Admission Record
SKY LAKES MEDICAL
SLM EMERGENCY DEPT
2865 DAGGETT AVE
KLAMATH FALLS OR 97601-1106
541-882-6311

Admit Date/Time:	3/10/2024
Hospital Account:	100014192815
MRN:	200222265
Contact Serial #:	300068661822
Care Everywhere #:	ASA-KH2C-3PLD-5FFV

Encounter

Patient Class:	E	Unit:	SLM ED
Hospital Service:	Emergency Medicine	Bed:	514-01
Emergency Admit Date:	3/10/2024	Emergency Admit Time:	1:24 PM
Outpatient/Observation		Outpatient/Observation Admit	
Inpatient Admit Date:		Inpatient Admit Time:	
Admitting Provider:		Referring Physician:	
Attending Provider:		Scheduled Provider:	
Adm Procedure Text:		Adm Diagnosis:	
Advance Directive Status:	<no information>	Adm Procedure Code:	

Patient

Preferred Name:	**Jenette**						
Name:	Norwest, Jenette Ann					DOB	9/24/1992 (31 yrs)
Mailing Address:	1934 Worden Ave, Klamath Falls, OR 97601					Sex:	Female
Physical/Temp Address:	, ,						E-mail: No e-mail address on record
Primary Phone	541-326-6579	Home Phone:		Mobile Phone:	541-326-6579	Work Phone:	
Spoken Language:	English	Written Language:	English			Interpreter Needed:	No
Primary Care	Klamath Tribal Health S*						

Emergency Contact

Contact Name	Mobile Phone	Home Phone	Work Phone	Relationship to Patient	Legal Guardian?
1. Garcia,Duane	541-363-1568			Significant Other / Partner	No
2. Weiser, Catherine "Mex"	541-591-2656			Mother	

Guarantor

Guarantor:	NORWEST,JENETTE ANN	DOB:	9/24/1992
Address:	1934 Worden Ave , Klamath Falls, OR 97601	Sex:	Female
Relation to Patient:	Self	Home Phone:	
		Mobile Phone:	541-281-1691
Guarantor ID:	747106	Work Phone:	
Employer:		Status	NOT EMPLO*

Coverage

PRIMARY INSURANCE

Payor:	MEDICAID	Plan:	MEDICAID PLUS
Group Number:		Member ID:	BJ01541B
Subscriber Name:	NORWEST,JENETTE ANN	Subscriber DOB:	09/24/1992
Subscriber ID:	BJ01541B	Pat. Rel. to Subscriber:	Self

SECONDARY INSURANCE

Payor:	TRIBAL HEALTH KLAMA*	Plan:	KLAMATH TRIBAL
Group Number:		Member ID:	BJ01541B
Subscriber Name:	NORWEST,JENETTE ANN	Subscriber DOB:	9/24/1992
Subscriber ID:	09241992	Pat. Rel. to Subscriber:	SELF

Chiloquin Fire & Rescue Signature/Claim Submission Authorization Form

Patient Name: Venette Narvest **Transport Date:** 3/10/24

Incident/Run#: 24-X 203

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **Chiloquin Fire & Rescue (CF&R)** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. ***A copy of this form is valid as an original***

SECTION I - PATIENT SIGNATURE

The patient MUST sign here UNLESS the patient is PHYSICALLY OR MENTALLY INCAPABLE of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **CF&R** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **CF&R,** regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to **CF&R** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **CF&R.** I authorize **CF&R** to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **CF&R** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **CF&R**, now, in the past, or in the future. I also authorize **CF&R to** obtain medical, insurance, billing, and other relevant information about me from any party, database or other source that maintains such information.

X _____ 3/10/24
Patient Signature or Mark — Date

If the patient signs with an "X" or other mark, a witness should sign below.

X _____ _____
Witness Signature — Date

_____
Witness Address

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **ONLY IF** the patient is PHYSICALLY OR MENTALLY INCAPABLE of signing.

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **CF&R** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient *(i.e., if available, a legal representative is preferred over a facility representative)*

X _____ _____ _____
Representative Signature — Date — Printed Name of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **ONLY IF**: (1) the patient was physically or mentally incapable of signing, **AND** (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

Describe the circumstances that make it impractical for the patient to sign: _____

Name and Location of Receiving Facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **CF&R.**

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

X _____ _____ _____
Signature of Crewmember — Date — Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X _____ _____ _____
Signature of Receiving Facility Representative — Date — Printed Name and Title of Receiving Facility Representative