SANTA FE SERVICE UNIT

1700 CERRILLOS ROAD, SANTA FE, NM 87505

Patient Registration Form

Patient Information				**Is this a Job Related Injury? Y N**		
Last	First			MI	Date of Birth	Marital Status M D S
City/State of Birth	Sex	SSN		Current Community/How Long?		
Mailing Address		City		State		Zip
Physical Address		City		State		Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )		Have you ever been seen at any of our Other clinics: (circle all that apply) 1. Santa Clara Clinic 2. San Felipe Clinic 3. Cochiti Clinic 4. Santo Domingo Clinic		
Religious Preference	Tribe of Membership	Tribe Quantum				
Indian Blood Quantum	Other Tribes	CIB/Enrollment				
Place of Employment Name & Address		City/State		Phone # ( )		
Fathers Name, (Last, First, Middle)		Mothers Maiden Name (Last, First, Middle)				
Fathers Place of Birth (City & State)		Mothers Place of Birth (City & State)				
Father's Place of Employment (required for patients under 18 years)		Mother's Place of Employment (required for patients under 18 years)				
Emergency Contact Name		Phone # ( )		Relationship		
Emergency Contact Address		City		State		Zip
Next of Kin Name		Phone # ( )		Relationship		
Next of Kin Address		City		State		Zip

Insurance Information

Do You have any of the following? Medicare Medicaid Private Insurance Workman's Comp
(Circle all that apply)

Tricare Tricare For Life Dental Insurance

Please Provide a Copy of Insurance Card(s)

Are you active Duty or a Dependent of Active Duty? Yes No	If Yes Circle the appropriate designation	If Active Duty or have Tricare, what Tricare Region are you Enrolled in?
	Commissioned Corps USPHS Military DoD Other Active Duty	West South North

Are you a Veteran of the Armed Forces? Yes No	Do you receive or Qualify for Health Care Benefits at the VA? Yes No
If yes what Branch?	

If you have none of the Third Party resources listed above, have you ever been screened by a Benefits Coordinator to see If you qualify for any third party assistance? Yes No

TURN PAGE OVER-Continued

If you have any of the listed resources on the previous page, please provide the following Insurance Information

Medical Insurance		**Other Insurance**	
Insurance Name		Insurance Name	
Policy Holder Name		Policy Holder Name	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Group Name		Group Name	
Policy #	Group #	Policy #	Group #
Expiration Date		Expiration Date	

Dental Insurance	**Pharmacy Insurance/ Medicare Part D Coverage**
Insurance Name	Insurance Name
Policy Holder Name	Policy Holder Name
Policy ID # or SS #	Policy ID # or SS #
Group #	Group #
Expiration Date	Expiration Date

Previous Health Care		
Please list the clinic(s), Hospital or IHS Facility you receive your health care at before coming to Santa Fe Indian Hospital: (including out of state)		
Name of Facility	City/State	Phone # ( )
Name of Facility	City/State	Phone # ( )
Name of Facility	City/State	Phone # ( )

New Chart Number_____ Registration Clerk Name_____

Acknowledgement of Receipt of IHS Notice of Privacy Practices

I hereby acknowledge of receipt of the Indian Health Services (IHS) Notice of Privacy Practices at:

Santa Fe Indian Hospital
1700 Cerrillos Road
Santa Fe, NM 87505

_____	_____
Signature of Patient	Date
_____	_____
Parent Signature if under 18 years	Date
_____	_____
Patient Registration Signature	Date

For Patients Unable to Acknowledge Receipt:

I hereby certify that the patient is unable to acknowledge receipt of the IHS Notice of Practices Because:

_____

_____	_____
Patient Registration Signature	Date

SANTA FE SERVICE UNIT-PHS INDIAN HOSPITAL
1700 Cerrillos Rd, SANTA FE, NEW MEXICO 87505
(505) 988-9821

SERVICE AGREEMENT

1. **AUTHORIZATION FOR HOSPITAL CARE AND EMERGENCY ROOM TREATMENT:**
The Undersigned voluntarily agrees to treatment and services that his/her physician deems necessary.

2. **RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:**
Santa Fe I.H.S. and Tribal Sites may disclose all or any reasonable part of the patient's record excluding information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the hospital's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any other purposes reasonably related to these activities. The undersigned understands that this authorization will remain in effect for a long term period of inpatient and outpatient services, unless revoked in writing prior to that date.

3. **ASSIGNMENT OF INSURANCE BENEFITS – PRIVATE HEALTH INSURANCE:**
I hereby authorize payment directly to the Santa Fe Service Unit for hospital benefits otherwise payable to me but not to exceed the hospitals regular charges for this period of services or hospitalization. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, Liability claims and/or reimbursable insurance for my services I receive.

4. **MEDICAID:**
State regulations require you to present a current identification card every time you are admitted or receive service. Every patient is required to submit an application for Medicaid if referred by a Physician, Benefits Coordinator, Contract Health Service or other provider. Lack of compliance with the Medicaid application process may result in a denial for Contract Health Service until an application is completed.

5. **MEDICARE:**
This program covers hospitalization if it is determined that it is medically necessary for the patient to be admitted to receive health care. By signing this agreement I have given this facility a "Statement of Permit for Payment of Medicare Benefits to this Provider" it is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable.

6. **NON-BENEFICIARY FINANCIAL AGREEMENT for Emergency Services ONLY:**
The undersigned agrees individually as follows: That in consideration for the services rendered to the patient, he/she obligates himself/herself and the patient to pay the account of the hospital in accordance with the regular rates and terms of this hospital. Any cost denied by an insurance agent or other responsible party, including co-payments and deductibles will be the responsibility of the parent/patient or guardian. Medicaid: If you do not identify yourself as a Medicaid recipient, you will be responsible for this bill. You will also be responsible for the Emergency Room charges for all Non-Emergency visits. Services not paid or covered under the Medicaid program will be billed to the patient or Guardian. Medicare: You are expected to pay the Medicare deductible and co-insurance. If for some reason your hospitalization does not meet the requirement of your insurance agency you will be responsible for the entire bill. **If you Do Not have on File a Certificate of Indian Blood (CIB) nor present proof of Eligibility from a Federally Recognized Tribe (IHS Circular Part 2 Ch 1 2-1.1) within 30-days; you will be billed for all services rendered and thereafter, You will Not be allowed to receive further services until proof is Provided. _____ inital**

7. **PATIENT RIGHTS AND RESPONSIBILITIES:**
Patient Rights and Responsibilities have been explained to me and I understand my rights as a patient or guardian. Advance Directives has been briefly explained to me and if I should have any questions, I must speak with my Physician or other designated Advance Directives liaison. Privacy Act: I have been given notice and read the Privacy Act Notice and the laws, which govern my rights as a patient. Additional, I was given information of where I may obtain additional Information on Advance Directives. I acknowledge I DO [ ] DO NOT [ ] Have an advance Directive

8. **PURCHASED/REFERRED CARE (PRC)**
I fully understand my responsibility under the CHS regulations. I understand the CHS is not an insurance program or an entitlement program. I must notify CHS within 72 hours or obtain Prior Approval for CHS services. I understand that I must comply with the regulations outlined under the alternate resource notice. **____ initial**

9. **AGREEMENT:**
By signing this form I understand the contents of the service agreement and have received a copy. Interpreting of this agreement was explained to me in English and/or in my native language.

_____ _____
Patient's/Guardian/Guarantor Signature **Date** **Interviewer's Signature** **Date**

Patient Name: _____ **Chart No:** _____

01/2012