STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Patient Registration

Confidential Information

Welcome to the Stockbridge-Munsee Health & Wellness Center!

Please fill out this form as completely as possible. If you have any questions or concerns, please don't hesitate to ask for assistance, we will be happy to help.

PATIENT INFORMATION:

Patient Name (Last, First, Middle): _____

Maiden/Other names used: _____ Sex: ◯Male ◯Female

Race: _____ Date of Birth: _____

Social Security Number: _____

Marital Status (circle one): ◯M ◯S ◯W ◯D Spouse Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address (if different): _____

City: _____ State: _____ Zip Code: _____

Date moved to this address: _____ Phone #: _____

Cell #: _____ Work #: _____

Employment Status (circle one): ◯Full time ◯Part time ◯Unemployed

Employer Name: _____ Employer Address:_____

Email Address: _____

Tribe of Membership (you must provide proof):_____

Enrollment #: _____ If not enrolled, then living descendent of which tribe? (you must provide written proof)_____

Do you have any children under the age of 18? ◯Yes ◯No

Are you a Veteran? ◯Yes ◯No

Who can we contact in case of an emergency?

Name: _____ Phone: _____

Relationship: _____ Address:_____

Parent/Legal Guardian (required only if patient is under 18):

Mother/Maiden Name: _____ Phone:_____

Father: _____ Phone: _____

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Primary Provider Name: _____

Do you need records transferred from another health care facility? ◯ Yes ◯ No If yes please completely fill out a Release of Information form, available at the front desk.

Insurance information: Please provide insurance cards to registration to be scanned into your record.

Primary Insurance Information:

Insurance Company: _____

Address: _____

Phone #: _____ Policy #: _____ Group #: _____

Plan coverage: ◯ Family ◯ Single Effective date: _____

What does the plan cover? ☐ Medical ☐ Dental ☐ Vision ☐ Rx ☐ Mental Health

Policy holders name: _____

Address: _____ Phone: _____

Relationship to patient: _____ Policy holder's SS#: _____

Policy holder's DOB: _____ Sex ◯ Male ◯ Female

Medicaid #: _____Effective date: _____

Medicare # _____ Effective date: _____

Medicare A effective date: _____Medicare B effective date: _____

Secondary Insurance Information:

Insurance Company Name: _____

Address: _____ Phone: _____

Phone #: _____ Policy #: _____ Group #: _____

Plan coverage: ◯ Family ◯ Single Effective date: _____

What does the plan cover? ☐ Medical ☐ Dental ☐ Vision ☐ Rx ☐ Mental Health

Policy holders name: _____

Address: _____ Phone: _____

Relationship to patient: _____ Policy holder's SS#: _____

Policy holder's DOB: _____ Sex ◯ Male ◯ Female

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

Consent to the use and disclosure of health information for treatment, payment, or health care operations

Authorization to furnish information and assignment of benefits (private insurance, Medicare and Medicaid)

The Stockbridge-Munsee Health and Wellness Center may disclose all or any part of the patient's health record to any person or corporation which is or may be liable under a contract to a hospital, medical service company, insurance company, workers compensation, public aid funds, patient's employer, Medicare, Medicaid, I.H.S., etc.

I hereby assign to the Stockbridge-Munsee Health and Wellness Center such benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me or dependents included in my insurance policy. I AUTHORIZE payment of such benefits to the Stockbridge-Munsee Health and Wellness Center. I understand this assignment will remain in effect until revoked by me in writing. A scanned copy of this assignment is to be considered as valid as the original.

_____

Patient Name Printed D.O.B.

_____

Patient Signature Date

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

Acknowledgement of Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of the Stockbridge- Munsee health and Wellness Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the SMI-IWC and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding I tic privacy of my health information.

Patient name (printed): _____Date of Birth: _____

Patient Signature: _____Date: _____

_____Date: _____

Signature of Patient Representative (State relationship to Patient)

Or Witness (If signature is by thumb print or mark

_____Title:_____Date: _____

Signature of SMHWC Staff Member

TO BE COMPLETED BY SMHWC EMPLOYEE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices? ◯Yes ◯No
2. Briefly describe efforts made to obtain the patient's acknowledgement of the Notice and explain why the patient was not able or willing to sign this form:

   _____
   _____
   _____

   _____Title:_____Date: _____

Signature of SMHWC Staff Member

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

CONTACT FORM

Patient Name: _____ DOB: _____
Phone: _____

Contact Permission – In the event that we need to need to contact you for matters including, but not limited to, test/lab results, appointment reminders, benefit determination, and coverage of services.
Stockbridge-Munsee Health and Wellness Center will attempt to reach you by the method you specify.
How may we contact you? **Phone:** ◯Yes ◯No **Patient Portal:** ◯Yes ◯No **Mail:** ◯Yes ◯No
Work #: _____ Address: _____
Home#:_____ _____
Cell#:_____ _____
May we identify ourselves as being from your doctor's office?
At home? ◯Yes ◯No
At work? ◯Yes ◯No
May we leave a voicemail or answering machine message?
At home? ◯Yes ◯No
At work? ◯Yes ◯No
May we leave a message with a family member? If yes, please identify in the next section. ◯Yes ◯No
What is your preferred method of information exchange? ◯Telephone ◯Patient Portal ◯Mail

Consent to Access of Protected Health Information – The following are representative to whom Stockbridge-Munsee Health and Wellness Center is permitted to disclose your protected health information. The disclosures may include, but are not limited to, test/lab results, appointment reminders, benefit determination, referrals, PRC billing questions, and coverage of services.

Access to your Patient Portal

Name: _____ Relationship: _____ ◯Yes ◯No
Name: _____ Relationship: _____ ◯Yes ◯No
Name: _____ Relationship: _____ ◯Yes ◯No
Name: _____ Relationship: _____ ◯Yes ◯No
Name: _____ Relationship: _____ ◯Yes ◯No

Restriction on Consent – Please indicate any restrictions you may have on the nature of the disclosures to be made to these representatives: _____
_____

I agree, that by signing this form, I am giving my consent for the Stockbridge-Munsee Health and Wellness Center to contact me in the manner described above, and to disclose my protected health information to the representatives identified above. I have the right to revoke this consent at any time by giving a written notice of revocation.

Printed Name: _____ Date: _____

Signature: _____ Witnessed by: _____

Patient Chart # _____

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

PATIENT PORTAL USER AGREEMENT

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider Greenway Health for the exclusive use of our patients. The Patient Portal is designed to enhance patient communication.
We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:
• View your medical records
• Send messages to clinical staff
• Request prescription refills
• Receive educational material
• Receive health maintenance reminders
• Fill out paperwork for a timely check-in

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations apply:

- No internet based triage and treatment requests. Diagnosis can only be made, and treatment rendered after the Provider sees the patient.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, or calling 911 should the emergency be life threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 72 hours to receive a response to a message sent through the Patient Portal. If you do not receive a response within 72 hours, please contact the office at (715)793-4144
- If you lose your password or username, you may request a new one through the Patient Portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information.

This Patient Portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. These unforeseen events may put your personal health information at risk of being accessed by others.

Patient Chart # _____

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Please read our Notice of Privacy Practices policy for information on how private health information is utilized in our office. If you do not recall having signed a Notice of Privacy Practice agreement or need to reacquaint with the HIPAA policy, you can request a copy from our registration personnel.

Once you have signed the Patient Portal User Agreement and have provided our office with an email address, an invitation to join the patient portal will be sent to the email address you provide.

The site may be accessed by:
Directly by going to this URL: https://myhealthrecord.com

Patient Acknowledgement and Agreement:

☐ **I would Like to sign up for the Patient Portal**

I acknowledge that I have read and fully understand this consent form. I have been provided with the risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between my physician and myself, and consent to the conditions outlined herein.
I acknowledge that using the Patient Portal is voluntary and will not influence the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the guidelines set forth herein, as well as any other instructions that my physician may impose for online communications. I have been offered an opportunity to ask questions related to this agreement and all my questions have been answered to my satisfaction.

☐ **I would not like to sign up for the Patient Portal**

I **do not agree** to the terms and conditions of this agreement, therefore I do not wish to participate in the Patient Portal offered by the Stockbridge Munsee Community nor want an invite sent to me to do so.

_____

Patient Name Print Date of Birth

_____

Patient/Guardian Signature Date

Private email: _____

(Please print clearly)

Patient Chart # _____