Dena'ina Wellness Center Patient Registration

Name: _____ **Previous Name(s) Used**: _____
First Middle Last Suffix *If Applicable**

Preferred Name: _____ **Date of Birth**: ____/_____/_____ **Social Security Number**: _____

Marital Status: _____**Sex**: _____ **Gender Identity**: _____

Mailing Address: _____
Street Address *City* *State* *ZIP*

Physical Address (*If different*):

_____

☐ **Same as Mailing Address** *Street Address* *City* *State* *ZIP*

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Preferred: Home ☐ Work ☐ Cell ☐ **OK to text appointment reminders?** Yes ☐ No ☐

E-mail: _____ **OK to communicate via email?** Yes ☐ No ☐

Ethnicity:
Non-Hispanic ☐ Hispanic ☐

Race:
____Alaska Native
____American Indian
____Asian
____White/Caucasian
____Black/African American
____Hawaiian or Pacific Islander
____Other

Primary Language: _____

Native Identity Information: *Tribe, Corporation, Descendent, Village (Yupik, Athabascan, etc.)*
_____

Veteran Status: _____

Do you need an interpreter? ☐ Yes ☐ No
Language/Accommodation Needed: _____
(Ex: American Sign Language, Spanish, Braille, Large-Print forms, etc.)

Parent/Guardian Information

Father's Name: _____Date of Birth: _____Contact Number: _____

Mother's Name: _____ Date of Birth: _____ Contact Number: _____

Guardian Name: _____ Relationship: _____

Date of Birth: _____Contact Number: _____

Emergency Contacts:

Name: _____Relationship:_____ Contact Number: _____

Name: _____Relationship:_____ Contact Number: _____

Name: _____Relationship:_____ Contact Number: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

Do you have insurance? Yes ☐ No ☐ IHS Only ☐ **Current Employer**: _____

**** PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) TO RECEPTIONIST****

☐ **Medicaid or Denali Kid Care ID Number**: _____ Effective Date _____

☐ **Medicare ID Number/Suffix**: _____ Effective Date: _____

☐ **Private Insurance Company**: _____
Member ID Number: _____ Group Number: _____
Policy Holder/Sponsor Name: _____ Sponsor Date of Birth: _____

☐ **Veteran's Administration ID Number:** _____

☐ **Workman's Comp**

☐ **Self-pay**

AM
PM

_____	_____	_____	_____
Printed Name of Patient/Guardian	**Signature of Patient/Guardian**	**Date**	**Time**

OFFICE USE ONLY

Department: _____ Staff member: _____ MRN: _____
EHR: _____ EHR: _____ Date: _____

Dena'ina Wellness Center

Authorizations, Notices & Consent for Treatment

Patient Name: _____ Patient Date of Birth:_____

I authorize the staff of the Kenaitze Indian Tribe's Dena'ina Wellness Center to render healthcare services that are deemed necessary for my care or the care of the patient listed above.

Please read and sign below:

Telehealth: I understand that a variety of alternative methods of care may be available to me, including Telehealth, and that I may choose one of these methods if it is appropriate for my situation after consultation with my healthcare provider.

Communication by Phone and Text Message: I consent to receive calls and unencrypted text messages from the Kenaitze Indian Tribe related to my healthcare, medical and behavioral health services, and any related financial obligation. I understand that there are risks with the use of unencrypted text messaging, and that I have the right to opt out of receiving calls or text messages at any time by notifying the Dena'ina Wellness Center front desk.

Medication Refills: I understand that refill requests need to be made via calling the Refill Line and may take 3-5 days for a refill authorization. For prescription pick-ups, I may send an authorized person to pick up medications so long as they are over 18, and can provide my date of birth, name, and name of the medication. Please note that there may be additional restrictions for controlled substances.

Photographs/Media: I understand that camera monitoring, videotaping, and photography of patient care may be used for clinical purposes and/or safety related purposes. I agree to allow the Kenaitze Indian Tribe to take, reproduce, and use photos, video tape, video monitoring/recording, or audio recording for the purpose of diagnosis, testing, medical evaluation, care, or treatment, patient safety, or medical education, and to preserve clinical information. I understand that this material may be treated as a part of my medical records and that privacy policies apply.

Assignment of Medical Benefit: I authorize direct payment to Kenaitze Indian Tribe of any insurance benefits received on behalf of the patient. I understand and agree that I am ultimately responsible for all charges associated with treatment. If after 45 days the insurance company has not settled billed claims, I will be responsible for the balance in full at that time.

Authorization to Release Information for Billing Purposes: I authorize Kenaitze Indian Tribe to furnish information regarding my treatment to my insurance company or, in the case of continued care, the requesting facility/physician. I understand that any insurance claim made on my behalf by Kenaitze Indian Tribe is strictly a courtesy provided by the staff.

Notice of Privacy Practices and Patient Rights: I acknowledge that I have received a copy of the Notice of Privacy Practices, which describes how my health information may be used, and the Patient's Rights and Responsibilities and was given the opportunity to read these documents.

No-Show Policy: I acknowledge that I have had the opportunity to read and receive a copy of the No-Show Procedure as provided by Kenaitze Indian Tribe. I understand that if I fail to abide by this policy, that my ability to schedule appointments may be impacted. Walk-in services at the Dena'ina Wellness Center will continue to be available to me. Walk-in appointments are provided on a first-come, first-served basis.

Office Billing: I acknowledge that any applicable co-payments and/or other associated charges are due at time of service, including fees for services not covered by the IHS (if an eligible IHS Beneficiary). I assign payment from my insurance directly to Kenaitze Indian Tribe and will update Kenaitze Indian Tribe on changes to my insurance information. I understand I am financially responsible to Kenaitze Indian Tribe for charges not paid by insurance or IHS, and the payment for those charges is due within 30 days of receiving my bill. I understand that Kenaitze Indian Tribe may use an outside collection agency for delinquent accounts.

_____ _____

Name of Person Signing **Signature of Patient/Parent/Legal Guardian**

_____ _____

Relationship to Patient **Date**

OFFICE USE ONLY

Department: _____ Staff Member:_____ Patient MRN: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

Dena'ina Wellness Center Appointment Authorization Form

I, _____, authorize the following people to make, reschedule, and cancel
Printed Name of Patient

appointments* on my behalf:

Name: _____

Relationship to Patient: _____

Contact Phone: _____

Name: _____

Relationship to Patient: _____

Contact Phone: _____

Name: _____

Relationship to Patient: _____

Contact Phone: _____

_____	_____	_____
Printed Name of Patient	**Signature**	**Date**

*Please note:

- This authorization does <u>not</u> allow individuals to receive information from your care team about the details of your health or medical condition(s). Such information requires a Release of Information form to be completed.
- This authorization does not apply to certain appointments in Behavioral Health.

Revised: 02/26/2026

Dena'ina Wellness Center
Consent for a Minor to Obtain Health Care

I am the parent or legal guardian of: _____ DOB: _____
(Name of patient) *(MM/DD/YY)*

I have the legal right to consent to healthcare treatment for this child. I authorize the following adult

_____ _____
(Name of authorized adult) *(Relationship to child)*

☐ **to make, reschedule, and cancel appointments for this child**

☐ **to accompany this child to the following types of appointments for routine and preventive care (must specify):**

- ☐ Medical
- ☐ Dental
- ☐ Vision/Optometry
- ☐ Behavioral Health (Outpatient Clinic)
- ☐ Well-child vaccines
- ☐ Only the specific treatment/visit type listed**:**

_____

*****NOTE: This consent form does not allow the authorized adult to seek major medical treatment for this child. In order to allow the authorized person to seek and consent to major medical care for this child, I understand that I must complete a notarized Limited Power of Attorney, available at https://public.courts.alaska.gov/web/forms/docs/pg-701.pdf. *****

EXAMPLES OF ROUTINE CARE
Well-child exams, sports physicals, regular counseling visits, teeth cleanings and exams, cold & flu visits, care for minor injury or accidents, speech therapy, physical therapy, eye exams, etc.

EXAMPLES OF MAJOR MEDICAL CARE
Surgery, invasive tests, dental extractions & fillings, implants, biopsies, nitrous oxide and sedation, use or prescription of medications with irreversible side effects or prescribed for mental illness or behavioral problems, etc.

This authorization shall expire one year after this authorization is signed, or sooner as indicated below:

- ☐ Specific Date: _____
- ☐ Specific Event:_____

By signing, I accept responsibility for all charges related to any medical treatment rendered by reason of this authorization.

*****This form must be signed in front of a Kenaitze Indian Tribe employee OR a notary public*****

Name of Parent/Legal Guardian: _____

Signature: _____ DATE: _____

OFFICE USE ONLY

Staff Name & ID #: _____ Staff Signature: _____
Date Witnessed: _____ Type of Identification Verified: _____

NOTARY:
(Only required if not signed in front of a Kenaitze Indian Tribe Staff member above)

Rev 2/26/2026 **** Authorization is only valid for person named in this consent and ID must be presented at each visit. ****