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

Pediatric Registration Form

REVISED 12/21/2023

MINOR'S PERSONAL INFORMATION

Minor's First name	MI	Minor's Last name	Preferred or chosen name

Minor's Date of birth (MM/DD/YYYY)	Minor's Social Security number	Previous name(s)

Minor's Phone Number	Minor's Email Address *(please print clearly)*

What is your Minor's primary language?	Does your minor have a hearing impairment?	Does your minor need an interpreter?
[ ] English [ ] Other: _____	[ ] Yes [ ] No	[ ] Yes [ ] No [ ] ASL

Minor's Employment Status:
If employed, Employer's Full Name: _____

[ ] Not Employed [ ] Full-time [ ] Migrant
[ ] Part-time [ ] Self-employed [ ] Seasonal [ ] Other_____

RESPONSIBLE PARTY/Legal Guardian – If you are filling out this form for your minor, enter your information here

Adult's First name	MI	Adult's Last name	Adult's Date of birth (DD/MM/YYYY)

Adult's Social Security number	Adult's Relationship to Minor? *(e.g. parent, grandparent, legal guardian, power of attorney)*

Mailing address	City	State	ZIP

Cell phone (for text reminders)	Home phone	Email address *(please print clearly)*

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

Your minor's health and safety is very important to us. To help us best care for your minor, please identify **all** parents, guardians and emergency contacts below (**including yourself**). Please also identify adults which can accompany your minor to an appointment.

ADULT INFORMATION – Other adults authorized to bring your minor for appointments at PHC

First and Last Name	Relationship to minor	Emergency Contact? *Does not grant verbal authorization – see below.	Accompany minor to visit?	Phone
		[ ] Yes [ ] No	[ ] Yes [ ] No	
		[ ] Yes [ ] No	[ ] Yes [ ] No	
		[ ] Yes [ ] No	[ ] Yes [ ] No	
		[ ] Yes [ ] No	[ ] Yes [ ] No	

LIMITATIONS

Are there any limitations you would like to place on the treatment PHC may provide to your minor?

[ ] None [ ] Limited to: _____

Minors under 14 must come to each appointment with a legal guardian or designated adult. May your minor age 14 and older come in for an appointment without you, or without an approved designated adult?

[ ] No [ ] Yes, limited to: _____

PHARMACY

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

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INSURANCE INFORMATION

Do you have **medical insurance**? *(check all that apply)*

Name of Insurance	Subscriber (self or person who holds insurance)	Insurance ID Number
[ ] Medicare		
[ ] Medicaid or HMK, HMK+		
[ ] VA, Tricare, or Military		
[ ] Private Insurance Name:_____		
[ ] No medical insurance		

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

Do you have **dental insurance**?	[ ] No [ ] Yes: Name of Insurance:_____
ID #:_____	Subscriber (self or person who holds insurance):_____
Do you have **prescription insurance?**	[ ] No [ ] Yes: Name of Insurance:_____ ID#:_____

Verbal Communication Authorization – Note – a separate request is required to release medical records

Would you like to allow PHC staff to speak with anyone other than parent/legal guardians about your minor's 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

[ ] I would like to revoke a previous verbal communication authorization. If yes, list those who should no longer have access:

_____

This verbal communication authorization will expire 30 months (2.5 years) from today.
Previous verbal communication authorization must be revoked 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.

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.

_____
INITIAL HERE

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 minor's sex at birth?	**What is your minor's gender identity?**		
[ ] Female [ ] Male	[ ] Female	[ ] Genderqueer	[ ] Choose not to answer
[ ] Choose not to answer	[ ] Two-Spirit	[ ]Non-binary/Gender fluid	
	[ ] Male	[ ]Identity not listed:_____	
What are your minor's pronouns?	**What is your minor's sexual orientation?**		
[ ] She/her/hers [ ] They/them/theirs	[ ] Heterosexual	[ ] Bisexual	[ ] Choose not to answer
[ ] He/him/his [ ] Pronoun not listed:_____	[ ] Lesbian or gay	[ ] Don't know	[ ] Orientation not listed

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What is your minor's race? *(check all that apply)*			
[ ] American Indian	Tribal Affiliation:_____		
[ ] Alaska Native	[ ] Black or African American		
[ ] White	[ ] Race not listed	[ ] Choose not to answer	
[ ] Asian Indian	[ ] Korean	[ ] Vietnamese	[ ] Chinese
[ ] Filipino	[ ] Japanese	[ ] Other Asian	
[ ] Native Hawaiian	[ ]Chamorro	[ ]Guamanian	[ ]Samoan
[ ] Tongan	[ ] Other Pacific Islander		

What is your minor's ethnicity?	[ ] Hispanic or Latino	[ ] Not Hispanic or Latino	[ ] Choose not to answer [ ] Ethnicity not listed
If Hispanic or Latino, please check all that apply:	[ ] Mexican, Mexican American	[ ] Puerto Rican	[ ] Cuban [ ] Ethnicity not listed

Is your minor a refugee?	[ ] Yes	[ ] No	[ ] Choose not to answer
Is your minor active service of the US armed forces?	[ ] Yes	[ ] No	[ ] Choose not to answer

Has your minor 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 has your minor finished?	[ ] Less than high school	[ ] High school diploma or GED	[ ] More than high school	[ ] Choose not to answer
Is your minor currently a student?	[ ] Yes (full-time)	[ ] Yes (part-time)	[ ] No	[ ] Choose not to answer

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

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

HOUSEHOLD INCOME INFORMATION

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?	**$**

Please Note: A separate application is required to apply for the Sliding Fee Scale

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. If I am experiencing houselessness or have Medicaid, a slide may be set for my benefit. I understand that after my insurance payments, I will be billed at full fee for balances not covered by my insurance.

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NOTICE OF PRIVACY PRACTICES

_____ INITIAL HERE

I have reviewed a copy of PHC's Notice of Privacy Practices and Patient Rights & Responsibilities 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 have reviewed a copy of PHC's Health Information Exchange procedure. I understand that I am automatically opted-in to the HIE. If I would like to change my HIE status, I can do so in writing at any time.

AUTHORIZATION AND ASSIGNMENT

PARENT/GUARDIAN CONSENT

It is best practice to see minors with their parent or legal guardian present. If you cannot be present at the appointment with your minor, we are legally obligated to have your written authorization *before* we treat your minor. In an emergency situation, we will provide treatment and contact you as soon as possible. Urgency will be determined by our medical professionals. Be advised that your minor's protected health information may be shared with the person (Designated Adult) to whom you give consent; if you do not want information to be shared, please specify your wishes in the limitations section of this form. Our clinical staff and providers reserve the right to postpone any non-urgent procedure if proper consent cannot be obtained before the time of an appointment.
I have the legal right to pre-authorize this facility to deliver treatment to my (our) minor. I request and authorize Partnership Health Center and its personnel to deliver health care to my minor, listed above. I understand that every effort will be made to obtain proper consent prior to each visit. I understand that in an emergency situation, treatment for my minor will be initiated immediately and PHC personnel will contact me as soon as possible. I understand that I am providing authority to the Designated Adult(s) to consent to treat my minor, and exercise his or her own best judgement upon the advice of licensed PHC personnel. I accept financial responsibility for services provided.

MEDICAL HOME RIGHTS AND RESPONSIBILITIES

For those receiving medical care, 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