Seattle Indian Health Board
For the Love of Native People

PATIENT REGISTRATION INFORMATION

Social Security Number: _____ - _____ - _____ DOB: _____

First Name:_____ Last Name: _____ MI: _____

Preferred Name: _____ Other Names Used: _____

Email Address: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Race

- ☐ American Indian / Alaskan Native
- ☐ White
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than One Race
- ☐ Choose not to disclose
- ☐ Other: _____

Tribal: _____

Band: _____ **Village:** _____

Primary / Preferred Language: _____

Marital Status:

- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Ethnicity:

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Choose not to disclose

Veteran?

- ☐ Yes
- ☐ No

Disability?

- ☐ Yes
- ☐ **No**

Homeless?

- ☐ Yes
- ☐ No

Sexual Orientation:

- ☐ Lesbian / Gay
- ☐ Bisexual
- ☐ Straight
- ☐ Something Else
- ☐ Don't Know
- ☐ Choose not to Disclose

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Transgender Male to Female
- ☐ Transgender Female to Male
- ☐ Two Spirit
- ☐ Non-Binary
- ☐ Other
- ☐ Choose not to disclose

Responsible Party (if under 18):

Name: _____ DOB: _____ Phone: _____

Social Security Number: : _____ - ____ - _____ Relation to Patient: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relation: _____

Insurance Information:

Medicaid: _____ Medicare: _____ Private Insurance: _____ None: _____ Other: _____

Insurance Carrier: _____ Member ID: _____

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Notice of Privacy Practices & Financial Responsibility
Acknowledgment of Receipt

1) We keep a record of the health care services we provide to you. You may ask to see that record and/or request copies for a fee. You may also ask to correct it. We will not disclose your record to others without your consent, unless the law authorizes or requires us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. If you have any questions about our privacy practices, contact our HIPAA Privacy and Security Officer at (206) 324-9360 ext. 2586.

2) I authorize my insurance benefits to be paid directly to the Seattle Indian Health Board (SIHB). I acknowledge that I am financially responsible for any non-covered services. I authorize SIHB to release any information required. A copy of the assignment is as valid as the original.

By my signature below, I acknowledge I have read a copy of the Notice of Privacy Practices and understand that I can request a copy to take with me. I also accept the financial responsibilities stated above.

_____
Individual name (please print)

_____ _____
Signature of individual or authorized representative — Date

_____ _____
Printed name if signed on behalf of individual — Relationship (parent, legal guardian, personal representative, etc.)

_____
Individual ID

Appointment Reminders:

◯ I do not wish to receive appointment reminders. Note: we will still contact you when clinically necessary.

◯ I authorize SIHB to leave automated phone, voice mail and/or text messages with appointment reminders/health information at the below numbers. Please note, you are responsible for alerting us to any phone number changes. Text messaging rates may apply.

Number for voice messages (____) _____ (patient initials) _____

Number for text messages (____) _____ (patient initials) _____

IMPORTANT: To receive text message appointment reminders you must also opt-in by sending a text message (see any Patient Services desk for instructions). Until you do this you will only receive voice message appointment reminders. If you do not indicate a voice message number above, voice messages will be sent to your text message number instead. If you do not indicate a text message number above, text messages will be sent to your voice message number instead (when possible).

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Consent to participate in a telemedicine appointment.

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me.
2. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.
4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me telemedicine consultation.
6. In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the Doxy.me video conference connection.
7. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and befits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Individual name (please print) **Relationship (parent, legal guardian, personal representative, etc.)**

_____ _____

Signature of individual or authorized representative **Date**