# Aleutian Pribilof Islands Association Patient Registration

APIA
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
*With Spirit and Strength*

**Anchorage** (907) 276-2700 **Anchorage Behavioral Health** (907) 222-9764
**Atka** (907) 839-2232 **Nikolski** (907) 576-2204 **St. George** (907) 859-2254
**Unalaska Primary Care** (907) 581-2742 **Unalaska Behavioral Health** (907) 581-2751

## Patient/Client Information

First Name: Middle: Last:

Date of Birth: SSN: Gender: ☐Male ☐Female

Address: City: State & Zip:

Please check preferred number for contact:
☐Home Phone:_____ ☐Mobile Phone:_____ ☐Work Phone:_____ Ok to send texts?☐
Can APIA leave a confidential voice message? ☐Yes ☐No

Email: Internet Access?☐ Yes ☐No Ok to send email?☐
(Emails are not encrypted)

## Additional Parent/Guardian Information (Responsible Party) ☐Same as Patient

First Name: Middle: Last:

Address: City: State & Zip:

Please check preferred number for contact:
☐Home Phone:_____ ☐Mobile Phone:_____ ☐Work Phone:_____

Email: Date of Birth: Employer:

## Tribal Affiliation/Ethnicity/ Language

Tribal/Native Corporation: Tribal Enrollment #

CIB: ☐Yes ☐ No
CIB Card in Medical Record? ☐Yes ☐No

Ethnicity: ☐Not Hispanic or Latino ☐ Hispanic or Latino
☐Unknown ☐Decline

Race (check all that apply): ☐Alaska Native: ☐American Indian: ☐Black/African American
☐Native Hawaiian ☐Pacific Islander ☐White ☐Asian ☐Other ☐Don't know ☐Decline

Primary Language if not English: ☐ Uuangam Tunuu ☐ Spanish ☐Russian ☐Tagalog ☐Other:_____
Translator/Interpreter Required: ☐Yes ☐No

## Employment

Employment Status: ☐Active Military Duty ☐Full Time ☐Part Time ☐Disabled ☐Retired ☐Student
☐Subsistence or Seasonal ☐Unemployed looking for work ☐Unemployed

Employer:

Address: City: State & Zip:

## Emergency Contact Information

Emergency Contact: Relationship:

Address: City: State & Zip:

Home Phone: Mobile Phone: Email :

| Next of Kin ☐Same as Emergency Contact | |
|---|---|
| Next of Kin: | Relationship: |
| Address: | State and Zip: |
| Home Phone: | Email: |

## Insurance Information (Please Provide your ID card)

Please list **ALL** members (people) in the household.
(spouse, child, foster child, grandparent, aunt, uncle, etc.)

| Full Name | Relationship | Age |
|---|---|---|
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Total Annual Household Income Estimate:

This information will help us screen if you are eligible to apply for the APIA Sliding Fee/Discount Schedule.

☐Under $15,000 ☐$15,000-$30,000 ☐$31,000 -$41,000 ☐$42,000-$52,000 ☐$53,000-$63,000

☐$64,000-$74,000 ☐$75,000-$85,000 ☐$86,000-$96,000 ☐$97,000-107,000 ☐Above $108,000

| | | | | |
|---|---|---|---|---|
| Medicare: ☐Yes ☐No | ☐Primary | ☐Secondary | Effective: | Exp Date: #: |
| Medicaid: ☐Yes ☐No | ☐Primary | ☐Secondary | Effective: | Exp Date: #: |
| Denali Kid: ☐Yes ☐No | ☐Primary | ☐Secondary | Effective: | Exp Date: #: |

| | |
|---|---|
| Private Insurance: ☐Yes☐ No (please provide your ID card) | Insurance Company: |

| | | |
|---|---|---|
| Policy Holder: | Policy #: | Group #: |
| Other Insurance: | Policy #: | Group #: |
| Veteran: ☐Yes ☐ No | VA Benefits: ☐Yes ☐No | Service Branch: |

| | | |
|---|---|---|
| Service Entry Date: | Service Exit Date: | Vietnam Service Indicated? ☐Yes ☐No |

☐I <u>DO NOT</u> have any other insurance coverage from any other source other than the above mentioned

| | | |
|---|---|---|
| Self Pay/Guarantor: | | Relationship: |
| DOB: | Phone: | Address: |
| City: | State/ Zip: | Effective Date: |

## Referral Information

☐Self-Referral ☐Family/Relative ☐Friend ☐Behavioral Health Provider ☐ Medical Provider ☐Court

☐Clergy ☐School ☐Social Services ☐SCF ☐OCS ☐Other:

## Advance Care Planning

I have an Advance Health Care Directive, also known as a living will, Durable Power of Attorney, POLST or Comfort One:
☐Yes ☐No ☐Pt Less than 18 yrs ☐Unable to Access: Reason_____

I have a Psychiatric Advance Directive: ☐Yes ☐No ☐Pt Less than 18 yrs ☐Unable to Access: Reason_____

If yes, is your Advance Health Care Directive on file? ☐Yes ☐No Last date reviewed:_____

If no, would you like information regarding Advance Health Care Directives? ☐Yes ☐No

## Consent

**Consent:** I hereby certify that all information provided is true and correct to the best of my knowledge and I give my consent for APIA to administer assessments and/or treatments to perform behavioral health or medical services. APIA operates as an integrated health system and may refer patients as necessary.

I _____(printed name) authorize APIA Behavioral Health Providers to disclose general mental health, housing, drug or alcohol use information to APIA staff for the purpose of program evaluation and grant reporting. I understand I may be contacted to complete a questionnaire over the telephone. I understand that I may revoke this authorization at any time preventing future use. Unless I revoke my consent earlier, this consent will expire automatically one year from active services at APIA.

**Assignment of Medical Insurance Benefits:** I hereby agree to full responsibility for all expenses incurred by or on account of this patient and assign to APIA, Inc. any and all insurance benefits due to me to the full extent of my financial obligation and said providers. This is certification and authorization is valid until otherwise revoking in writing.

I consent to full financial responsibility for services rendered at APIA, Inc.

Signed: _____ Date: _____

Guardian: _____ Date: _____

Release of Confidential Information (ROI) on file? ☐Yes ☐No