Thank you for choosing the Kickapoo Tribal Health Clinic as your facility for your Health/Dental Care. Please fill out the following forms and return them to upon your first visit. We will also need the following original documents for scanning at the time of visit.

- State Photo Id/Driver's License (current)
- Social Security Card
- U.S. Federally Recognized Tribal Membership/Citizenship card OR Certificate Degree of Indian Blood (CDIB).
- Vital Statistics or State Certified Birth Certificate (Under the age of 18)
- Insurance Cards (Private Insurance, Medicare or Medicaid)
- Proof of Residency (for patients who reside within the Kickapoo CHS boundaries, must be for the current Fiscal Year.)
- Guardianship Documentation

Please arrive 1 hour before your appointment time.

If you have any questions, please feel free to contact our clinic at 405-964-2081 ext. 221, 242 or 223.

We look forward to seeing you soon!

Kickapoo Tribal Health Center

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

HRN: _____

REGISTRATION FORM

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INT.	DATE OF BIRTH
HOME ADDRESS	PO BOX		SOCIAL SECURITY NUMBER
CITY STATE ZIP CODE		MARITAL STATUS MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW(ER) ☐	
DIRECTIONS TO HOME (NEEDED FOR CONTRACT HEALTH PURPOSES)		HOW LONG AT ADDRESS? YRS MONTHS	INTERNET ACCESS ☐YES ☐ NO
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
PATIENTS CITY OF BIRTH		STATE OF BIRTH	
TRIBE:	DEGREE (BLOOD QUANTUM)	☐ ENROLLED MEMBER ROLL #	☐DESCENDANT
OTHER TRIBES			
FATHERS NAME	FATHERS CITY & STATE OF BIRTH		
MOTHERS FIRST NAME	MAIDEN NAME	MOTHERS CITY & STATE OF BIRTH	
EMPLOYER INFORMATION			
NAME OF EMPLOYER	PHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP
NAME OF SPOUSE EMPLOYER	PHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP
COMPLETE IF PATIENT IS A MINOR			
FATHERS EMPLOYER	PHONE NUMBER		
EMPLOYER ADDRESS			
MOTHERS EMPLOYER	PHONE NUMBER		
EMPLOYER ADDRESS			
EMERGENCY CONTACT PERSON			
NAME	PHONE NUMBER	RELATIONSHIP	
STREET ADDRESS	CITY	STATE	ZIP
NEXT OF KIN- MUST BE DIFFERENT FROM EMERGENCY CONTACT PERSON			
NAME	PHONE	RELATIONSHIP	
STREET ADDRESS	CITY	STATE	ZIP

CONTINUED ON BACK PAGE

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

INSURANCE INFORMATION

DO YOU HAVE: MEDICARE YES ☐ NO ☐ MEDICAID YES ☐ NO ☐

RAILROAD INSURANCE YES ☐ NO ☐ PRIVATE INSURANCE YES ☐ NO ☐

IF YOU ANSWERED YES TO THE ABOVE INSURANCE QUESTIONS, PLEASE FILL OUT SEPARATE INSURANCE SHEET & GIVE A COPY OF YOUR INSURANCE CARD TO THE REGISTRATION TECH. THANK YOU

VETERAN INFORMATION

ARE YOU A VETERAN YES ☐ NO ☐ IF SO, WHAT BRANCH

SERVICE ENTRY DATE SERVICE EXIT DATE

OTHER PATIENT DATA

ETHNICITY: RACE : ☐ AMERICAN INDIAN/ALASKA NATIVE
☐ HISPANIC ☐ NOT HISPANIC ☐ DECLINE TO ANSWER ☐ OTHER:

PRIMARY LANGUAGE: INTERPRETER REQUIRED ☐ YES ☐ NO
OTHER LANGUAGE SPOKEN PREFERRED LANGUAGE:

MIGRANT WORKER YES ☐ NO ☐ IF YES, WHAT TYPE MIGRANT AGRICULTURAL WORKER ☐
SEASONAL AGRICULTURAL WORKER ☐

ARE YOU HOMELESS YES ☐ NO ☐ IF YES, WHAT TYPE ☐ HOMELESS SHELTER ☐ STREET
☐ TRANSITIONAL ☐ DOUBLING UP
☐ OTHER ☐ UNKNOWN

NUMBER IN HOUSEHOLD TOTAL HOUSEHOLD INCOME $ HOW OFTEN

SEXUAL ORIENTATION/GENDER IDENTITY: LEGAL SEX: PROUNOUN:

GENDER IDENTITY : SEXUAL ORIENTATION:

I UNDERSTAND THAT THE INFORMATION GIVEN ABOVE IS NECESSARY FOR THE KICKAPOO TRIBAL HEALTH CENTER TO PROVIDE SERVICES FOR MY HEALTH AND WELL BEING. I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TO THE KICKAPOO TRIBAL HEALTH CENTER IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
SIGNATURE OF PATIENT (PARENT/LEGAL GUARDIAN) DATE

_____ _____
WITNESS SIGNATURE (IF PATIENT UNABLE TO SIGN) DATE

INSURANCE INFORMATION SHEET

_____ HRN: _____

PATIENT NAME

PRIVATE INSURANCE INFORMATION (PLEASE PROVIDE COPY OF CARD)			
MEDICAL INSURANCE NAME:		PHONE NUMBER:	
MEDICAL INSURANCE ADDRESS: STREET	CITY	STATE	ZIP
POLICY HOLDER NAME:		RELATIONSHIP TO PATIENT	
POLICY HOLDER DATE OF BIRTH:	GENDER: ☐ MALE ☐ FEMALE	POLICY HOLDER SS#	
POLICY HOLDER ADDRESS: STREET	CITY	STATE	ZIP
EFFECTIVE DATE:	IS THIS INURANCE PRIMARY:	YES ☐	NO ☐
POLICY HOLDER ID#	GROUP NAME/NUMBER		
EMPLOYER ADDRESS: STREET	CITY	STATE	ZIP
ARE YOU EMPLOYED WITH THIS COMPANY	☐ FULL TIME	☐ PART TIME	
SECONDARY INSURANCE INFORMATION (PLEASE PROVIDE COPY OF CARD)			
MEDICAL INSURANCE NAME:		PHONE NUMBER:	
MEDICAL INSURANCE ADDRESS: STREET	CITY	STATE	ZIP
POLICY HOLDER NAME:		RELATIONSHIP TO PATIENT	
POLICY HOLDER DATE OF BIRTH:	GENDER: ☐ MALE ☐ FEMALE	POLICY HOLDER SS#	
POLICY HOLDER ADDRESS: STREET	CITY	STATE	ZIP
EFFECTIVE DATE:	IS THIS INURANCE PRIMARY:	YES ☐	NO ☐
POLICY HOLDER ID#	GROUP NAME/NUMBER		
EMPLOYER ADDRESS: STREET	CITY	STATE	ZIP
ARE YOU EMPLOYED WITH THIS COMPANY	☐ FULL TIME	☐ PART TIME	
DENTAL INSURANCE (PLEASE PROVIDE COPY OF CARD)			
DENTAL INSURANCE NAME:		PHONE NUMBER:	
DENTAL INSURANCE ADDRESS: STREET	CITY	STATE	ZIP
POLICY HOLDER NAME:		RELATIONSHIP TO PATIENT	
POLICY HOLDER DATE OF BIRTH:	GENDER: ☐ MALE ☐ FEMALE	POLICY HOLDER SS#	
EFFECTIVE DATE	ID/POLICY NUMBER	GROUP NUMBER	
MEDICARE/MEDICATID (PLEASE PROVIDE COPY OF CARD)			
DO YOU HAVE MEDICARE? ☐ YES ☐ NO	DO YOU HAVE MEDICAID? ☐ YES	☐ NO	
DEPENDENTS COVERED ON INSURANCE			
NAME OF DEPENDENT	BIRTHDATE	RELATIONSHIP TO POLICY HOLDER	

FORM REVISED 1/5/2018

DDC

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

HRN:_____

RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:

I hereby authorize Kickapoo Tribal Health Center to release any information necessary to insurance carriers regarding my illness and treatment; to process insurance claims generated in the course of the examination or treatment; and to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Kickapoo Tribal Health Center for any services or benefits rendered to myself and/or dependents regardless of my insurance benefits, for all services I received. I understand the information I have given to the Kickapoo Tribal Health Center is TRUE and CORRECT to the best of my knowledge.

ACKNOWLEDGEMENT OF RECEIPT OF KTHC NOTICE OF PRIVACY PRACTICES

I understand that I have been provided with the HIPPA notice of Privacy Practices policies for the Kickapoo Tribal Health Center that provides complete information of uses and disclosures. I understand that the organization reserves the right to review or change their notice and practices and prior to implementation will mail a copy of any revised notices to the address I have provided. I understand that the information given by me and/or collected is necessary for the Kickapoo Tribal Health Center to provide services for my health and well-being. Per Privacy Act of 1974, my record is maintained in the Health/Medical Records system at the Kickapoo Tribal Health Center.

REFERRAL TO ANOTHER HEALTH CARE FACILITY

One of our Doctors, Nurses, Dentist, Counselors or other providers may refer you or your children to another health facility for services that the clinic cannot provide. If you have private insurance, Medicare or Medicaid, it is your obligation to advise the facility you are referred to, of these alternate resources as they may reduce your out-of-pocket expense, unless it is approved by the CHS to assist in this referral. You may of course refuse to go to the referral facility, but please remember the purpose of the referral is to provide you with the opportunity to get the health care you need.

RIGHT TO REFUSE SERVICES

The Kickapoo Tribal Health Center reserves the right to refuse service to anyone for cause which includes but not limited to belligerent or abusive behavior or non-compliance with treatment.

STATEMENT OF UNDERSTANDING

_____ _____
SIGNATURE OF PATIENT &/OR LEGAL GUARDIAN **DATE**

_____ _____
PRINTED NAME OF PATIENT **DATE**

_____ _____
SIGNATURE OF KTHC STAFF **DATE**

CONTINUED ON BACK

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

HRN:_____

Third Party Communication and Restriction of Health Information

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

PATIENT NAME:_____ PREFERRED METHOD OF COMMUNICATION: ☐ MAIL ☐ PHONE

ADDRESS:_____ CITY_____ ST_____ ZIP_____

PH NUMBER:_____ ALTERNATE PH NUMBER_____

In addition to my Emergency Contact and my Next of Kin, information may be released to the following individual/organizations regarding appointments, insurance and billing:

☐ Communication Form intentionally left blank

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

_____ _____
SIGNATURE OF PATIENT &/OR LEGAL GUARDIAN **PRINTED NAME OF PATIENT**

_____ _____
DATE **DATE**

I request the following **restrictions** to use and/or disclosure of my health information:

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

_____ _____
PATIENT NAME (PRINT) DATE OF BIRTH

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE NOTICE EFFECTIVE

Kickapoo Tribal Health Center ☐ ACCEPTS ☐ DENIES ☐ ACCEPTS CONDITIONALLY the restrictions imposed on release of information as stated above.

_____ _____
SIGNATURE/TITLE DATE

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

HRN:_____

CONSENT OF PARENT/LEGAL GUARDIAN WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THIS CHILD

_____ _____
NAME OF MINOR DATE OF BIRTH

As Parent/Legal Guardian of the above named patient, I give my consent for the Kickapoo Tribal Health Center to arrange for, or to provide the following health services for this child.

1. Health Care including medical examinations, routing laboratory studies, x-ray procedures, and skin tests.
2. Dental Care including dental examinations, preventative use of fluorides and necessary emergency dental.
3. Mental Health services including evaluations and treatment as necessary.
4. Emergency Health care for accidents or illness.
5. Transportation of the child to and/or from another health facility for these services.

☐ I hereby give consent for all the above services.
☐ Exceptions or special instructions:

_____
_____
_____

This consent is effective until revoked in writing by parent/guardian or when the patient turns 18 years of age.

As Parent/Legal Guardian of above name patient, I hereby grant and give permission to the following person(s) to bring my child in for the above mentioned care.

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Signature of Parent/Guardian Date

_____
Print Parent/Guardian Name

FORM REVISED 10/3/2019
TMM

Kickapoo Tribal Health Center
105365 S. Hwy. 102 P.O. Box 720
McLoud, OK 74851

HRN:_____

APPOINTMENT REMINDER MESSAGES

OPT IN / OPT OUT

You may now receive your appointment reminder via text message. To receive your reminder via text message or to opt out, please complete the following:

Name:_____

Date of Birth:_____ Last 4 of Social:_____

Cell phone number (with area code): _____

Please be advised, if you opt in for a text message appointment reminder, you will not or no longer receive a phone call reminder in conjunction.

****THERE IS NO CHARGE FOR THIS SERVICE, BUT STANDARD TEXT MESSAGING RATES FROM YOUR CARRIER MAY APPLY****

☐ **(Opt In) I would like to receive my appointment reminder as a text message.**

☐ **(Opt Out) I am currently receiving text reminders and I wish to receive a phone call instead.**

This service is not available to minors for use. If you would like a text message reminder for your child's appointments please ensure your name and current cell phone number are listed in your child's patient record as well as completion of a separate Appointment Reminder Messages form with the parent's cell phone listed. These numbers will be cross checked to ensure privacy and accuracy. All HIPAA and Privacy policies apply.

_____ _____ _____

Signature of Patient or Parent/Guardian **Relationship** **Date**

NOTICE OF PRIVACY PRACTICE
KICKAPOO TRIBAL HEALTH CENTER

HIPAA

Health Insurance Portability and Accountability Act

PRIVACY RULE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Effective Date April 14, 2003

REVISED May 7, 2018

I. Understanding Your Health Record/Information

Each time you visit Kickapoo Tribal Health Center for services, a record of your visit is made. If you are referred by the Kickapoo Health Services through the Contract Health Services (CHS) program, the Kickapoo Health Services also keeps a record of your CHS visit. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment
- Communication source between health care professionals
- Tool with which we can check results and continually work to improve the care we provide
- Means by which Medicare, Medicaid or Private Insurance payers can verify the services billed
- Source of information for public health authorities charged with improving the health of the people
- Source of data for medical research, facility planning and marketing
- Legal document that describes the care you receive

Understanding what is in your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

II. Your Health Information Rights

Although your health record is the physical property of the Kickapoo Tribal Health Center, the information belongs to you.

You have the right to:

- Inspect and obtain a copy of your protected health information that is contained in a designated record set forth as long as Kickapoo Health Center maintains the protected health information. A "designated record set" contains medical and billing records and any other records that we received and utilizes in making medical decisions about you and your claims. You may request for your records to be provided to your electronically and in that event, Kickapoo Health Center will ascertain how best to accomplish your request.
- However, under federal law, you may not inspect or copy the following records: Information collected in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding and protected health information that is subject by laws that prohibit access to protected health information. Depending upon the circumstances, a decision to deny access may be reviewable. Please contact our Privacy Officer or Health Director, if you have any questions about access to your protected health information.
- You have the right: to the privacy and security of your Protected Health Information by Kickapoo Tribal Health Center, which includes genetic information as defined by the Genetic Information Nondiscrimination Act ("GINA") 105(a) and corresponding Federal Regulations. Any genetic health information will be kept secure and private and your coverage with Kickapoo Tribal Health Center will not be based, or influences by, any suck knowledge of such genetic information by Kickapoo Tribal Health Center
- Request a restriction of certain uses and disclosures of your health information. For example, you may ask that we not disclose your health information and or treatment to a family member. Kickapoo Tribal Health Center is not required to agree to your request; but if we do, we will comply with your request unless the information is needed to provide you with emergency services.
- Request a correction/amendment to your health record if you believe the health information we have about you is incorrect or incomplete, we may ament your record or include your statement of disagreement.
- Request confidential communications about your health information. You may ask that we communicate with you at a location other than your home or by a different means of communication such as a telephone or mail.
- Receive a listing of certain disclosures Kickapoo Tribal Health Center has made for your health information. You have the right and may request an accounting of information for up to a maximum of six years. You may request a shorter time frame for an accounting period. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- Revoke your written authorization to use or disclose health information. This does not apply to health information already disclosed or used or in circumstances where we have taken action on your authorization or the authorization obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.
- Receive notifications of breaches of your unsecured protected health formation that requires a breach notification in compliance with the Health Insurance Portability and Accountability Act of 1996. You will receive, from us, a notification of breach of unsecured protected health information of which the Health Insurance Portability and Accountability of 1996 requires notice.
- **Obtain a paper copy of the Kickapoo Tribal Health Center Notice of Privacy Practices upon request.**

III. Kickapoo Tribal Health Center Responsibilities

The Kickapoo Tribal Health Center is requires by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or in an electronic format or at alternative location.
- Notification of breaches of unsecured protected health information of which the Health Insurance Portability of 1996 requires notice.
- Honor the terms of this notice or any subsequent revisions of this notice.

Kickapoo Tribal Health Center reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. If Kickapoo Tribal Health Center makes any significant changes to this Notice, you will be provided a copy. Kickapoo Tribal Health Center also will post any revised Notice of Privacy Practices at public places in its healthcare facilities and you may also request a copy of the notice.

Kickapoo Tribal Health Center understands that health information about you is personal and is committed to protecting your health information. Kickapoo Tribal Health Center will not use or disclose your health information without your permission, except as described in this notice.

IV. How Kickapoo Tribal Health Center may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

For Example: Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider will document in your health record her/his instructions to members of your health care team. The actions taken and the observations made by the member of your health care team will be recorded in your health record so your health care provider will know how you are responding to treatment.

If Kickapoo Tribal Health Center refers you to another health care facility under the Contract Health Services (CHS) program, Kickapoo Tribal Health Center may disclose your health information to that health care provider for treatment decisions.

If you are transferred to another facility for further care and treatment, Kickapoo Tribal Health Center may disclose information to that facility to enable them to know the extent of treatment you have received and other information about your condition.

Your healthcare provider(s) may give copies of your health information to others to assist in your treatment.

We will use and disclose your health information for payment purposes.

For example: If you have private insurance, Medicare, or Medicaid coverage, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment. If Kickapoo Tribal Health Center refers you to another health care provider under the Contract Health Service (CHS) program, Kickapoo Tribal Health Center may disclose your health information with that provider for health care payment purposes.

We will use and disclose your health information for health care operations:

For example: We may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under Contract Health Services (CHS) program.

Business Associates: Kickapoo Tribal Health Center provides some health care services and related functions through the use of contracts with business associates. For example: Kickapoo Tribal Health Center may have contracts for medical transcription. When services are contracted, Kickapoo Tribal Health Center may disclose your health information to business associates so they can perform their obs. We require our business associates to have a written contract in place containing terms and conditions that will protect the privacy of your protected health information.

Notifications: Kickapoo Tribal Health Center may use or disclose your health information to notify or assist in the notification of a family member, personal representative or other authorized person(s) responsible for your care, if a "Consent to Discuss My Health Care with Others" form is on file.

Communication with Family: The Kickapoo Tribal Health Center providers may use or disclose your health information to others responsible for your care if a Consent to Discuss My Health Care With Others" form is on file. For example; the KTHC may provide your family members, other relatives, close personal friends, or any other person you identify with health information which is relevant to that person's involvement with our care or payment for such care.

Interpreters: In order to provide you proper care and services, the KTHC may use the services of an interpreter. This may require the use or disclosure of your personal health information to the interpreter.

Research: Kickapoo Tribal Health Center may use or disclose your health information for research purposes that has been approved by the Kickapoo Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The KTHC may also use or disclose your health information for research purposes based on your written authorization.

Uses and Disclosures about Decedents: Kickapoo Tribal Health Center may use or disclose health information about decedents to a coroner or medical examiner, and /or funeral directors for the purpose of a deceased person, determining a cause of death consistent with applicable law as necessary to carry out their duties. In addition, the KTHC may disclose protected health information about decedents where required under the Freedom of Information Act or otherwise required by law.

Organ Procurement Organizations: Kickapoo Tribal Health Center may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of facilitating organ, eye or tissue donation and transplant.

Treatment Alternatives and Other Health-Related Benefits and Services: Kickapoo Tribal Health Center may contact you to provide information about treatment alternatives or other types of health-related benefits and services that may be of interest to you. For example, we may contact you about the availability of new treatment or services for diabetes.

Food and Drug Administration: KTHC may use or disclose your health information to the Food and Drug Administration (FDA) in connection with a FDA-regulated product or activity. For example, we may disclose to the FDA information concerning adverse events involving food, dietary supplements, product defects, or problems, and information needed to tract FDA-regulated products or to conduct product recalls, repairs, replacements, or look backs (including locating people who have received products that have been recalled or withdrawn), or post marketing surveillance.

Appointment Reminders: KTHC may contact you with a reminder that you have an appointment for medical care at the Kickapoo Tribal Health Center or to advise you of a missed appointment.

Workers Compensation: KTHC may use or disclose your health information for workers compensation purposes as authorized as required by law.

Public Health: KTHC may use or disclose your health information to public health or other appropriate government authorities as follows:
(1)KTHC may use or disclose your health information to government authorities that are authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions.
(2)KTHC may disclose your health information to government authorities that are authorized by law to receive reports of child abuse or neglect, and
(3)KTHC may disclose your health information to government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic violence as required by law, or as authorized by law if the KTHC believes it is necessary to prevent serious harm. Where authorized by law, the KTHC may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. (In some situations KTHC, if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public) KTHC may disclose to your employer health information concerning a work-related illness or injury or a workplace-related medical surveillance.
Correctional Institution: If you are an inmate of a correctional institution, the KTHC may use or disclose to the institution, health information necessary for your health and the health and safety of other individuals such as officers, employees or other inmates.

Law Enforcement: Kickapoo Tribal Health Center may use or disclose your health information for law enforcement activities by law or in response to a court of competent jurisdiction.

Members of the Military: If you are a member of the military services including the United States Public Health Service Commissioned Corps, the KTHC may use or disclose your health information, if necessary, to the appropriate military command authorities as authorized by law.

Health Oversight Authorities: KTHC may use or disclose your health information to a health oversight agency for activities authorized by law, such audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and civil rights laws. KTHC is required by law to disclose protected health information to the Secretary of HHS to investigate or determine compliance.

Compelling Circumstances: KTHC may use or disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances:
a. KTHC may disclose limited protected health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
b. If you believe to be a victim of a crime, law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency circumstances we may disclose the requested information if we determine that such disclosure would be in your best interests.
c. KTHC may use or disclose protected health information, as we believe is necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person.
d. KTHC may use or disclose protected health information in the course of judiciary and administrative proceedings if required or authorized by law.
e. KTHC may use or disclose protected health information to report a crime committed on KTHC healthcare facility premises or when the KTHC is providing emergency health care: and
f. KTHC may make disclosures to you, when required by the Secretary of the Department of Health and Human Services (HHS), to investigate or determine our compliance with HIPAA.

Certain uses and disclosures may be limited or prohibited by law. In the event or use of disclosure is determined to be limited or prohibited by law, or becomes prohibited by law Kickapoo Tribal Health Center will adhere to these restrictions in accordance with that law.

Non Violation of this Notice: KTHC is not in violation of this "Notice" or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses protected health information under the following circumstances:
a. Disclosure to Whistle blowers: If a KTHC employees or contractor (business associate), in good faith, believes KTHC has engages in conduct that is unlawful or otherwise violates clinical and professional standards, or that the care or services provided by the KTHC has the potential of endangering one or more patients or members of the workplace or the public, and discloses such information to:
(i) A Public Health Authority or Health Oversight Authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions, or the suspected violation, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the KTHC: or
(ii) An attorney on behalf of the workforce member, or contractor (business associate) or hired by the workforce member or contractor (business associate) for the purpose of determining their legal options regarding the suspected violation.

b. Disclosures by Workforce Member Crime Victims: Under certain circumstances, a KTHC workforce member (either employee or contractor) who is a victim of a crime on or off the clinic premises may disclose information about the suspect to law enforcement official provided that:
(i)The information disclosed is about the suspect who committed the criminal act.
(ii)The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time. Such revocation would not apply where the health information already has been disclosed or used or in circumstances where the KTHC has taken action in reliance on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or policy itself.

To exercise your rights under this "NOTICE" to ask for more information, or to report a problem, contact the Privacy Officer or Health Director at:

Kickapoo Tribal Health Center
PO BOX 1059
McLoud, OK 74851
405-964-2081

If you believe your privacy rights have been violated, you file a complaint with the Kickapoo Tribal Health Services, or with the Secretary of the Department of Health and Human Services, HHS, and Washington, D.C., 20201. To file a complaint with the KTHC, contact the Privacy Officer or Health Director. There will be no retaliation for filing a complaint.

Kickapoo Tribal Health Center

Medicaid Screening Form

Please answer all questions. If question does not apply, please write N/A.

NAME: _____ DOB: _____

MARITAL STATUS:

❑ Single	❑ Married	❑ Divorced	❑ Widow

Are you pregnant? ***(Females ONLY)***	☐ ***YES***	☐ ***NO***
Has SSA Deemed you Aged, Blind or Disabled?	☐ ***YES***	☐ ***NO***
Are you employed?	☐ ***YES***	☐ ***NO***
• Employer Name:		
If married, is spouse employed?	☐ ***YES***	☐ ***NO***
• Employer Name:		
Do you have health insurance?	☐ ***YES***	☐ ***NO***
• Name of insurance **(example: BCBS)**		
• Policy Holder DOB		

You may qualify for additional services ***PLEASE DO NOT LEAVE BLANK***

Total Household Income (earned and unearned)

$_____

LIST HOUSEHOLD MEMBERS / DOB

If you are 19 years of age or older, living with relatives; do not include:

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____

You agree the information you provided is true and accurate to the best of your ability. This form is confidential and will be used as means of alternate resources (IHS requirements) and/or for Contract Health Services eligibility and will be retained for audit purposes. If after Medicaid screening is complete and reviewed and you may qualify for benefits, we may ask you to apply for SoonerCare with a Patient Benefit Coordinator.

In general, you may qualify for SoonerCare services if:

- ✓ Adults with children under 19
- ✓ Children under 19 and pregnant women
- ✓ Individuals 65 and older
- ✓ Individuals who are blind or who have a disability
- ✓ Sooner Plan – People 19 and older with family planning needs.

Signature: _____ Date: _____

OFFICIAL USE ONLY: SoonerCare Eligible? YES NO ----------"YES" refer to Benefit Coordinator "NO" list
Denial reason: _____

Reviewed by: _____ Date: _____