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
2021 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
2021 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? ☐ YES ☐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? ☐ YES ☐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
2021 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
2021 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
2021 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.*