Pierre Indian Learning Center
3001 E. Sully Avenue
Pierre, South Dakota 57501-4419
Phone: (605) 224-8661 Fax: (605) 224-8465

TO: Parents/Guardians

FROM: Health Services, PILC

DATE: November 25, 2019

SUBJECT: Registration and consent forms

Enclosed are registration and consent forms to be completed for your child(ren) so we can take them to the IHS clinic in Fort Thompson, SD. Before the clinic can start a chart and see your child(ren), this paperwork must be completed in its entirety.

Due to rising healthcare costs, and student's health/dental/optometry needs, we are utilizing all avenues of healthcare we possibly can, so every student's needs are met in a timely manner.

Complete all the forms.

I'm happy to help if you have any questions, please give me a call at 605-224-8661 ext. 134

Thank you!

Brittany Kenzy

Health Services, PILC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON [1] WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

(Before completing this form, please read information on reverse side.)

Name of Student _____ **Birth Date** _____

I (We), _____
have read the Consent Form for the Indian Health to arrange for or to provide the following health services for this child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and necessary emergency dental care.
3. Mental health services including evaluation 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 of the above services.**

☐ **Exceptions or Special Instructions:** PILC Staff

_____

_____

Signed _____

Address _____

Relationship _____

Date _____ **Valid Until:** _____

PLEASE RETURN THIS FORM TO THE SCHOOL

(The third page of this form is for you to keep)

[1] Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

IHS-47
(10/88)

COPY 1 (IHS RECORD)

ACKNOWLEDGEMENT OF RECEIPT OF IHS NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE RECEIPT OF THE INDIAN HEALTH SERVICE (IHS) NOTICE OF PRIVACY PRACTICES AT:

FORT THOMPSON INDIAN HEALTH SERVICES
PO BOX 200
FORT THOMPSON, South Dakota 57339

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(State Relationship to patient or witness (if signature is by thumb print or mark)

_____
Date

_____
Signature and Title of IHS Employee

_____
Date

FOR PATIENTS UNABLE TO ACKNOWLEDGE RECEIPT

I HEREBY CERTIFY THAT THE PATIENT WAS UNABLE TO ACKNOWLEDGE RECEIPT OF THE IHS NOTICE OF PRIVACY PRACTICES
BECAUSE_____

_____
Signature and Title of IHS Employee

_____
Date

NOTICE TO PATIENTS

ELIGIBILITY FOR DIRECT CARE:

You must be eligible for DIRECT CARE. This care provided at the Ft. Thompson IHS Health Center. To be eligible for DIRECT CARE you must be an Indian/Native American from a Federally Recognized Tribe of the United States. You may reside anywhere within the United States. You are allowed up to 30 days to provide proof of being Indian/Native American and allowed 1 clinic visit. Proof shall be in the form of a letter, statement or BIA Form 4432 from your tribe, which contains either enrollment number or degree of Indian blood OR if NOT enrolled, proof of descendancy/lineage. It is the responsibility of the patient to obtain this proof. If proof is not shown within the time frame specified further services WILL NOT be allowed at the Ft. Thompson IHS Health Center.

A medical doctor of the IHS may refer a person when medical care required cannot be provided by the Ft. Thompson IHS Health Center. IHS WILL NOT AUTHORIZE PAYMENT for this care until the following eligibility requirements are met.

ELIGIBILITY FOR PATIENT REFERRALS:

You must be eligible for PURCHASE REFERRED CARE. This is care provided away from the IHS Facility. You must first meet the Direct Care requirement and you must reside within delivery area called "ON or NEAR Regulation." The "ON" refers to an Indian/Native American eligible for Direct Care and lives within the boundaries of the Crow Creek Sioux Reservation. The "NEAR" refers to the members of the Crow Creek Sioux Tribe who live near the Crow Creek reservation where the Ft. Thompson IHS Health Center is located. Members of the Crow Creek Sioux Tribe who reside within our CHS delivery is (i.e., Buffalo, Brule, Hand, Hughes, Hyde, Lyman, and Stanley Counties) will meet the "NEAR" regulation. If the patient is not enrolled with the Crow Creek Sioux Tribe and "DOES NOT" live on the Crow Creek Sioux Reservation the patient "IS NOT" eligible for Purchase Referred Care services.

If the patient does not meet BOTH eligibility requirements for DIRECT CARE and Purchase Referred Care, "IHS WILL NOT PAY" for the care provided at the non-IHS health care facility.

NON-INDIAN BENEFICIARIES:

Any Non-Indian woman pregnant with an eligible Indian/Native American child will be required to show proof that she is eligible for prenatal and postnatal services either through marriage to an eligible Indian/Native American male or by statement from the eligible Indian/Native American that she is carrying his child.

I have read & received a copy of the above information.

_____ _____

Signature Date

CROW CREEK SERVICE UNIT
FT. THOMPSON IHS HEALTH CENTER
BUSINESS OFFICE
PO BOX 200
FT. THOMPSON, SD 57339
(605) 245-1540

AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Ft. Thompson IHS Health Center to release medical information about me to my insurance carrier, workmen's compensation carrier or SD Medicaid.

I hereby assign insurance benefits that I may be eligible to receive, to the Ft. Thompson IHS Health Center as payment for medical services and supplies furnished to by the IHS. I authorize direct payment of such benefits to the Indian Health Service – Ft. Thompson, SD 57339.

_____
Patient's Name

_____
Patient/Parent/Guardian Signature

_____
Date

THIS CONSENT SHALL REMAIN VALID UNTIL REVOKED IN WRITING

Ft Thompson IHS #_____

PATIENT REGISTRATION INFORMATION

In order for the Ft. Thompson Indian Health Center to continue providing efficient health services to you and your family, we must update your demographic information at every visit. This statistical information assists the Indian Health Center in providing a variety of services to you. If you have any questions please ask the Patient Registration Clerk or Patient Benefits coordinator for assistance.

Patient Information:

Last Name **First Name** **Middle Name** **Date of Birth** **Social Security Number**

Birth Place – City and State **Male or Female** **Current Community** **Date Moved There**

Marital Status **ALIAS Used (name)** **Religious Preference**

Mailing Address – City, State Zip Code **Home Phone #** **Work Phone #** **Cell or Message Phone #**

Name of Tribe **Blood Quantum** **Tribal Enrollment #**

**** If you do not have your Tribal Enrollment Card/Paper with you, you will need to sign a 30 day Notice ****

**** If you are not enrolled with any Tribe you must show proof that you are a Tribal Descendant****

Parent Information: *****Please write DEC - Behind Name if Deceased*****

Father's Name_____ **Mother's Name**_____

Father's Place of Birth _____ **Mother's Place of Birth**_____

Father's Phone #_____ **Mother's Phone #**_____

Father's Email Address _____ **Mother's Email Address**_____

Mother's Maiden Name_____

Employer Information: *****If Minor Child – Please write Parent/Guardian Employer Info*****

Employer Name_____ **Address**_____

Employer Phone #_____

Full Time/Part Time/Seasonal (circle one) _____

Spouse Employer Name_____ **Address**_____

Spouse Employer Phone #_____

Full Time/Part Time/Seasonal (Circle one) _____

Emergency Contact Information:

Name_____

Address_____

_____

Phone #_____ **2nd Phone #**_____

Relationship To You_____

Next of Kin Information: ***Must be a relative***

Name_____

Address_____

_____

Phone #_____ **2nd Phone #**_____

Relationship To You_____

Alternate Resource Information:

** This information is necessary for billing and other resources such as MEDICAID or other Health Insurance **

** Insurance is billed directly to the carrier and not to you as the patient **

Are you covered by MEDICAID? **Yes** **No** **PLEASE SUBMIT CARD FOR FILE**
If Yes, ID #_____ **(Brown Card)**

Are you covered by MEDICARE? **Yes** **No** **PLEASE SUBMIT CARD FOR FILE**
If Yes, ID #_____ **(White Card with Red & Blue Stripe)**

Are you covered by Private Health Insurance? **Yes** **No** **PLEASE SUBMIT CARD FOR FILE**
If Yes, ID #_____

Name of Insurance Company_____ **Effective Date**_____

Group #_____

Name(S) of all Insured_____

Veteran Information:

Are you a Veteran? **Yes** **No** **If Yes, what was your Serial Number**_____

Branch of Service_____ **Entry Date**_____ **Discharge Date**_____

Vietnam Connected? **Yes** **No** **Service Connected Disability?** **Yes** **No**

Other Patient Data:

What Race are you? (Circle one) **American Indian or Alaska Native/Asian/African American/White/Other**
Are you Hispanic or Latino? **Yes** **No** **Unknown**
What is your Primary Language? **Do you need an Interpreter?** **Yes** **No**
What is your Preferred Language?
Do you have access to the Internet? **Yes** **No** **If Yes, Where?**
Do you have an Email address? **Yes** **No**
If yes, what is your email address? _____
What is your Preferred Method of Contact? (Circle one) **Mail** **Email** **Phone**

** You should have received a NOTICE OF PRIVACY PRACTICES, ASSIGNMENT OF BENEFITS FORM, and DIRECT CARE/CHS INFORMATION FORM for you to sign and date. This information will be electronically filed into our database as well as a hard copy placed in your chart. Please Note that all the information you have given is CONFIDENTIAL and will be used only for your continued Health Care. Thank you for your cooperation **

Interview Information:

WAS YOUR INTERVIEW WITH PATIENT REGISTRATION IN A FRIENDLY MANNER?	YES	NO
DO YOU FEEL SECURE THAT YOUR RIGHTS AS A PATIENT ARE RESPECTED?	YES	NO
DO YOU FEEL YOUR RIGHTS TO PRIVACY, AS A PATIENT, ARE RESPECTED?	YES	NO

PATIENT or PARENT/GUARDIAN SIGNATURE_____ DATE_____

** THIS CONCLUDES THE PATIENT REGISTRATION PROCESS. PLEASE REVIEW THIS DOCUMENT TO MAKE SURE THAT YOU HAVE FILLED IT OUT COMPLETELY **

THANK YOU

This section to be completed by Patient Registration Staff:

DATE RECEIVED: _____ STAFF INITIALS: _____

DATE ENTERED: _____ STAFF INITIALS: _____