



**PATIENT INFORMATION**

|   |  |  |                     |       |               |
|---|--|--|---------------------|-------|---------------|
| Last name   |  | First name   |                     | MI    | Date of birth |
| Social Security number  | Sex at birth   | Marital status<br>[ ] Single [ ] Married [ ] Divorced [ ] Other: |                     |       |               |
| Mailing address   |  |  | City                | State | ZIP           |
| Physical address (if different from mailing address)  |  |  | City                | State | ZIP           |
| Are you homeless?<br>[ ] Yes [ ] No   | If you are homeless, where do you currently live?<br>[ ] On the street [ ] Doubling up (staying with family or friends)<br>[ ] Transitional housing [ ] Shelter [ ] Other: |  |                     |       |               |
| Home phone  | Cell phone   | Email address  |                     |       |               |
| Contact preferences: [ ] Home phone [ ] Cell phone [ ] Email [ ] No preference<br>Is it okay for PHC staff to leave voicemail on your phone? [ ] Yes [ ] No |  |  |                     |       |               |
| Emergency contact person  |  |  | Relationship to you | Phone |               |

|   |                              |                               |                                  |                              |
|---|------------------------------|-------------------------------|----------------------------------|------------------------------|
| Employer(s)   |                              |                               |                                  | Phone                        |
| Employment<br>(check all that apply)  | [ ] Full-time<br>[ ] Retired | [ ] Part-time<br>[ ] Seasonal | [ ] Self-employed<br>[ ] Migrant | [ ] Unemployed<br>[ ] Other: |
| Are you currently a student? [ ] Yes (full-time) [ ] Yes (part-time) [ ] No |                              |                               |                                  |                              |

**SHARING OF HEALTH INFORMATION (verbal communication authorization)**

Would you like to allow PHC staff to speak with anyone other than yourself about your health record? [ ] Yes [ ] No

If YES, name your trusted person(s) in the table below, and set their level of access to your personal health information.

| Full name | DOB | Relationship | Level 1:<br>All information in my record | Level 2:<br>Appointments & scheduling only | Level 3:<br>Specific info (please specify) |
|-----------|-----|--------------|--|--|--|
|           |     |              |  |  |  |
|           |     |              |  |  |  |
|           |     |              |  |  |  |

Unless otherwise revoked, this authorization will expire 30 months (2.5 years) after it is created. You may revoke this authorization in writing at any time. Once released to another individual, your personal health information is no longer protected under federal law, and may be re-disclosed by the recipient.

Expiration date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Receptionist initials: \_\_\_\_\_

**Please initial below to acknowledge:**

|                 |   |
|-----------------|---|
| <b>INITIALS</b> | I authorize the above person(s) to obtain verbal information about my medical records at PHC. |
|-----------------|---|



# Partnership Health Center

401 Railroad St W  
Missoula, MT 59802  
(406) 258-4789

## RESPONSIBLE PARTY INFORMATION (if patient is under 18 years of age)

### Person responsible for this account:

|                        |            |   |  |       |               |
|------------------------|------------|---|--|-------|---------------|
| Last name              |            | First name  |  | MI    | Date of birth |
| Social Security number |            | Gender<br>[ ] Male [ ] Female [ ] Other:  |  |       |               |
| Mailing address        |            |   | City   | State | ZIP           |
| Phone                  | Email      |   | May we call you? [ ] Yes [ ] No<br>Do you prefer email? [ ] Yes [ ] No |       |               |
| Employer(s)            | Work phone | Employment status<br>[ ] Full-time [ ] Part-time [ ] Unemployed<br>[ ] Retired [ ] Other: |  |       |               |

## INSURANCE INFORMATION (please present all insurance cards for scanning, front and back)

### What type of insurance do you have? Check all that apply:

- [ ] Medicare or Medicare Advantage [ ] Private insurance  
 [ ] Medicaid [ ] VA or military insurance  
 [ ] Auto accident (Claim # \_\_\_\_\_) [ ] No insurance  
 [ ] Worker's compensation (Claim # \_\_\_\_\_)

### PRIMARY INSURANCE

Insurance name: \_\_\_\_\_ Group number: \_\_\_\_\_  
 Subscriber number: \_\_\_\_\_ Active date: \_\_\_\_\_  
 Insurance billing address (usually on back of card): \_\_\_\_\_  
 Who carries this insurance (insured party)? [ ] Self [ ] Spouse [ ] Parent [ ] Other: \_\_\_\_\_

*If the insured party is someone other than yourself, we need their information in order to submit your claim →*

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance name: \_\_\_\_\_ Group number: \_\_\_\_\_  
 Subscriber number: \_\_\_\_\_ Active date: \_\_\_\_\_  
 Insurance billing address (usually on back of card): \_\_\_\_\_  
 Who carries this insurance (insured party)? [ ] Self [ ] Spouse [ ] Parent [ ] Other: \_\_\_\_\_

*If the insured party is someone other than yourself, we need their information in order to submit your claim →*

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

### Please initial below to acknowledge:

INITIALS

*I accept responsibility for any fees for services not covered by my insurance or sliding fee scale assignment.*



**ADDITIONAL INFORMATION (federally mandated questions)**

**What is your race or origin? Check all that apply:**

- American Indian or Alaska Native                       White                       Black or African American
- Native Hawaiian or other Pacific Islander                       Asian                       Other:
- Choose not to disclose

**What is your ethnicity?**

- Hispanic or Latino                       Not Hispanic or Latino                       Choose not to disclose

**What is your primary language?**

- English     Spanish     Russian     Hmong     Other:

**Will you require a translator?**

- Yes                       No

**Are you a veteran?**

- Yes                       No

**What is your gender identity?**

- Male                       Transgender male (female-to-male)                       Other:
- Female                       Transgender female (male-to-female)                       Choose not to disclose

**What is your sexual orientation?**

- Straight                       Lesbian or gay                       Bisexual
- Something else                       Don't know                       Choose not to disclose

**HOUSEHOLD INFORMATION**

*To maintain funding for our discounted services, we are required to collect household size and income information from all our patients, including those who choose not to apply for financial support. Please assist us in continuing these programs by answering the following two questions:*

|   |  |
|---|--|
| <b>Including yourself, how many people are in your household?</b> | <b>What is your estimated annual household income?</b> |
|   |  |

**SLIDING FEE SCALE INFORMATION (fill in the fields below for each member of your household)**

| Full name | Date of birth | Relationship to you | SSN | Insured? |
|-----------|---------------|---------------------|-----|----------|
|           |               |                     |     | Yes   No |

**Would you like to apply for the sliding fee scale?**                       Yes                       No, I decline

**Please initial below to acknowledge:**

|                 |   |
|-----------------|---|
| <b>INITIALS</b> | <i>I understand that in order to complete my application for a sliding fee scale discount, I need to provide proof of income for every working member of my household within 5 business days of my appointment.</i> |
| <b>INITIALS</b> | <i>I have received a copy of Partnership Health Center's sliding fee scale brochure.</i>  |



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## ACCESS TO SERVICES

Please let us know about any special accommodations you may need (wheelchair, ASL interpreter, etc).

## NOTICE OF PRIVACY PRACTICES

INITIALS

*I have received a copy of PHC's Notice of Privacy Practices informing me of how my medical information may be used and disclosed; this document also explains how I can access medical information for myself and my dependents.*

## CONFIRMATION OF INFORMATION GIVEN

INITIALS

*The information given on this form is true and correct. I understand that it is in my best interest to report all changes in a timely manner.*

## AUTHORIZATION AND ASSIGNMENT

### MEDICAL HOME RIGHTS AND RESPONSIBILITIES

I understand that Partnership Health Center will be my Medical Home. As such, I am entitled to choose my clinician and have continuity in care by working together with my chosen clinician and their care team. I will inform PHC and/or my care team of all matters concerning my health. I have received the Partnership Health Center Medical Home information brochure which explains in detail my rights and responsibilities.

### TREATMENT/PAYMENT AGREEMENT FOR PARTNERSHIP HEALTH CENTER (PHC)

I request that Partnership Health Center provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fee schedule established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. Also, I authorize PHC to bill my insurance and release information to the insurance company if requested. I understand and agree to communicate to PHC all changes to my income and/or insurance status.

I understand and give consent for my information to be accessed by outside entities for the purposes of auditing the facilities compliance with federal, state, and pharmaceutical program business rules.

\_\_\_\_\_  
Patient or parent/legal guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by parent/legal guardian, please print name

\_\_\_\_\_  
Relationship to patient

### PHC STAFF USE ONLY

Form received &  
processed by:

Review date:                    /                    / 2017

Notes: