Central Montana Family Planning
Patient Intake Form

300 1st Ave N, Ste 202 · Lewistown, MT 59457
P (406) 535-8811 · F (406) 535-9590

General

Patient Legal Name: _____

Patient Preferred Name (if different than legal name): _____

Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____

Mailing Address: _____ _____ _____ _____
(Street / PO Box) (City) (State) (Zip Code)

Email Address: _____

Cell Phone: (_____) _____-_____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

Check all the ways we may contact you: O Call Cell O Call Home O Call Work O Text O Email O Facebook

May we send mail for statements, supplies and other correspondence to your listed address: O Yes O No

If we need to leave a message, may we say "Family Planning": O Yes O No

If you are **under 18** years of age are your parents aware of your visit: O Yes O No O NA

If ***yes***, then who is aware? _____

In case of a medical emergency, an unpaid balance or call-backs when you are not available, please list a person ***not*** living with you:

Name: _____

Relationship to you: _____

Phone #: (_____) _____-_____

Statistical

The Federal Government requires the information asked below:

Sex assigned at birth: O Male O Female

Identify as: O Man O Non-binary O Woman O Prefer to describe: _____

Personal Gender Pronouns, please check all that apply: O He/Him O She/Her O They/Them

Are you Hispanic / Latino (defined as Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin):

O Yes O No O Unknown

Please check all that best describes your race: O White O Black American O American Indian / Alaskan Native O Asian

O Pacific Islander / Native Hawaiian O Other / Unknown

Do you have limited English proficiency and need a translator: O Yes O No

Consents

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.

Central Montana Family Planning complies with applicable Federal civil rights laws and does not discriminate based on my religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, marital status or ability to pay. 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 or spoken information given during my healthcare visits.

Patient initials: _____

I understand that my medical services and records will receive confidential treatment. My medical records can be disclosed to others only with my written consent, or as otherwise required by law such as suspicion of child abuse and neglect or reportable communicable disease like some sexually transmitted infections. If my insurance is billed for my visit, some health information could be shared with the insurance policy holder. I can request that my insurance not be billed for certain services or visits if I am concerned about the policy holder learning that I received services.

Patient initials: _____

I understand that receiving sexual and reproductive health services is voluntary. I can change my mind about receiving these services at any time. I know that I do not need to accept these services to receive any other services or assistance.

Patient initials: _____

My signature on this form indicates that I have received or been offered a copy of the Notice of Privacy Practices. I understand that I may request a copy of the Privacy Notice at any time.

Patient initials: _____

I am aware of the location of emergency services in Lewistown being Central Montana Medical Center - 408 Wendell Ave · (406) 535-7711

Patient 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 HIPAA).

Patient initials: _____

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.

Patient initials: _____

Billing

Central Montana Family Planning receives 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 may keep our services affordable for all. Our continued services rely heavily on your payments and donations.

Do your parents support you financially for your visits with our program: ○ Yes ○ No

If ***yes***, please complete their income information. If **no**, we *only* need your income information completed below.

Parent Gross Monthly Income $_____ **or** Parent Gross Yearly Income $_____

Your current income:

Total hours per week _____ at $_____ per hour **or** salary per year before taxes $_____

If you have a 2nd job:

Total hours per week _____ at $_____ per hour **or** salary per year before taxes $_____

If you live with a partner or spouse, please include their income as well:

Total hours per week _____ at $_____ per hour **or** salary per year before taxes $_____

If they have a 2nd job:

Total hours per week _____ at $_____ per hour **or** salary per year before taxes $_____

Please include any other forms of income:

Parental support per month $_____

Tips or commission per week $_____

Grants, stipends or scholarships per month $_____

Trust accounts per month $_____

Unemployment or disability per month $_____

Child support or alimony per month $_____

Rental income that you receive per month $_____

Other per month $_____

Number of household members this income supports, including yourself: ☐

Office Use: $_____/_____ = _____% sliding fee

I would like to be considered for the Montana Cancer Screening Program which, depending on my eligibility, may provide financial assistance for breast and cervical cancer screenings and diagnostic testing: O Yes O No

Are you interested in volunteer work to satisfy any debt: O Yes O No

Are you covered by your own or someone else's insurance (this includes Medicaid): O Yes O No

If ***yes***, please provide the following information:

Insurance Company: _____

Subscriber Card ID: _____

Card Group #: _____ Deductible Amount: $_____

Name listed on the insurance card as the subscriber: _____

Your relationship to the subscriber: O Self O Spouse O Child O Other: _____

Subscriber Address: _____ _____ _____ _____

(Street / PO Box) (City) (State) (Zip Code)

Subscriber Date of Birth: _____/_____/_____

Out of concern for your privacy, we are able to offer enhanced confidentiality and **not all of your visits need to be billed** to yours or your parent's insurance.

Is the provided insurance billable in full: O Yes O No

If ***no***, be sure to advise us of your desire for billing certain visits, otherwise we will bill every visit.

I hereby certify that all of the information given is correct.

Patient Signature: _____ Date: _____/_____/_____

Staff Signature: _____ Date: _____/_____/_____