WHITE EAGLE HEALTH CENTER
MEDICAL CHART APPLICATION

200 WHITE EAGLE DRIVE
PONCA CITY, OK 74601
P: 580-765-2501 F: 580-765-0984

Applications missing the required documents listed below WILL NOT be processed until the documents are presented at Patient Registration.

YOU MUST PROVIDE ORIGINALS FOR THE FOLLOWING DOCUMENTS:

- ☐ **CDIB** (Certificate Degree of Indian Blood) Tribe membership, or proof of descent from a federally recognized Native American tribe of the United States
- ☐ **STATE ISSUED BIRTH CERTIFICATE** (REQUIRED for child under 18, using parent's CDIB)
- ☐ **VALID STATE ISSUED ID OR DRIVER'S LICENSE** (18 years and older)
- ☐ **HEALTH INSURANCE CARDS** (Medical, Vision, and/or Dental)
- ☐ **PROOF OF RESIDENCY** (Current utility or lease/rental agreement showing physical address)
- ☐ **SOCIAL SECURITY CARD**

To provide exceptional medical care, we will need to request 6 months - 1 year of medical records

If you are uninsured, you are required to be screened for other coverage options by a Patient Benefit Coordinator. You will need to provide ID, income, and social security numbers for all household members.

PURCHASE REFERRED CARE SERVICES (PRC)

PRC services are important benefits for your and your family. It provides emergency care in hospitals, emergency rooms, surgical centers, and specialist services for eligible patients who reside in Oklahoma in the following counties: Garfield, Grant, Kay, Noble, Pawnee, and Payne. Certain restrictions apply for Osage county residents, if eligible.

It is the Patient's responsibility to contact White Eagle Health Center PRC and the medical provider you are referred to for all referral appointments you miss, cancel, or reschedule. White Eagle Health Center and the outside medical provider contact information is available on the referral paperwork.

_____
PATIENT NAME (PRINT):

_____ _____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE: DATE:

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PATIENT INFORMATION:

LEGAL LAST NAME: FIRST NAME: MIDDLE NAME:

DATE OF BIRTH: SOCIAL SECURITY #: MALE / FEMALE:

RACE: ARE YOU HISPANIC/LATINO ☐ YES ☐ NO

TRIBE: BLOOD QUANTUM: RELIGIOUS PREFRENCE:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED

PATIENT PLACE OF BIRTH CITY: STATE:

FATHER'S LAST NAME: FIRST NAME:

FATHER'S PLACE OF BIRTH CITY: STATE:

MOTHER'S MAIDEN NAME: FIRST NAME:

MOTHER'S PLACE OF BIRTH CITY: STATE:

PATIENT CONTACT INFORMATION:

MAILING ADDRESS: CITY: STATE: ZIP:

DATE MOVED TO CURRENT ADDRESS:

PHONE NUMBER CELL: WORK: MESSAGE:

INTERNET ACCESS:

DO YOU HAVE ACCESS TO THE INTERNET: ☐ YES ☐ NO

IF YES, CIRCLE ONE OF THE FOLLOWING HOME WORK SCHOOL LIBRARY TRIBAL CENTER

EMERGENCY CONTACT:

NAME OF EMERGENCY CONTACT:

STREET ADDRESS CITY: STATE: ZIP:

RELATIONSHIP TO PATIENT:

PHONE NUMBER:

NEXT OF KIN:

NAME OF NEXT OF KIN:

STREET ADDRESS: CITY: STATE: ZIP:

RELATIONSHIP TO PATIENT:

PHONE NUMBER:

PATIENT PLACE OF EMPLOYMENT OR SCHOOL:

PATIENT PLACE OF EMPLOYMENT OR SCHOOL:

STREET ADDRESS: CITY: STATE: ZIP:

PHONE NUMBER:

IF MARRIED, SPOUSE'S EMPLOYER:

FOR CHILD UNDER 18, PARENT'S PLACE OF EMPLOYMENT

FATHER'S PLACE OF EMPLOYMENT: PHONE NUMBER:

MOTHER'S PLACE OF EMPLOYMENT: PHONE NUMBER:

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VETERAN INFORMATION:

VETERAN: YES NO BRANCH OF SERVICE:

ENTRY DATE: DISCHARGE DATE:

VIETNAM SERVICE INDICATED: YES NO SERVICE CONNECTED: YES NO

VALID VA CARD: YES NO CLAIM NUMBER:

BRIEF DESCRIPTION OF VA DISABILITY:

INSURANCE INFORMATION:

SOONERCARE OR MEDICAID: YES NO MEDICARE A AND/OR B: YES NO

MEDICARE D (RX CARD): YES NO PRIVATE INSURANCE: YES NO

PRESENT INSURANCE CARD(S) TO PATIENT REGISTRATION

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand the information given by me and/or collected is necessary for the White Eagle Health Center to provider services for my health and well-being. Furthermore, I understand that the White Eagle Health Center will seek payment from any medical program that I might be eligible in and I assign the clinic benefits for services rendered. The information given by me is true and correct to the best of my knowledge. I authorize the release of any and all medical information necessary to process my claims.

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CERTIFICATE DEGREE OF INDIAN BLOOD (CDIB)

On this date, I have been given a one time visit for direct care, excluding any Contract Health Services. Also, I have been informed this date and fully understand that I must furnish a Certificate of Degree of Indian Blood before I receive any further medical and/or dental care. I understand that I will be billed for any emergency care received until this proof is furnished. I have 30 days to comply.

***For a child with no CDIB, a copy of the parent's CDIB and the child's state birth certificate must be provided. This information is retained until the child turns 18 years of age.

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PATIENT SELF-DETERMINATION AND ADVANCE DIRECTIVE FOR HEALTH CARE (18 YEARS AND OLDER)

Every competent person has the right to make decisions about his or her Medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive (living will). This means putting into writing before you are seriously ill the kind of health care measures you do or do not, or naming someone to make those choices if you become unable to make them for yourself.

If you would like more information about Advance Directives (living will), please tell Patient Registration, Physician, or nurse and they will arrange for the Patient Benefits Coordinator to meet with you and answer your questions.

I have read this Patient Self-Determination form and Advance Directive for Health Care (living will).

☐ I WISH TO COMPLETE THE ADVANCE DIRECTIVE FORM AT THIS TIME

☐ I DO NOT WISH TO COMPLETE THE ADVANCE DIRECTIVE FORM AT THIS TIME

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES FOR HIPAA

By signing this form, you acknowledge receipt of the White Eagle Health Center Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

PATIENT NAME (PRINT): _____

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

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PATIENT SERVICE AGREEMENT:

RIGHT TO REFUSE SERVICES

The White Eagle Health Center reserves the right to refuse services to anyone for cause, which includes, but is not limited to, belligerent or abusive behavior; non-compliance with treatment; or any other violation of the patient's rights and responsibilities.

CONSENT TO TREAT

The undersigned hereby gives consent to the staff of the White Eagle Health Center for medical examination, treatment, laboratory services and professional services including but not limited to, Behavioral Health services, Dental and Optometry to the undersigned and/or minor child listed below.

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO FURNISH INFORMATION FOR BILLING

I understand that the Indian Health Amendment of 1988, Public Law 100-713, allows the White Eagle Health Center to seek and collect payment from any medical program that my minor children and I may be eligible to participate in and I assign benefits to the White Eagle Health Center for services rendered.

MAINTAING "CURRENT MEDICAL PATIENT" STATUS

A "current medical patient" is a patient who has been seen by a Medical Provider within the last year. By law, prescriptions with refills expire after one year. (Prescriptions for pain medication expire sooner.) To continue receiving medication, you must follow the provider's treatment plan and keep your appointments. If you have not been seen in over one year you will not be able to receive prescriptions.

PATIENT HANDBOOK

I hereby acknowledge the receipt of the White Eagle Health Center patient handbook that outlines Patient Rights and Responsibilities, Generic Drug Policy and additional departmental information.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the White Eagle Health Center's Notice of Privacy Practices at 200 White Eagle Drive, Ponca City, OK 74601

PRIVACY ACT ACKNOWLEDGEMENT

I have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical records system at White Eagle Health Center, 200 White Eagle Drive, Ponca City, OK 74601.

I understand that the information given by me and/or collected and stored in my health record is necessary for the White Eagle Health Center staff or contractors to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use without my consent.

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NO SHOW / LATE POLICY

This policy is designed and effective 01/01/2025 to ensure quality care is provided to our patients. A NO SHOW is when a patient does not show for their scheduled appointment or arrives later than 15 minutes past their scheduled appointment time. A patient is required to call to cancel their appointment at least 30 minutes before their scheduled appointment time.

1st NO SHOW	No show will be documents in patient account
2nd NO SHOW	Patient will be required to call back for a same day appointment only
3rd NO SHOW	(Occurring within 6 months) Patient will be suspended from pre-booked appointments for 3 months

By signing below, I acknowledge that I have read the No Show and Late policy and agree to it.

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PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE:

DATE:

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ASSIGNMENT OF BENEFITS

I hereby give authorization for payment of insurance benefits to be made directly to White Eagle Health Center and any assisting physicians, for services rendered. I understand that this assignment applies to medical services, prescriptions, and supplies furnished to me by the White Eagle Health Center. I authorize this healthcare provider to release all information necessary to secure the payment of benefits.

AUTHORIZATION TO FURNISH INFORMATION

The White Eagle Health Center may disclose all or any part of the patients record to any person or corporation which is or who may be liable under contract to the health center, the patient, a family member and/or employer of patient for all or part of the visit charges, including but not limited to: hospital or medical service companies, workman's compensation carriers, welfare funds or the patient's employer.

The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immune deficiency virus, also known as acquired immune deficiency syndrome (AIDS).

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APPOINTMENT REMINDERS BY PHONE AND TEXT

You will receive a phone call for your appointment to Confirm, Cancel, or Reschedule. You may also opt into receiving text messages instead of calls at that time.

SCAN THIS CODE TO ADD THEM TO YOUR CONTACTS

Phone calls are from: 580-576-8560
Text messages are from: 844-390-2282

PHARMACY NOTICE

New and refilled medication will be returned to stock if they are not picked up:
Refrigerated - ONE WEEK
Non-Refigerated - TWO WEEKS

ALL REFILLS MUST BE CALLED IN 48 HOURS IN ADVANCE AT 580-765-2501 , OPTION 7