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 upon your first visit. We will also need the following original documents for scanning at time of visit for each patient.

- State Photo Id/Driver's License (current)
- Social Security Card
- Certificate Degree of Indian Blood (CDIB) must have the degree
- Vital Statistics 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 physical year.)
- Guardianship Documentation

If you have any questions or concerns, please feel free to contact our clinic. 405-964-2081

We look forward to seeing you soon.

David James
Health Director, Kickapoo Health Center

Linda M. Blunt MD
Medical Director, Kickapoo Health Center

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

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 care. (Specific procedure must be signed by parent or legal guardian.
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:
_____
_____
_____

_____ _____
Signature Date

_____
Address

_____
Relationship to minor

Valid until: _____(If you wish for this to be continuous, please enter one (1) year from today's date, this form must be filled out and updated yearly.)

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

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

INSURANCE INFORMATION SHEET

_____ _____
PATIENT NAME CHART #

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 5/2018
DC

Kickapoo Tribal Health Center
Medicaid Screening Form

Name: _____ DOB _____

Marital Status: SINGLE MARRIED DIVORCED WIDOW

Females Only: Are you pregnant? YES NO
Are you considered Aged, Blind or disabled: (Deemed by SSA) YES NO

List Household Members w DOB (as filed on income taxes)

*If you are age 19 and older and live with a relative, do not include:

_____ _____

_____ _____

_____ _____

Are you employed? YES NO Employer Name: _____

If married, is spouse employed? YES NO Employer Name: _____

TOTAL HOUSEHOLD INCOME (Employment & Unearned) _____

Do you have Health Insurance? YES NO

If yes, Name of Insurance (ex. BCBS) _____

Policy Holder/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 requirement) and /or for Contract Health Services eligibility and will be retained for audit purposes. If after Medicaid screening is complete and reviewed and it appears you may qualify for benefits, we may ask you to apply for Sooner Care with a Patient Benefit Coordinator.

In general, you may qualify for Sooner Care services if:

- Adults with children under 19
- Children under 19 and pregnant women
- Individuals 65 and older
- Individuals who are blind or who have disabilities
- SoonerPlan – Men and women 19 and older with family planning needs

Signature: _____ Date: _____

Official Use Only: Eligible for Sooner Care? YES NO If 'yes' refer to Benefit Coordinator

If 'no' list denial reason: _____

Reviewed by: _____ Date:_____

CONFIDENTIAL

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

CHART # _____

REGISTRATION FORM

PATIENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE INT.	DATE OF BIRTH	MALE ☐ FEMALE ☐
HOME ADDRESS	PO BOX		SOCIAL SECURITY NUMBER	
CITY STATE	ZIP CODE	MARITAL STATUS MARRIED ☐	SINGLE ☐	DIVORCED ☐
DIRECTIONS TO HOME (NEEDED FOR CONTRACT HEALTH PURPOSES)			INTERNET ACCESS YES ☐	NO ☐
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS	
PATIENTS CITY OF BIRTH		STATE OF BIRTH		
ENROLLED TRIBE MEMBERSHIP		DEGREE		
OTHER TRIBES				
FATHERS NAME		FATHERS CITY & STATE OF BIRTH		
MOTHERS 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	

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KICKAPOO TRIBAL HEALTH CENTER
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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			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 ☐ TRANSITIONAL ☐ OTHER ☐		STREET ☐ DOUBLING UP ☐ UNKNOWN ☐		
NUMBER IN HOUSEHOLD			TOTAL HOUSEHOLD INCOME $			HOW OFTEN		

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

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

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

I understand that any copies received during this application and eligibility process becomes the property of the KTHC and will not be duplicated for any future request, specifically SSN, Driver's License, CDIB, Birth Certificates, Marriage License and Divorce Decree. These must be requested from the issuing agency.

_____ _____
PATIENT'S NAME (PRINT) **DATE**

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

_____ _____
SIGNATURE OF KTHC STAFF **DATE**

CONSENT FOR TREATMENT

I HEREBY GIVE MY CONSENT FOR MYSELF OR MY CHILD (AGE 17 & UNDER) TO RECEIVE ANY MEDICAL, DENTAL AND LAB TESTS CONSIDERED NECESSARY.

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

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FORM REVISED 5/4/2018
DC

KICKAPOO TRIBAL HEALTH CENTER
PO BOX 1059
MCLOUD, OK 74851

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).

Information may be released to the following individual/organizations for the indicated purpose:

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

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