Klamath Tribal Health & Family Services
Patient Registration Department
PO Box 490
Chiloquin, OR 97624
(541) 882-1487 1-800-552-6290

Application for Health Care Services

Take the time to complete the attached application and forms and please remember to **sign and date them.**

This application can be returned in person to:

yawqsalks- (Medicine Place)
Wellness Center
330 Chiloquin Blvd
Chiloquin, Oregon 97624

wah? we'ah owite-(Healing Place)
6000 New Way
Klamath Falls, OR 97601

Klamath Tribal Health & Family Services
3949 S 6th Street
Klamath Falls, Oregon 97603

You may also mail the application to:
Klamath Tribal Health
Patient Registration Department
PO Box 490
Chiloquin, Oregon 97624

Email application to:
patientregistration@klamathtribalhealth.org

The following documents are required with your tribal health application:

Copies of these documents are acceptable if you are mailing the application in.

- Tribal card or certification from a **Federally Recognized Tribe**
- Birth certificate/Photo Identification (e.g. State Issued Identification or Driver's License)
- Social security card
- Insurance cards (Private, Oregon Health Plan, Medicare)
- Proof of income if you do not have insurance

In addition to the above, we need proof of residency in Klamath county:

- Current utility bill or rental receipt with rental contract showing residency

Normal processing time for applications received by the Patient Registration staff will be at least three business days. Expedited processing will be done in emergency situations only. After your application has been processed, you will receive a letter informing you if your application has been approved or denied for services.

Alternate Resources

KTHFS and the Indian Health Service policies require you to apply for and use all available alternate resources you are eligible for. Alternate Resources are other sources of health care or health care payment such as the Oregon Health Plan (Medicaid), Medicare, Private Insurance, etc. Alternate Resources pay for and can be a source of health care services that KTHFS is unable to provide. The use of Alternate Resources is to your advantage and enables KTHFS to provide more health care services to our patients. All patients eligible for the Oregon Health Plan or Medicare Savings Programs/Limited Income Subsidies (LIS) are required to apply. Assistance with these applications is available from the Patient Benefits Staff.

Oregon Health Plan (OHP)

The following documents are required when applying for the Oregon Health Plan:

- Proof of Oregon residency
- Social security cards of all household members listed on the application
- Income verification for the current month
- Insurance card if any
- Proof of pregnancy if applicable
- Student aid report if a student

Medicare Savings Program (MSP)

This is a state program that helps to pay for Medicare Part B premiums. The Patient Benefits staff can give you information on the program guidelines, but you will need to contact the local SPD office to apply.

Limited Income Subsidy (LIS)

This is a federal program that provides subsidies for Limited Income clients to help pay for Medicare D (prescription) premiums. The Patient Benefits staff can assist you with an application online for this program.

Patient Benefits Staff

Patient Benefits staff are available to help you at the Medicine Place in Chiloquin, and Healing Place in Klamath Falls.

Contact – (541) 882-1487 Option 6 for Patient Registration

Klamath Tribal Health & Family Services
Patient Registration Form

Please **PRINT** in **Legible Handwriting**

KTHFS Use Only
❑ New ❑ Update
MRN

Patient Information

1. _____ **2.** _____
Full Legal Name — Maiden Name/Other Name Used/Nickname

3. _____ **4.** _____ **5.** _____ **6.** _____
Sex — Date of Birth — Social Security Number — City & State of Birth

7. _____ _____ _____ _____
Mailing Address — City — State — Zip Code

8. _____ _____ _____ _____
Physical Address (If Different from Mailing Address) — City — State — Zip Code

9. _____ _____ _____ Ext_____
Day/Home Phone Number — Cell Phone Number — Work Number

10. The best number to contact you: ☐ Cell ☐ Day/Home ☐ Work ☐ Other _____ **11.** The best time to call _____ ☐ AM ☐ PM

12. What is your primary language? _____ **13.** Can we leave a message? ☐ Yes ☐ No

14. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced **15.** Your Religious Preference: _____

16. Are you a student? ☐ Yes ☐ No **17.** Are you a smoker? ☐ Yes ☐ No **18.** Are you currently homeless? ☐ Yes ☐ No

Tribal Affiliation

Email Address: _____

19. _____ _____ _____ _____
Tribe of Membership — Enrollment Number — Degree of Blood — Other Tribe

20. _____ _____
Father's Full Name — City and State of Birth

21. _____ _____
Mother's Full Maiden Name — City and State of Birth

Employment Information

22. _____ _____ _____ _____ _____ ☐ Full Time ☐ Part Time
Employer Name — Address — City — State — Zip Code

23. _____ _____ _____ _____ _____ ☐ Full Time ☐ Part Time
Spouse's Employer Name — Address — City — State — Zip Code

24. _____ **25.** _____ **26.** $_____ **27.** Are you a Migrant or Seasonal Farm Worker? ☐ Yes ☐ No
Spouse's Work Number — Total Household Members — Monthly Household (Gross) Income

Emergency Contact Information

28. _____ _____ _____
Emergency Contact Name — Relationship — Telephone Number

Please Complete Reverse Side

Insurance Information

29. Do you have Medicare or Railroad Retirement? ☐ Yes ☐ No _____
Policy Number

_____ _____ _____
Part A Date Part B Date Part D Date

30. Do you have the Oregon Health Plan or Medicaid? ☐ Yes ☐ No _____ _____
Recipient ID Number Eligibility Date

31. Do you have Insurance through your or anyone else's employer, or other source? ☐ Yes ☐ No

_____ _____ _____
Policy Number Name of Policy Holder Policy Holder's Date of Birth

_____ _____ _____ _____
Relationship to Holder Employer Group Name Policy Effective date Group Number

_____ _____ _____
Insurance Company's Name Address City

_____ _____ _____
State Zip Code Phone Number

32. List any other household members who are also covered by this insurance policy:

_____

_____

Veterans Information

33. Are you a veteran? ☐ Yes ☐ No Branch:_____ Entry Date:_____ Separation Date:_____

34. Did you serve in Vietnam? ☐ Yes ☐ No **35.** Do you have a serious disability? ☐ Yes ☐ No Claim Number:_____

36. Do you receive Veteran's health benefits? ☐ Yes ☐ No

List Other Dependant Household Members

Full Legal Name	Relationship	Sex	Date of Birth	Social Security Number

The information provided on this application is protected under the Privacy Act of 1974. I certify that this information is accurate and true to the best of my knowledge and I authorize Klamath Tribal Health & Family Services to verify its accuracy. I understand that under federal law, I have a responsibility to apply for and maintain any Alternate Resources that I qualify to receive and that failure to comply can result in the loss of access to and payment for health services.

Signature (Parent or Guardian if Minor):_____ Date:_____

Klamath Tribal Health & Wellness Center
330 Chiloquin Blvd, PO Box 490
Chiloquin, OR 97624

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Authorization to Furnish Information

I authorize the release of all protected health information necessary to process all claims for services provided by Klamath Tribal Health and Family Services that are pertinent to the patient's health care; including but not limited to medical service companies, insurance companies, workers' compensation carriers, welfare agencies and/or the patient's employer. I understand that all health information will be kept in strict confidentially in accordance with Privacy Act of 1974, 5 U.S.C., Sec. 522a and Health Insurance Portability and Accountability Act, Privacy Rules, 45 CFR, Part 164.

Assignment of Benefits

I hereby give Klamath Tribal Health & Family Services my authorization to collect payment from third party payers on my behalf. I assign all medical, dental, behavioral health, pharmacy, transportation and supply benefits to Klamath Tribal Health & Family Services.

Consent for Treatment

General Consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Klamath Tribal Health & Family Services and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries.

_____ _____

Signature of patient, legal guardian, or policy holder for private insurance **Date**

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Privacy Act of 1974 – Statement for Maintenance of Health Records

The purpose of requesting your personal medical history is to obtain information necessary for effective medical treatment. Your medical record contains what you tell the health care provider is wrong with you or how you feel. The health care provider writes (into your record) your family medical history as you answer the questions. Your answers could have an effect on the type of care you receive. Therefore, it is in your best interest to provide complete and correct information so that we will be able to carry out our responsibility of providing you proper care. The results of your physical examination, laboratory tests, medications, treatments, or surgical procedures you receive in Indian health facilities are recorded in your medical record. Certain information is stored in the Indian Health Service data system for statistical purposes.

Indian Health Service personnel may not reveal the contents of your record without your written permission, except when they are permitted to do so by law. Examples of situations where we will release information without your prior written consent are:

1. Pursuant to the order of a court of competent jurisdiction;

2. Certain medical conditions (primarily communicable diseases) that must be reported to various health departments and other health statistical gathering centers;

3. To qualified organizations which provide health services to American Indians and Alaska Natives for the purpose of planning for or providing such services, to conduct research and evaluation studies, to report to state agencies as required by state law, to prepare for litigation on behalf of the federal government;

4. To third parties (other than the Indian Health Service) responsible for the payment of medical expenses incurred by the patient while being treated by Indian Health Service medical staff or private providers under contract with the Indian Health Service.

Public laws 83-568, 85-151, and 93-222 give Indian Health Service the authority to collect and maintain health records. For a comprehensive list of situations in which Indian Health Service may release information from your records without your permission, you should see the Department of Health and Human Services annual publication of system of records which is published annually in the federal register.

I certify that I have read and understand the Privacy Act information.

Signature (Parent or Guardian if minor):_____ **Date**_____

Advance Directive Acknowledgement Form

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1. You have the right to give written directions about future treatment **before** you become seriously ill or unable to make healthcare decisions. This is called an "Advance Directive".

2. You have the right to accept or refuse medical or surgical treatment.

3. An employee of the KTHFS Patient Registration Department will provide you with information to help you develop an Advance Directive regarding your healthcare. You are not required to make any Advance Directive about your future medical treatment. **This practice is completely voluntary.** It is entirely your choice.

4. You may consult your doctor, family, lawyer, or others before making a written Advance Directive.

5. If you decide to make an Advance Directive about future medical care it will become a part of your medical record at KTHFS. Photocopies of your fully executed and witnessed directive should be made for your personal records, your family members and your proxy and alternate if you have chosen them. The original or a copy should be furnished to your hospital of choice whenever you receive inpatient care.

6. You may revoke your Advance Directive at any time, in writing or simply by telling your attending physician or other healthcare provider or a witness, regardless of your physical or mental condition.

I understand my rights as set forth above. Please check one of the following statements:

☐ I have received information regarding my right to make an Advance Directive.

☐ I do not have an Advance Directive ☐ I would like receive more information.

☐ I do not have an Advance Directive and I do not want any information at this time.

☐ Yes, I do have an Advance Directive.

☐ Please find it attached ☐ Copy requested by KTHFS

Note: ***It is the patient's responsibility to provide KTHFS with a copy of any Advance Directive document (living will, health care proxy, or medical power of attorney) or other document that could affect your care, if such document(s) exist.***

Patient Name: _____ E.H.R. No. _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Relationship to Patient: _____

Rev.: January 2025

Klamath Tribal Health & Wellness Center
330 Chiloquin Blvd, PO Box 490
Chiloquin, OR 97624
(541) 882-1487

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Klamath Tribal Health & Family Services Notice of Privacy Practices:

Patient Name: _____
(Please Print)

Signature of Patient _____ Date_____
Or Patient Representative
Or Witness (if signature is by thumb print or mark)

Print Name of Patient Representative or Witness:_____

State relationship to Patient: _____

Signature and Title of KTH&FS Employee: _____ Date_____

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the KTH&FS Notice of Practices because:

_____

_____

_____

Signature and Title of KTH&FS Employee: _____ Date_____

Rev.: January 2025

Patient Rights & Responsibilities

Klamath Tribal Health & Family Services

KTHFS Use Only

☐ New
☐ Update

_____

MRN

Klamath Tribal Health & Family Services is committed to providing high quality care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but also to address any concerns they may have regarding such services. We encourage all of our patients to be aware of their rights and responsibilities and to take an active role in maintaining and improving their health and strengthening their relationships with our health care providers.

A. Patient Rights. Every patient shall have the right to:

1. Receive high quality care based on professional standards of practice.

2. Be treated with courtesy, consideration and respect by all KTHFS staff, at all times and under all circumstances, and in a manner that respects his or her dignity and privacy.

3. Be informed of KTHFS's Privacy Policies and Procedures, as the policies relate to individually identifiable health information. Every patient will receive a copy of the KTHFS Notice of Privacy Practices.

4. Expect that KTHFS will keep all medical records confidential and will release such information only with his or her written authorization, in response to court order or subpoenas, or as otherwise permitted or required by law.

5. Access, review and/or copy his or her medical records, upon request, at a mutually designated time (or, as appropriate, have a legal custodian access, review and/or copy such records), and request amendment to such records.

6. Know the name and qualifications of all individuals responsible for his or her health care and be informed of how to contact these individuals.

7. Consent or decline the presence of all other persons allowed in patient care areas that are not authorized staff (for example, student/observers, etc.).

8. Request a different health care provider if he or she is dissatisfied with the person assigned to him or her by KTHFS. KTHFS will use best efforts, but cannot guarantee that reassignment requests will be accommodated.

9. Receive a complete, accurate, easily understood, and culturally and linguistically competent explanation of (and, as necessary, other information regarding) any diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives (including no treatment), and associated risks/benefits.

10. Receive information regarding services available, including provisions for after-hours and emergency care, support services such as but not limited to non-emergent transportation and health education services.

11. Receive sufficient information to participate fully in decisions related to his or her health care and to provide informed consent prior to any diagnostic or therapeutic procedure (except in emergencies). If a patient is unable to participate fully, he or she has the right to be represented by parents, guardians, family members or other designated surrogates.

12. Ask questions (at any time before, during or after receiving services) regarding any diagnosis, treatment, prognosis and/or planned course of treatment, alternatives and risks, and receive understandable and clear answers to such questions.

13. Refuse any treatment (except as prohibited by law), be informed of the alternatives and/or consequences of refusing treatment, which may include KTHFS having to inform the appropriate authorities of this decision, and express preferences regarding any future treatments.

14. Be informed if any treatment is for purposes of research or is experimental in nature, and be given the opportunity to provide his or her informed consent before such research or experiment will begin (unless such consent is otherwise waived).

15. Develop advance directives (or living will, medical power of attorney) and be assured that all health care providers will comply with those directives in accordance with law.

16. Designate a surrogate to make health care decision if he or she is or becomes incapacitated.

17. Ask for and receive information regarding his or her financial responsibility for any services that the patient is referred out for, (services not performed by KTHFS such as lab work).

18. Obtain services without discrimination on the basis of race, ethnicity, gender, age, religion, physical or mental disability, sexual orientation or preference, marital status, socio-economic status or diagnosis/condition.

19. Request any additional assistance necessary to understand and/or comply with KTHFS's administrative procedures and rules, access health care and related services, participate in treatments, or satisfy payment obligations by contacting the [PATIENT REGISTRATION DESK].

20. File a grievance regarding treatment or care that is (or fails to be) furnished or file a complaint about KTHFS or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. For additional information, please contact the [ADMINISTRATIVE OFFICER]. Confidential Patient Grievance or Complaint Forms (Form QMI-1000) are available the KTHFS website (www.klamathtribalhealth.org), the KTHFS Policy Library (Quality Management and Improvement Chapter), or by asking any receptionist or employee.

B. Patient Responsibilities. Every patient is responsible for:

1. Providing accurate personal, demographic (such as a current address and telephone number), health insurance information, and personal medical information (including past illnesses, current treatments and medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities) prior to receiving services from KTHFS and its health care providers.

2. Following all KTHFS administrative and operational rules and procedures posted within KTHFS facility(s).

3. Following Klamath Tribal Health & Family Services guidelines for patient conduct, to include:

    a. Behaving at all times in a polite, courteous, considerate and respectful manner to KTHFS staff, contractors, and patients, including respecting the privacy and dignity of other patients.

    b. Supervising his or her children/grandchildren while in KTHFS facility(s).

    c. Refraining from abusive, harmful, threatening, or rude conduct towards other patients and/or KTHFS staff.

    d. Not carrying any type of alcohol, illegal drugs, weapons or explosives onto any KTHFS facility(s) or leased GSA vehicle.

    e. Demonstrating respect for KTHFS property, including leased GSA vehicles, as well as the personal property of others persons.

4. Keeping all scheduled appointments and arriving on time.

5. Notifying KTHFS no later than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled.

6. Participating in and following the treatment plan recommended by his or her health care providers, to the extent he or she is able, and working with providers to achieve desired health outcomes.

7. Asking questions if he or she does not understand the explanation of (or information regarding) his or her diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives or associated risks/benefits, or any other information provided to him or her regarding services.

8. Providing an explanation to his or her health care providers if refusing to (or unable to) participate in treatment, to the extent he or she is able, and clearly communicating wants and needs.

9. Informing his or her health care providers of any changes or reactions to medication and/or treatment.

10. Familiarizing himself or herself with his or her health program eligibility benefits and any exclusions, deductibles, co-payments, and treatment costs.

11. Advising KTHFS of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.

12. Updating emergency contact information to include any children under the age of 18 who reside in the household and are eligible for services.

    a. In case of a life-threatening emergency situation, a provider or staff member will dial 911. If the patient is coherent, the patient will be responsible for requesting their provider or a KTHFS staff member to call his/her emergency contact as a courtesy. If the patient is not coherent or unconscious and has a minor(s) accompanying them or no other family member or attendee with them, their emergency contact will be notified.

13. To provide KTHFS with a copy of any advance directive documents (living will, health care proxy, medical power of attorney) or other document that could affect your care, if such documents exist.

14. Utilizing all services, including grievance and complaint procedures, in a responsible, non-abusive manner, consistent with the rules and procedures of KTHFS (including being aware of KTHFS's obligation to treat all patients in an efficient and equitable manner).

15. Provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider.

16. Acknowledging receipt, reading, understanding, and upholding the KTHFS policy on patient rights and responsibilities.

Patient Statement of Receipt and Understanding.

I have read my rights and responsibilities as a patient of Klamath Tribal Health & Family Services and I have received a copy of the document. I understand that violations of any of the responsibilities as a patient may result in warnings or sanctions as described in the Klamath Tribal Health & Family Services Quality Management & Improvement Policy & Procedures, Policy QMI-2011-1000. Copies of these are available by request.

_____

Print Patient Name

_____ _____ _____

Signature of Patient (or Parent/Guardian) Date