

# **TRENTON COMMUNITY CLINIC**

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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 ser you. We would like to take this time to review some important points prior to your first appointment.

### **Clinic Location**

331 4<sup>th</sup> Ave. East  
Trenton, North Dakota 58853  
[www.mytisa.org](http://www.mytisa.org)

### **Hours of Operation**

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

### **Appointment Check in Policy**

We require all 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 advanced 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 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 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 or Birth Certificate)
- \_\_\_\_\_ Private Insurance Card/s (copy of both sides of cards)
- \_\_\_\_\_ Medicaid, Medicare or letter of denial (copy of both sides of cards)

## **Pregnant woman (non-Native) also need to submit:**

- \_\_\_\_\_ Signed paternity paper from native father (located at reception desk)

## **College Students also need to submit the following:**

- \_\_\_\_\_ Student status verification (office letter/ official transcript from institute verifying full-time student status and duration of attendance)

**If all documents are NOT submitted with your application, registration will be delayed until all documents are received.**



REGISTRATION FOR SERVICE  
 Trenton Community Clinic  
 PO Box 210 Trenton ND 58853  
 PH (701)774-0461 Fax (701) 774-8003

**RECIPIENT INFORMATION**

\_\_\_\_\_  
 FIRST NAME                      MIDDLE                      LAST                      BIRTHDAY                      AGE

Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Veteran: Yes No Gender: Female Male Marital Status: \_\_\_\_\_

\_\_\_\_\_  
 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 Advanced Directive: Yes No If Yes, is it a: \_\_\_Power of Attorney OR \_\_\_ Living Will  
 Please designate a Primary Care Provider \_\_\_Nora Keating, MD \_\_\_Misty Falcon, FNP-C

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Next of Kin: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance information**

Medicaid: \_\_\_Yes \_\_\_No Veteran Health Benefits: \_\_\_Yes \_\_\_No

Medicare: \_\_\_Part A \_\_\_Part B \_\_\_Part C \_\_\_Part D Medicare #: \_\_\_\_\_

Private Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_

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 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 therefore 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