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

Patient Intake Form

REVISED 12/31/2017

PATIENT INFORMATION

Last name	First name	MI	Date of birth

Social Security number	Sex at birth	Marital status	Nick name

Mailing address	City	State	ZIP

Physical address *(if different from mailing address)*	City	State	ZIP

Are you homeless?	*If you are homeless, where do you currently live?*
[ ] Yes [ ] No	[ ] On the street [ ] Doubling up (staying with family or friends) [ ] Transitional housing [ ] Shelter [ ] Other:

Home phone	Cell phone	Email address

Contact preferences: [ ] Home phone [ ] Cell phone [ ] Email [ ] No preference
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 *(check all that apply)*				
	[ ] Full-time	[ ] Part-time	[ ] Self-employed	[ ] Unemployed
	[ ] Retired	[ ] Seasonal	[ ] Migrant	[ ] 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:** All information in my record	**Level 2:** Appointments & scheduling only	**Level 3:** 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: _____

_____
INITIAL HERE

I authorize the above person(s) to obtain verbal information about my medical records at PHC.

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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
	[ ] Male [ ] Female [ ] Other:

Mailing address	City, State, ZIP

Phone	Email	May we call you? / Do you prefer email?
		May we call you? [ ] Yes [ ] No Do you prefer email? [ ] Yes [ ] No

Employer(s)	Work phone	Employment status
		[ ] Full-time [ ] Part-time [ ] Unemployed [ ] 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
[ ] Medicaid
[ ] Auto accident (Claim #_____)
[ ] Worker's compensation (Claim #_____)
[ ] Private insurance
[ ] VA or military insurance
[ ] No insurance

PRIMARY INSURANCE

Insurance name: _____ Group number: _____
Subscriber number: _____ Active date: _____
Insurance billing address *(usually on back of card)*: _____
Who carries this insurance (insured party)? _____

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)? _____

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: _____

_____ INITIAL HERE

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

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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:

Including yourself, how many people are in your household?	What is your estimated annual household income?

SLIDING FEE SCALE

INITIAL HERE

YES – I have received information on PHC's sliding fee scale, and I would like to apply for this discount. I will complete the section below, and provide proof of income for every working member of my household within 5 business days.

To start your application, fill in the fields below for each member of your household

Full name	Date of birth	Relationship to you	SSN	Employed?
		SELF		Yes | No
				Yes | No
				Yes | No
				Yes | No
				Yes | No

INITIAL HERE

NO – I have received information on PHC's sliding fee scale, and I choose not to apply for this discount. I understand that I will be billed at full price.

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DO YOU HAVE A PRIMARY CARE PROVIDER (PCP)?

[ ] Yes [ ] No

PCP name:

If you don't have a PCP, would you be interested in getting primary care services at PHC? [ ] Yes [ ] No

ACCESS TO SERVICES

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

NOTICE OF PRIVACY PRACTICES

_____
INITIAL HERE

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 PROVIDED

_____
INITIAL HERE

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. This means that I am entitled to choose my clinician, and to receive 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 will communicate to PHC any 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: _____ / _____ / 2018

Slide set? [ ] Yes [ ] No

Notes: