Central Montana Family Planning Intake Form
300 1st Ave No. - Suite #202- Lewistown, MT 59457 - (406) 535-8811 - http://www.cmtfp.org

Name: **Birthdate:**

Mailing Address: Soc. Sec. #: - -

City: State: County: Zip:

Home Phone #: Work #: Cell #:

eMail:

PLEASE LIST A PERSON NOT LIVING WITH YOU IN CASE OF A MEDICAL EMERGENCY, AN UNPAID ACCOUNT, OR CALL BACKS WHEN YOU ARE NOT AVAILABLE.

Name: **Relationship:**

Address: **Phone #:**

Check all ways to be contacted: ☐Call Home ☐Call Cell ☐Text ☐Call Work ☐E-mail ☐ Facebook Message
May we contact you through the mail for statements, supplies and other correspondence: ☐ Yes ☐ No
If we need to leave a message may we say "Family Planning"? ☐ Yes ☐ No
If you are under 18 Are your parents aware of your visit? ☐ Yes: Who? _____ ☐ No

WE RECEIVE ***PARTIAL*** FUNDING FROM FEDERAL AND STATE GRANTS THAT REQUIRE US TO COLLECT INCOME INFORMATION ON ALL OF OUR CLIENTS**.**
IT IS IMPORTANT THAT YOU PROVIDE THIS INFORMATION SO THAT WE CAN KEEP OUR SERVICES AFFORDABLE FOR ALL. OUR *CONTINUED* SERVICES RELY *HEAVILY* ON ***YOUR*** **PAYMENTS** AND **DONATIONS**.
LEASE PROVIDE THE FOLLOWING FOR ALL INCOMES (YOURS, PARTNER'S, PARENTS WHO FINANCIALLY SUPPORT YOU, ETC.) **THAT SUPPORT YOUR HOUSEHOLD, INCLUDING TIPS.** PLEASE REPORT INCOME BEFORE TAXES

_____ # hours per week/ $_____hourly wage/ $_____monthly income/ $_____ yearly income (circle one)
_____ # hours per week/ $_____hourly wage/ $_____monthly income/ $_____ yearly income (circle one)
_____ # hours per week/ $_____hourly wage/ $_____monthly income/ $_____ yearly income (circle one)
********** # of people this income supports, including yourself: _____ *****

☐ I wish to pay 100% of my charges regardless of my income/insurance status
☐ I wish to be charged on a sliding fee scale based on my income
☐ **I would like to be considered for the Montana Cancer Screening Program (please complete enrollment form)**
☐ I am interested in volunteer work to satisfy any debt. Please let us know when you are available

Insurance: ☐ Medicaid ☐ Private Insurance ☐ Plan First ☐ Unknown ☐ Un-Insured
Company Name:_____ Who's name is on the card as the Subscriber: _____
Subscriber Employer: _____ What is your relationship to Subscriber: _____
Subscriber Card ID:_____ Card Group #: _____Subscriber Date of Birth: _____
Copy of card(s) on file? ☐ Yes ☐ No Subscriber Address: _____

The Federal Government **requires** the statistical information asked below.
Sex Assigned at Birth: ☐ Female ☐ Male Ethnicity: Are you Hispanic/Latino? ☐ Yes ☐ No ☐ Unknown
(Mexican, Puerto Rican, Cuban, Central or South American, or Spanish Culture or Origin)
Race: What best describes you (select all that apply)? ☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Other ☐ Asian ☐ Pacific Islander/Hawaiian ☐ Unknown
Do you have limited English proficiency (do you need a translator)? ☐ Yes ☐ No

- **ALL INFORMATION IS CONFIDENTIAL** and will not be released without your permission. We are mandatory reporters and the law requires us t report all suspected child abuse or neglect, and positive results for some sexually transmitted infections for all aged persons. Your personal information m also be disclosed pursuant to legal subpoenas; and with medical or law enforcement officials if your life is in danger; or in making a referral to another se provider. (INITIALS) _____
- I hereby voluntarily request, understand, and consent to Central Montana Family Planning services which include but are not limited to: Examinations, lab work, treatment, and vaccinations (includes data entry and communication of vaccinations both current and historical with the Web-ba Immunization Registry Database), from Central Montana Family Planning. (INITIALS) _____
- I am aware of the location of emergency services in Lewistown: CMMC 408 Wendell Ave. 406.535.7711. (INITIALS)_____
- I understand that I will be counseled on the importance for further evaluation and follow-up if/when needed, and that it is my responsibility to comply with the referral(s). I authorize the release of additional information necessary for the referral to the referring provider and for that provider to release records of that referral and corresponding appointments (when applicable) to Central Montana Family Planning for Continuity of Care (per HIPA (INITIALS) _____
- I am aware that receipt of family planning services is not a prerequisite to receive any other services offered by the service site. (INITIALS) _____
- I hereby certify that all of the information given is correct. I accept financial responsibility for any debts incurred and authorize the release of any medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Central Montana Family Planning. (INITIALS)_____

Signature: _____(valid for 12 months) Date: _____
Staff Signature: _____ Date: _____ MCSP X3 X19 _____%
Plan First eligibility dates: _____ NON TX _____%

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REQUEST FOR MEDICAL SERVICES
&
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

NAME: _____ DOB: _____ PATIENT #:_____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written of spoken information given during my healthcare visits.

I have been given information about the test(s), treatment(s), procedure(s), contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Central Montana Family Planning.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Central Montana Family Planning's *Notice of Health Information Privacy Practices (HIPAA)*. I consent to the use and disclosure of my health information as described in the *Notice of Health Information Privacy Practices*.

For Title X Patients receiving contraceptive services on a sliding fee scale without an exam:
I understand that I can receive 3 months of hormonal contraceptives and defer having a physical exam based on information I provide about my medical history, family history, blood pressure, and weight. I agree to request records of an exam done in the last 12 months (breast, pelvic, and Pap smear) or will schedule to have an exam at this clinic as soon as possible. Future exams must be done at this clinic to receive Title X services. I realize that postponing an exam may delay a diagnosis of an infection or condition that might exist now.

I hereby request that a person authorized by Central Montana Family Planning provide appropriate evaluation, testing, and treatment (including a birth control drug or devise, if I request it). I hereby acknowledge receipt of Central Montana Family Planning's *Notice of Health Information Privacy Practices*.

Patient Signature:_____ **(Valid for 12 months from signature) Date:** _____

I hereby witness the fact that the patient received the above-mentioned information and said s/he read and understood same and had the opportunity to ask questions.

Witness Signature:_____ **Date:** _____

☐ CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other Person Consenting: _____ Date: _____
Relationship to Patient: _____

I witness the fact that the Patient's Legal Guardian (or person consenting in her/his behalf) received the above-mentioned information and said s/he read and understood same.
Witness Signature: _____ Date: _____