Patient Intake Form

Patient's Legal Name (First, MI, Last)			
Mailing Address (City, State, Zip)			
Home Phone	Cell Phone	Work Phone	Preferred Method of Communication ____Voice ____Text ____Email

Who is your primary care physician? Physician: ____________________ Facility: ____________________ Phone: ____________________	DOB (MM/DD/YYYY) Marital Status ____Married ____Single ____Widowed ____Divorced ____Separated ____Partner	What is your gender identification? ____Male ____Female ____Transgender Male/Female to Male ____Transgender Female/Male to Female ____Other ____Choose Not to Disclose
Social Security # Are you a student? ____Full-Time ____Part-Time ____Not a student	Employer: ____________________ Phone: ____________________	Employment Status ____Full-Time ____Part-Time ____Unemployed ____Self-Employed ____Retired ____Active Military ____Reserve ____Seasonal/Migrant
Emergency Contact	Contact Phone	Relationship to you

Information on individual responsible for bill (if other than self):		
Legal Name (First, MI, Last)	Relationship to you: ____Mother ____Father ____Guardian ____Spouse ____Other	
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip)		
Employment Status ____Full-Time ____Part-Time ____Retired ____Unemployed	Employer: ____________________ Phone: ____________________	

Would you like to see if you are eligible for a discount on your care? ____Yes ____No

If yes, you must fill out required forms and provide proof of income. You are also required to make a minimum payment equal to the following according to department: ***Medical $10, Dental $50, Behavioral Health $10.***

If patient is under 18 years of age, please fill out the following:		
Father's Legal Name (First, MI, Last)		
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip)		

Mother's Legal Name (First, MI, Last)		
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip)		

If legal guardian is someone other than the birth parent, please fill out the information below and provide guardianship documentation.		
Guardian's Legal Name (First, MI, Last)		
Social Security #	DOB (MM/DD/YYYY)	Contact Phone
Physical Address (City, State, Zip)		

Medical Insurance Information (Please present each insurance card to staff)

	If patient is not the policyholder, please complete the fields below:
Company: ____________________	Policyholder's Name: ____________________
Subscriber #: ____________________	Policyholder's DOB: ____________________
Group #: ____________________	Policyholder's SSN: ____________________

Behavioral Health Insurance Information (Please present each insurance card to staff)

	If patient is not the policyholder, please complete the fields below:
Company: ____________________	Policyholder's Name: ____________________
Subscriber #: ____________________	Policyholder's DOB: ____________________
Group #: ____________________	Policyholder's SSN: ____________________

Dental Insurance Information (Please present each insurance card to staff)

	If patient is not the policyholder, please complete the fields below:
Company: ____________________	Policyholder's Name: ____________________
Subscriber #: ____________________	Policyholder's DOB: ____________________
Group #: ____________________	Policyholder's SSN: ____________________

Number of people living in your household? __________

Household Income (Please circle one)

$10,000 or less	$10,000 – 15,000	$15,000-20,000	$20,000-25,000	$25,000-30,000	$30,000-35,000
$35,000-40,000	$40,000-45,000	$45,000-55,000	$55,000-65,000	$65,000-75,000	$75,000+

Unencrypted Text Message – Email Language

We offer regular text messaging and email to provide helpful information like appointment reminders. Regular text messages and emails are not secured by a technical process called encryption so there may be some level of risk the information could be read by someone besides you. Please let us know if you would like us to communicate with you by text message or email.

____Yes, please communicate with me by email. My email address is: ____________________

I will let you know right away if my email address changes.

____No, please do not communicate with me by regular (unencrypted) email.

____Yes, please communicate with me by text message. My cell phone number is: ____________________

I will let you know right away if my cell phone number changes.

____No, please do not communicate with me by regular (unencrypted) text message.

Race (Check all that apply)	Ethnicity	Preferred Pharmacy
____White ____Asian ____American Indian/Alaska Native ____Black/African American ____Native Hawaiian ____Other Pacific Islander	____Hispanic/Latino ____Not Hispanic/Latino **Preferred Language** ________________________	____Bullhook Community Health Center ____Other: ________________________________

Please list all individuals you would like to allow access to your Protected Health Information and which records they can access. You have the right to deny or approve anyone access to your information.	
Name (First, MI, Last)	
Relationship to you	Contact Phone
Grant access to: ____Medical Records ____Dental Records ____Behavioral Health Records ____Financial Records	
Name (First, MI, Last)	
Relationship to you	Contact Phone
Grant access to: ____Medical Records ____Dental Records ____Behavioral Health Records ____Financial Records	
Name (First, MI, Last)	
Relationship to you	Contact Phone
Grant access to: ____Medical Records ____Dental Records ____Behavioral Health Records ____Financial Records	

Please check the statement which best describes your housing situation:

____I live in my home which I rent, lease, or own
____I am staying with a series of friends and/or extended family members on a temporary basis
____I am staying in supportive or transitional housing (such as a sober living facility or recovery home)
____I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility or motel
____I have been released from an institution (such as a jail or hospital) without stable housing to return to
____I live on the streets, in a car, park, sidewalk, in an abandoned building, or any unstable or non-permanent situation
____I live in a foster care environment

Do you have a dentist you see regularly?	Have you seen a dentist in the past year?	Have you recently had a toothache or other problems with your teeth?
_____ Yes _____ No	_____ Yes _____ No	______ Yes ______ No

Are you a Veteran?	Do you understand the assistance offered through the Montana Legal Service (MLS)?	Would you like to request assistance from the MLS?
____Yes ____No	____Yes ____No	____Yes ____No

What is your sexual orientation?
Lesbian or Gay_____ Straight____ Bisexual ____ Something Else ____Don't Know ____Choose Not To Disclose____

CONSENT FOR TREATMENT AND FINANCIAL PAYMENT

Bullhook Community Health Center (BCHC) is dedicated to providing integrated medical, dental and behavioral health services to everyone. Because wellness involves both the body and mind, our multidisciplinary team of providers work together to offer you high quality whole person healthcare. In order to provide you with comprehensive and coordinated care, your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care.

Patient may be seen by advance appointment only except in emergencies. Patient shall call in advance if Patient cannot keep his/her appointment.

Information about Patient will NOT be given to anyone outside BCHC, including family and friends, unless Patient (parent or legal guardian, if a minor) gives written permission. Patient may consent to release of his/her information if Patient is age 16 or older for behavioral care and 18 or older for medical or dental care. However, we may release Patient's information to others without the Patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; 5) Patient's clinical records are requested under court order including a subpoena to which Patient does not object promptly; or 6) Patient is referred to a collection agency in order to collect on an overdue account.

There are fees for all services, and Patient should pay on the day Patient is seen. Health insurance policies may cover a portion of the fees and payment plans are available. Patient shall tell BCHC staff about changes in financial status including insurance.

The professional staff of BCHC will depend on statements made by Patient, Patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Some services at Bullhook Community Health Center may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet or saved in any way.

Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the provider nor outcomes of treatment. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. The patient accepts the risks of medication and other treatment.

I understand, that if I am 16 years of age or older, I may consent for behavioral health services; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Notice of Administrative Use of Confidential Health Care Information:

I have been informed and understand that:

1. Confidential health care information concerning me or the person for whom I am legally responsible provided or recorded in the course of receiving immunizations from this Health Facility is electronically recorded and retained in the Montana Immunization Information System – imMTrax.

2. Unless I specifically direct otherwise, the immunization information in imMTrax will be shared with all my immunization providers to help prevent both over- and under-immunization and to create a consolidated vaccine record for me or the person for whom I am legally responsible:
3. Any confidential health care information concerning me or the person for whom I am legally responsible may be used for the administration and direct provision of services that are to be provided to me or to the person for whom I am legally responsible.
4. Health Department and State health care and administrative personnel associated with the delivery of those services and the administration of the programs of services and the imMTrax data system may access the information as necessary for the provision and administration of services. Administration of services may include, but not limited to, the billing of insurers, scheduling of appointments, coordination immunizations, and facilitating enrollment in other programs; and
5. All persons who have access to this confidential information are obligated under federal and state law to protect the information from inappropriate disclosure.

I have reviewed and verify that my patient demographics in the EMR are correct.

Written Acknowledgement

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Patient Right and Responsibilities

I have been informed and understand my rights and responsibilities as a patient.

Patient's Consent to Medical, Dental or Behavioral Health Consent to Release Information

1. I hereby consent to the rendering of such care, including routine diagnostic procedures, immunizations and such medical, dental or behavioral health treatment as my physician, dentist and other clinical staff of BCHC considers being necessary. I understand that this consent covers all procedures rendered at BCHC for myself (or my child, as indicated below). I understand the BCHC practitioners, or other involved providers may electronically share clinical information with case managers as recommended, or other involved providers.
2. I understand that each patient has the right to consent or to refuse consent, to any proposed procedure or therapeutic course and shall be given the opportunity to adequately discuss all proposed procedures and treatments.
3. I understand that I am responsible for the cost of my care and that payment is expected for services provided by the professionals at BCHC.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that BCHC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

I understand if I do not wish to receive information from Bullhook Community Health Center, Inc. via email, text or voice mail I must notify Bullhook Community Health Center, Inc. in writing.

______________________________ ______________

Patient or Guardian Signature Date

______________________________ ______________

Witness Signature Date