TRENTON COMMUNITY CLINIC

P.O. Box 210
Trenton, North Dakota 58853
Telephone: (701) 774-0461
Fax: (701) 774-8003

Welcome to Trenton Community Clinic

We look forward to your first visit to our clinic and the opportunity to serve you. We would like to take this time to review some important points prior to your first appointment.

Clinic Location
331 4th Ave. East
Trenton, North Dakota 58853
www.mytisa.org

Hours of Operation
Monday – Friday: 8:00 a.m. – 4:30 p.m.
Closed for Lunch 12:00pm – 12:30pm

Appointment Check In Policy
We require patients to arrive 15 minutes early for all scheduled appointments. Should any patient arrive and check in after the scheduled appointment, they will be asked to reschedule for the next available appointment.

Cancellation Policy
We ask for at least 1 hour advance notice should you need to cancel or reschedule your appointment.

Q - What should I bring to my appointment?

- Your Picture ID
- Your Insurance Card/s

Should you have any further questions please call and someone will be happy to assist you. Again, thank you and we look forward to meeting your medical and dental needs.

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The Following items are needed for this application:

______ Proof of Tribal Enrollment or Descendancy (official letter from tribe)
______ State Certified Birth Certificate
______ Social Security Card
______ POR: Current Driver's License or State ID (must have current address on card)
______ Marriage Certificate (If your last name differs from Tribal info and/or Birth Certificate)
______ Private Insurance Card (copy of both sides of the card)
______ Medicaid, Medicare, or letter of denial (copy of both sides of card)

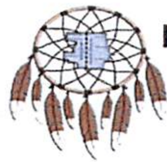
Pregnant women (non-Native) also need to submit:

______ Signed paternity paper from native father (located at clinic front reception desk)

College Students also need to submit the following:

______ Student status verification (official letter / official transcripts from the institute verifying full-time student status and duration of attendance)

If all required documents are NOT submitted with your application your eligibility status will be "Direct Care Only". An Eligibility Determination cannot be made until your application is complete. This means there will be no medical services paid by Trenton Community Clinic for medical treatment received outside of our facility.



REGISTRATION FOR SERVICE

Trenton Community Clinic
P.O. Box 210 Trenton, North Dakota 58853
Ph (701) 774-0461 Fax (701) 774-8003

RECIPIENT INFORMATION

First Name Middle Name Last Name ______ Birthdate ______ Age ______

Social Security #: _____ / ______ / ______ Veteran: Yes No Gender: Female Male Marital Status: ______________

Tribal Affiliation: __________________________ Enrollment #: ______________

Indian Blood Quantum: _________ Tribal Descendant: Yes No Verification Attached: Yes No

____

Mailing Address City State Zip

____

Physical Address City State Zip

____

Primary Phone Work Phone Message Phone

Email: ______________________________ Permission to send Health updates: Yes No

Do you have an Advanced Directive: Yes No If YES, is it a: ___ Power of Attorney -or- ___Living Will
(Please provide a COPY for our records)

Please designate a Primary Care Provider (PCP): ____ Nora Keating, MD ____ Rain Potter, FNP-C

____

Emergency Contact: Name Relationship Phone

____

Next of Kin: (2nd Emergency Contact) Name Relationship Phone

INSURANCE INFORMATION

If available, please provide proof of insurance.

Medicaid/ Sanford Health: Yes No Veteran Healthcare Benefits: Yes No

Medicare: Part A Part B Part C Part D Medicare #: ______________________

Private Insurance: ______________________ ______________________
Name of Insurance Policy #

Policy Holder: ______________ Date of Birth: ______________ Relationship: ______________

Policy Holder's SS#: ______________________ Effective Date: ______________

List ALL members covered under this insurance with names & birthdates: ______________________
______________________ ______________________
______________________ ______________________

OFFICE USE ONLY

Date record Established / Updated: ____________ By: ______________________ Chart # : ____________

RECIPIENT NAME:
____

RECIPIENT PRIVACY RIGHTS (Public Law 93-579) I understand that the information given to me and/or collected is necessary for Trenton Community Clinic to provide for my wellbeing. Furthermore I have been informed that my records shall not be disclosed to any other agency or person without my consent.

TRENTON COMMUNITY CLINIC

APPLICATION FOR SERVICE

PO BOX 210 Trenton, ND 58853
PH (701) 774-0461 Fax (701) 774-8003

RECIPIENT NAME: ____

RECIPIENT PRIVACY RIGHTS (Public Law 93-579) I understand that the information given by me and/or collected is necessary for Trenton Community Clinic to provide for my well-being. Furthermore, I have been informed that my records shall not be disclosed to any other agency or person without my signed consent.

ASSIGNMENT OF BENEFITS (AOB) I understand that Trenton Community Clinic (TCC) has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. This AOB authorization is in effect until revoked by patient in writing. Further, I understand that Trenton Community Clinic may bring a claim or cause of action against the third party for recovery of such medical expenses.

Therefore, I agree as follows:

1) To assign to Trenton Community Clinic any claim of cause of action against the third party to the extent of the medical expense paid, or any portion thereof.
2) To furnish such information as may be requested concerning the circumstances giving rise to the injured or deceased for which care, and treatment is being given and concerning any action instituted by or against a third party.
3) The AOB authorization is in effect until revoked by Recipient.

I hereby authorize Trenton Community Clinic to furnish information to insurance carriers and other third-party payers concerning my illness and treatment, and hereby assign all payments for medical service rendered to myself or my dependent.

RELEASE OF INFORMATION

I authorize Trenton Community Clinic to collect information on behalf of myself and my dependents. I understand that information received by Trenton Community Clinic will be kept confidential and used for professional purpose only in terms of facilitating services for me and my dependents. I acknowledge that Trenton Community Clinic is the PAYER OF LAST RESORT, and there fore I must apply and accept all medical benefits and /or alternate resource coverage when available.

CONSENT OF SERVICE

Recipient hereby consents to any services provided in connection with Recipient's treatment by Trenton Community Clinic (TCC) health service providers and by independent health service providers affiliated with TCC. These services may include, but are not limited to, inpatient, outpatient, and/or emergency services; diagnostic procedures; transportation; nursing care; and other healthcare services provided to Recipient upon the instructions of Recipient's providers. "Recipient acknowledges that no guarantees have been made regarding the outcome of these services. If the Recipient is unable to sign, consent for treatment: (1) is hereby given by representative(s) authorized to make decisions and sign this agreement on Recipient's behalf, or (2) in cases of emergency, shall be implied. The term "TCC" includes the health care service providers owned or controlled by Trenton Community Clinic.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which crime, and shall also be subject to a civil penalty for each violation.

____ ____________________
Signature of Applicant Date

____
Signature of Legal Representative, if other than Applicant

____
Printed Name

Form updated: 7/13/21