Indian Health Board ~ PATIENT REGISTRATION

Please Provide Registration Staff with Current Insurance Information

PATIENT INFORMATION

Last Name **First Name** **MI** **Birth Date** / / month day year

Address **City** **State** **Zip code**

Public Housing ☐ Yes ☐ No **Marital Status** ☐ Single ☐ Married **Social Security Number**

Primary Phone ☐ Home ☐ Cell ☐ Work **E-Mail Address**

Primary Language ☐ English ☐ Spanish ☐ Hmong ☐ Somali ☐ Other_____ **Interpreter Needed?** ☐Yes ☐ No

U.S. Citizenship ☐ Yes ☐ No **If No: U.S. Resident for over 5 years?** ☐ Yes ☐ No **Military Veteran** ☐ Yes ☐ No

Tribal Enrollment ☐ Yes ☐No **Tribal Affiliation** : **Reason for visit:**

Sex(Assigned at Birth) ☐ Male ☐ Female **Sexual Orientation** ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Other ☐ I do not wish to disclose

Current Gender Identity ☐ Male ☐ Female ☐ Genderqueer ☐ Transgender F to M ☐ Transgender M to F ☐ Other ☐ I do not wish to disclose

Race **Ethnicity** **Country of Origin**

RESPONSIBLE PARTY *(Person responsible for payment of any account balance – if different than the patient)* ☐ Same as Patient~

Guarantor: Last Name First Name Date of Birth

Emergency Contact: Last Name First Name Phone

INCOME VERIFICATION *(If Patient has insurance, Fill out the Income Verification table below)~*

1) First, check the box below next to the line that describes the total number of persons in your family.
2) Next, check the income level under that line that describes your total family income. When calculating total family income, please consider all income earned from the sources listed on the reverse side.

☐ 1 person in family	☐ 3 persons in family	☐ 5 persons in family	☐ 7 persons in family
__ Less than $11,770	__ Less than $20,090	__ Less than $28,410	__ Less than $36,730
__ $11,771 to $14,713	__ $20,091 to $25,113	__ $28,411 to $35,513	__ $36,731 to $45,913
__ $14,714 to $17,655	__ $24,114to $30,135	__ $35,514 to $42,615	__ $45,914 to $55,095
__ $17,656 to $20,598	__ $30,158 to $35,158	__ $42,616 to $49,718	__ $55,096 to $64,278
__ $20,599 to $23,540	__ $35,159 to $40,180	__ $49,719 to $56,820	__ $64,279 to $73,460
__ More than $23,541	__ More than $40,181	__ More than $56,821	__ More than $73,461
☐ 2 persons in family	**☐ 4 persons in family**	**☐ 6 persons in family**	**☐ 8 persons in family**
__ Less than $15,930	__ Less than $24,250	__ Less than $32,570	__ Less than $40,890
__ $15,931 to $19,913	__ $24,251 to $30,313	__ $32,571 to $40,713	__ $40,891 to $51,113
__ $19,914 to $23,895	__ $30,314 to $36,375	__ $40,714 to $48,855	__ $51,114 to $61,335
__ $23,896 to $27,878	__ $36,376 to $42,438	__ $48,856 to $56,998	__ $61,336 to $71,558
__ $27,879 to $31,860	__ $42,439 to $48,500	__ $56,999 to $65,140	__ $71,559 to $81,780
__ More than $31,861	__ More than $48,501	__ More than $65,141	__ More than $81,781

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby consent to treatment by the Minneapolis Indian Health Board. I hereby assign, transfer, and set over to IHB all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits for the purpose of payment, treatment, or health care operations based on the "Notice of Health Information Privacy Practices" provided to me I understand that I am financially responsible for all charges whether or not they are covered by insurance. I also understand IHB can contact me via phone call, text, secure message, or other form of communication necessary for appointment reminders, clinic updates, or information about the services provided by IHB.

Your signature below indicates you understand and agree to the above statements. Without your signature, we cannot provide health care services.

PRINTED NAME OF PATIENT -or- PATIENT'S REPRESENTATIVE DATE

SIGNATURE OF PATIENT -or- PATIENT'S REPRESENTATIVE RELATIONSHIP TO PATIENT (if applicable)