PHC PARTNERSHIP HEALTH CENTER

401 Railroad St. W
Missoula, MT 59802
Phone: (406) 258-4789
Fax: (406) 258-4732
partnershiphealthcenter.org

Registration Form

REVISED 6/25/2021

PERSONAL INFORMATION

First name	MI	Last name	Preferred or chosen name

Date of birth	Social Security number	Previous name(s)

Cell phone	Home phone	Email address *(please print clearly)*

Is it okay for us to leave you voicemail messages? [ ] Yes (brief) [ ] Yes (extended) [ ] No

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

What is your primary language?	Do you have a hearing impairment?	Do you need an interpreter?
[ ] English [ ] Other: ______________________	[ ] Yes [ ] No	[ ] Yes [ ] No [ ] ASL

What is your marital status?
[ ] Single [ ] Partnered [ ] Divorced [ ] Choose not to answer
[ ] Married [ ] Legally separated [ ] Widowed

EMERGENCY CONTACT

Full name	Relationship to you	Phone

PHARMACY

If you need to pick up medications, what pharmacy would you like to use? Please specify the pharmacy's general location.

INSURANCE INFORMATION

Please bring all of your insurance cards with you to each appointment.

What type of primary insurance do you have? *(check all that apply)*

[ ] Medicare
[ ] Medicare Advantage Plan
[ ] Auto accident (Claim #_________________)
[ ] Worker's compensation (Claim #_________________)
[ ] Medicaid or HMK CHIP
[ ] Private insurance (BCBS, etc)
[ ] VA, Tricare, or military insurance
[ ] No insurance

Is this your own coverage?

[ ] **YES** [ ] **NO – I'm covered on someone else's plan**

Name of person carrying the plan: ____
DOB: ___________________ *Relationship to you:* __________________________
SSN: ___________________ *Phone number:* ______________________________

Do you have secondary (supplemental) insurance?

[ ] No [ ] Yes: ____

Do you have dental insurance?	Do you have prescription insurance?
[ ] No [ ] Yes: _______________________________	[ ] No [ ] Yes: ________________________________

Would you like help applying for Medicaid or Marketplace insurance? [ ] Yes [ ] No

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RESPONSIBLE PARTY – If you are filling out this form for your dependent, enter your information here

First name	MI	Last name	Date of birth

Social Security number	Gender
	[ ] Female [ ] Male [ ] Other: ______________________

Relationship to patient? *(e.g. parent, grandparent, legal guardian, power of attorney)*

Mailing address	City	State	ZIP

SHARING OF HEALTH INFORMATION (verbal communication)

Would you like to allow PHC staff to speak with anyone other than you about your care?

*If **NO**, skip to the next section*

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

CHECK ALL THAT APPLY

Full name or organization name	Relationship to you	Level 1: Medical & dental treatment & PHI	Level 2: Appointments & scheduling	Level 3: Limited PHI, ***specifically:***	Level 4: Behavioral health PHI

This authorization will expire 30 months (2.5 years) from today, or earlier if you make changes to this annual registration form. *You may also 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.*

_________ INITIAL HERE

I authorize the above person(s) to be able to communicate with PHC staff about my protected health information and records at Partnership Health Center.

ADDITIONAL INFORMATION

Our life experiences play an important role in our health and well-being. We ask you these questions so we can better understand your experience and give you the best care possible. Please answer what you feel comfortable answering. Thank you!

What was your sex at birth?	What is your gender identity?
[ ] Female [ ] Male [ ] Choose not to answer	[ ] Female [ ] Genderqueer [ ] Choose not to answer [ ] Male [ ] Other: ______________________

What are your pronouns?	What is your sexual orientation?
[ ] She/her/hers [ ] They/them/theirs [ ] He/him/his [ ] Other:	[ ] Straight [ ] Bisexual [ ] Choose not to answer [ ] Lesbian or gay [ ] Don't know [ ] Something else

What is your race? *(check all that apply)*

[ ] American Indian or Alaska Native [ ] White [ ] Native Hawaiian [ ] Other Pacific Islander
[ ] Black or African American [ ] Asian [ ] Choose not to answer [ ] Other:

What is your ethnicity? [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Choose not to answer

Are you a refugee? [ ] Yes [ ] No [ ] Choose not to answer

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Are you in active service or a veteran of the US armed forces?	[ ] Yes	[ ] No	[ ] Choose not to answer
Have you ever been placed in foster care (placed in a home, group home, or with an approved family member)?	[ ] Yes	[ ] No	[ ] Choose not to answer

What level of school have you finished?	[ ] Less than high school	[ ] High school diploma or GED	[ ] More than high school	[ ] Choose not to answer
Are you currently a student?	[ ] Yes (full-time)	[ ] Yes (part-time)	[ ] No	[ ] Choose not to answer

In the past year have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correctional facility?	[ ] Yes	[ ] No	[ ] Choose not to answer

Are you experiencing homelessness, or are you worried about losing your housing?	[ ] Yes	[ ] No	[ ] Choose not to answer
If you are currently homeless, where do you sleep at night?	[ ] On the street or in a car [ ] Transitional housing	[ ] Doubling up (staying with family or friends) [ ] Permanent supportive housing	[ ] Shelter [ ] Other

In the past year have you or your family experienced financial hardship?	[ ] Yes	[ ] No	[ ] Choose not to answer

HOUSEHOLD INCOME INFORMATION & SLIDING FEE SCALE

To maintain federal funding for our discounted services, we are required to collect household and income information from all our patients, including those who choose not to apply for financial support. Even if you do not plan on applying for assistance, please help us continue to offer discounts by answering the questions below. Thank you!

WHAT IS A HOUSEHOLD?

A household includes all individuals who live together and are related by birth, marriage, or adoption.

It also includes all individuals who may or may not live together, but share a taxed household.

Including yourself, how many people live in your household?	
What is your estimated yearly household income?	$

Complete this section for all adults in your household, starting with yourself:

Full name:		
Relationship to patient:		
Employer's full name:		
Employment status:	[ ] Full-time	[ ] Part-time
[ ] Self-employed	[ ] Unemployed	[ ] Retired
[ ] Seasonal	[ ] Migrant	[ ] Other
Receives benefits? (check all that apply)	[ ] SSI or SSDI [ ] SNAP benefits	[ ] Child support [ ] Student grant
[ ] Veteran benefits	[ ] Unemployment	[ ] Worker's comp.
[ ] Retirement income, pension	[ ] Annuities, interest, dividends	[ ] Other:

Full name:		
Relationship to patient:		
Employer's full name:		
Employment status:	[ ] Full-time	[ ] Part-time
[ ] Self-employed	[ ] Unemployed	[ ] Retired
[ ] Seasonal	[ ] Migrant	[ ] Other
Receives benefits? (check all that apply)	[ ] SSI or SSDI [ ] SNAP benefits	[ ] Child support [ ] Student grant
[ ] Veteran benefits	[ ] Unemployment	[ ] Worker's comp.
[ ] Retirement income, pension	[ ] Annuities, interest, dividends	[ ] Other:

List all minors under the age of 18 that are part of your household:

Full name:	
Date of birth:	
Relationship to you:	

Full name:	
Date of birth:	
Relationship to you:	

Full name:	
Date of birth:	
Relationship to you:	

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Are you interested in applying for the sliding fee scale? *(initial one)*

INITIAL HERE **YES** – *I have received information on PHC's sliding fee scale, and I would like to apply for this discount. I will provide proof of income for every working member of my household as soon as possible.*

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 after my insurance payments, I will be billed at full fee for balances not covered by my insurance.*

NOTICE OF PRIVACY PRACTICES

INITIAL HERE *I have reviewed 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.*

NOTICE OF IMMUNIZATION & INFECTIOUS DISEASE REPORTING AND RECORD KEEPING

INITIAL HERE *I understand that PHC reports and collects immunization data using the Montana State Registry (imMTrax). I understand that PHC is obligated to report certain cases of infectious disease to my local health department. I understand that if I have concerns about how my information is collected and shared with imMTrax I should talk to my provider.*

HEALTH INFORMATION EXCHANGE (HIE)

INITIAL HERE *By initialing here, I acknowledge that PHC participates in the Health Information Exchange. I understand that the HIE allows health care providers, hospitals, and patients to electronically access and securely share vital health information. This exchange improves the coordination, speed, quality, safety & cost of care. I have been informed that I may opt out of the HIE.*
[ ] I wish to opt out of the Health Information Exchange.

MONTANA CANCER CONTROL PROGRAM (MCCP)

INITIAL HERE *By initialing here, I allow MCCP to enroll me into a program that can help me get breast and cervical cancer screening and diagnostic services. I understand that MCCP and/or PHC are not financially responsible for any expenses I may incur.*

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 consent to team-based care. Care may be under a collaborative practice agreement (CPA). A CPA is an agreement between medical providers and pharmacists. A CPA allows pharmacists to provide specific patient care functions.

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 for any fees for services not covered by my insurance or sliding fee scale assignment. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. I authorize PHC to bill my insurance and release my information to the insurance company if they request it. 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.

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

Patient or parent/legal guardian signature **Date**

If signed by parent/legal guardian, please print name Relationship to patient