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

Registration Form

REVISED 12/21/2023

PERSONAL INFORMATION

First name	MI	Last name	Preferred or chosen name

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

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

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

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

[ ] Full-time [ ] Self-employed [ ] Retired [ ] Migrant
[ ] Part-time [ ] Unemployed [ ] Seasonal [ ] Other_____

What is your marital status?

[ ] Single [ ] Partnered [ ] Divorced [ ] Choose not to answer
[ ] Married [ ] Legally separated [ ] Widowed

EMERGENCY CONTACT – For emergency use only, does not grant verbal authorization (see next page)

Full name	Relationship to you	Phone

INSURANCE INFORMATION

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

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

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

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#:_____

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PHARMACY

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

RESPONSIBLE PARTY/Legal Guardian – 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	Relationship to patient? *(e.g. parent, grandparent, legal guardian, power of attorney)*

Mailing address	City	State	ZIP

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 you and/or your legal guardians 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

[ ] 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 after 30 months (2.5 years).
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 sex at birth?	What is your gender identity?
[ ] Female [ ] Male [ ] Choose not to answer	[ ] Female [ ] Genderqueer [ ] Choose not to answer [ ] Two-Spirit [ ]Non-binary/Gender fluid [ ] Male [ ]Identity not listed:_____
What are your pronouns?	**What is your sexual orientation?**
[ ] She/her/hers [ ] They/them/theirs [ ] He/him/his [ ] Pronoun not listed:___	[ ] Heterosexual [ ] Bisexual [ ] Choose not to answer [ ] Lesbian or gay [ ] Don't know [ ] Orientation not listed

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

[ ] American Indian Tribal Affiliation:_____
[ ] Alaska Native [ ] Black or African American
[ ] White [ ] Race not listed [ ] Choose not to answer

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[ ] Asian Indian	[ ] Korean	[ ] Vietnamese	[ ] Chinese
[ ] Filipino	[ ] Japanese	[ ] Other Asian	
[ ] Native Hawaiian	[ ]Chamorro	[ ]Guamanian	[ ]Samoan
[ ] Tongan	[ ] Other Pacific Islander		

What is your 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

Are you a refugee?	[ ] Yes	[ ] No	[ ] Choose not to answer	
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 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. I understand that 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

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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

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 pharmacy, behavioral health, medical, and/or dental service(s) 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 legal guardian signature	**Date**
If signed by legal guardian, please print name	Relationship to patient