic Information:

Last Name: _____	First Name: _____	MI: _____
Date of Birth: _____	Social Security #: _____	
Sex: _____	Race: _____	Ethnicity: _____
Mailing Address: _____		Physical Address: _____
City: _____	State: _____	Zip: _____

Contact Information:

Home Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone Ext: _____
E-Mail Address: _____	
Can we text you regarding appointment information?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Guarantor/Parent/Caretaker/Responsible Party Information:

Guarantor First & Last Name: _____	
Guarantor Home Phone: _____	Cell Phone: _____
Relationship to Patient: _____	Address: _____
City: _____	State: _____ Zip: _____

Emergency Contact Information:

Contact First & Last Name: _____	
Contact Phone: _____	Relationship to Patient: _____
Would you like us to share your medical information with someone? <input type="checkbox"/> YES <input type="checkbox"/> NO	
First & Last Name: _____	Contact Phone: _____

Insurance card & photo ID are required at the time of your visit.

By signing below, I attest that the above information provided is true and accurate.

Patient Signature

Date Signed

Ninilchik Traditional Council Community Clinic 2020 Patient Responsibility Form

1. Individual's Financial Responsibility:

- I understand that I am financially responsible for my health insurance deductible, co-insurance, and any non-covered service.
- I understand that co-payments are due at time of service.
- If my plan requires a referral, I must obtain one prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge, and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services provided to me, at the time of service.

2. Insurance Authorization for Assignment of Benefits:

I hereby authorize and direct payment of my medical benefits to the Ninilchik Traditional Council Community Clinic, on my behalf, for any services furnished to me, by the providers.

3. Authorization to Release Records:

I hereby authorize the Ninilchik Traditional Council Community Clinic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis, and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services, as well as information require for precertification, authorization, or referral to other medical providers.

4. Medicare Request for Payment:

I request payment of authorized Medicare benefits, to me or on my behalf, for any services furnished to me, by or in the Ninilchik Traditional Council Community Clinic. I authorize any holder of medical, or other, information about me, to release to Medicare, and its agents, any information required to determine these benefits, or benefits for related services.

Print Name of Patient, Authorized Representative, or Responsible Party

Relationship to Patient

Signature of Patient, Authorized Representative, or Responsible Party

Date Signed

Ninilchik Traditional Council Community Clinic 2020 Patient Billing Information

Primary Insurance:

Insurance Company: _____	Co-Pay: _____	
Insurance ID/Subscriber #: _____	Group #: _____	
Insured First Name: _____	Last Name: _____	MI: _____
Insured Date of Birth: _____	Insured Social Security #: _____	
Relationship to Patient: _____		
Mailing Address: _____	City: _____	State: ____ Zip: _____
Insured Phone: _____	Insured Employed By: _____	
Business Address: _____	City: _____	State: ____ Zip: _____

Additional Insurance, if applicable:

Insurance Company: _____	Co-Pay: _____	
Insurance ID/Subscriber #: _____	Group #: _____	
Insured First Name: _____	Last Name: _____	MI: _____
Insured Date of Birth: _____	Insured Social Security #: _____	
Relationship to Patient: _____		
Mailing Address: _____	City: _____	State: ____ Zip: _____
Insured Phone: _____	Insured Employed By: _____	
Business Address: _____	City: _____	State: ____ Zip: _____

Advance Directive: Yes No Filed at Medical Facility: _____

By signing below, I attest that the above information provided is true and accurate.

Signature of Patient, Authorized Representative, or Responsible Party

Date Signed

Ninilchik Traditional Council Community Clinic 2020 Appointment No-Show Policy

PURPOSE:

It is the policy of NTCCC to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment beforehand or arrives 15 minutes (or later) after their scheduled time is considered a “no-show”. A no-show non-beneficiary patient, after three consecutive no shows, will be considered a chronic no-show.*

1. A patient who fails to appear for their scheduled appointment three times in a row will be considered a chronic no-show. This type of patient will not be given scheduled appointment slots after they've been labeled a chronic no-show for up to a full year.

2. A patient who fails to appear for their scheduled appointment three times or more without the requested advanced notification will be informed that all future appointments for up to a full year will be on a walk-in basis and any needed clinical visit will only be on a first-come, first-served basis depending on provider availability.

By signing below, I attest that I fully understand and accept the above policy.

Patient Signature

Date Signed

**Absence of a reminder call previous to appointment time as well as patient cognitive impairments will be taken into consideration prior to any policy enforcement.*