PUREVIEW Health Center

Printed *Patient* Name ____ **Date of Birth** ___/___/_____

PureView Health Center Consent for Treatment

I hereby give my consent and authorize PureView Health Center to treat any medical, dental, or mental health condition providing that the care provider has explained my condition.

I authorize the care provider to perform any additional or different treatment, which is thought necessary, should a condition be discovered during treatment that was not known previously.

I have carefully read and fully understand the PureView Health Center Consent for Treatment and all my questions have been adequately answered.

Treatment, Payment, Data Agreement and Communications

- I authorize examination and treatment for this and all following medical, dental, mental health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible to ask for confirmation of payment via receipt.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that PureView Health Center may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I authorize my insurance benefits be paid directly to PureView Health Center, I also authorize PureView or Insurance company to release any information required to process my claims.
- I authorize PureView Health Center to contact me by phone, text or email. I understand that while PureView will use reasonable safeguards to protect text and email communications, no electronic communication is guaranteed to be secure.

I certify that the provided information is true and correct. I have received a copy of PureView's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

General Information: Informed consent will be obtained from all patients accessing medical, dental, mental health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patients' condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

No Show (Missed Appointment) Policy

PureView Health Center adopted a No-Show (missed appointment) Policy in March of 2016. This means any appointment that a patient does not attend and did not call the office to cancel or reschedule within an appropriate amount of time has no showed an appointment. Please be advised that we require at least 24 hours of notice for any appointments that a patient is not able to keep. A call less than 24 hours prior to an appointment will be considered a NO SHOW, unless an emergency or health issue is involved. Arriving more than 10 minutes late for an appointment will result in a No Show.

- **MEDICAL**: If a patient No Shows (2) two appointments within a 12-month period, patients can only use walk-ins/same day for a (3) three month period.
- **DENTAL:** If a patient No Shows (2) two appointments within a 12-month period, patients can only use walk-ins/same day for a (3) three month period. Future appointments will be cancelled.
- **MENTAL HEALTH:** If a patient misses (3) three or more appointments in a (6) six-month period, patients can only use walk-ins/same day for a (3) three month period.

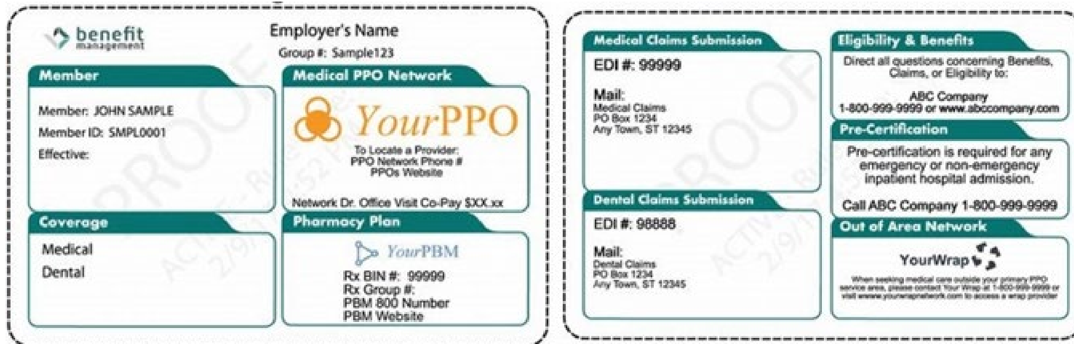
By signing below, the patient is stating that they have read and understand the *PureView Health Center Consent for Treatment, Treatment, Payment, Data Agreement and Communications and No-Show (Missed Appointment) Policy* as above.

Signature ____________________________ **Printed Name** ______________________ **Date** _______________

(Patient or Guardian if under 18)

PUREVIEW | Health Center

Please provide a picture/copy of the front and back of *ALL* insurance cards to be turned in with paperwork.



If the patient has Medicaid please make sure their Social Security Number is on the Intake form.

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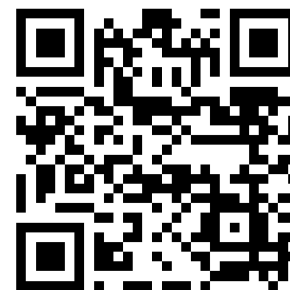
Today's Date____________________________

Legal Name Last	First	Middle Initial	**Preferred Name**
Legal Sex (please check one) O Female O Male *While PureView recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*		**Insurance Information** Primary Medical Insurance: ________ Secondary Insurance: ________ Tertiary Insurance: ________	
Date of Birth Month / Day / Year	**Social Security #**	Dental Insurance Only: O Yes ________ O I do not have Insurance. ***(Free insurance enrollment services available.)***	

If this is not included with your paperwork the guardian will be billed directly for all services.

This can be emailed to:

FrontDesk@PureViewHealthcenter.org



*Please note: PureView will use reasonable safeguards to protect email communications, no electronic communication is guaranteed to be secure.

PureView Health Center

Today's Date________________________

Legal Name Last	First	Middle Initial	**Preferred Name**

Legal Sex (please check one) Female Male

While PureView recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.

Insurance Information

Primary Medical Insurance: ________________________________

Secondary Insurance: ________________________________

Tertiary Insurance: ________________________________

Dental Insurance Only: Yes ________________________________

I do not have Insurance. ***(Free insurance enrollment services available.)***

Date of Birth Month Day Year	**Social Security #**

Home Phone	**Cell Phone**	**Work Phone**	**Best number to use:**
( )	( )	( )	Home
Okay to leave voice mail?	Okay to leave voice mail?	Okay to leave voice mail?	Cell
Yes No	Yes No	Yes No	Work

Address	**City**	**State**	**Zip**

Billing Address (if different from above)	**City**	**State**	**Zip**

Are You Homeless? Yes No **If yes select one:** **Shelter** **Transitional** **RV/Tent** **Doubling-Up** **Street** **Other** __________

Preferred Pharmacy (Low-cost prescriptions available at both Helena PureView Pharmacies)
Main Clinic Downtown Clinic Other (Please List) ____________________

Do you want to sign up for the patient portal? (*A secure web program to communicate with your care team. Email address required below.)* Yes No Already Signed Up

Email Address: None Choose not to share

Are You a Veteran? Yes No **Occupation/Employer:**

Emergency Contact Name:	**Phone #**	**Relationship to You:**

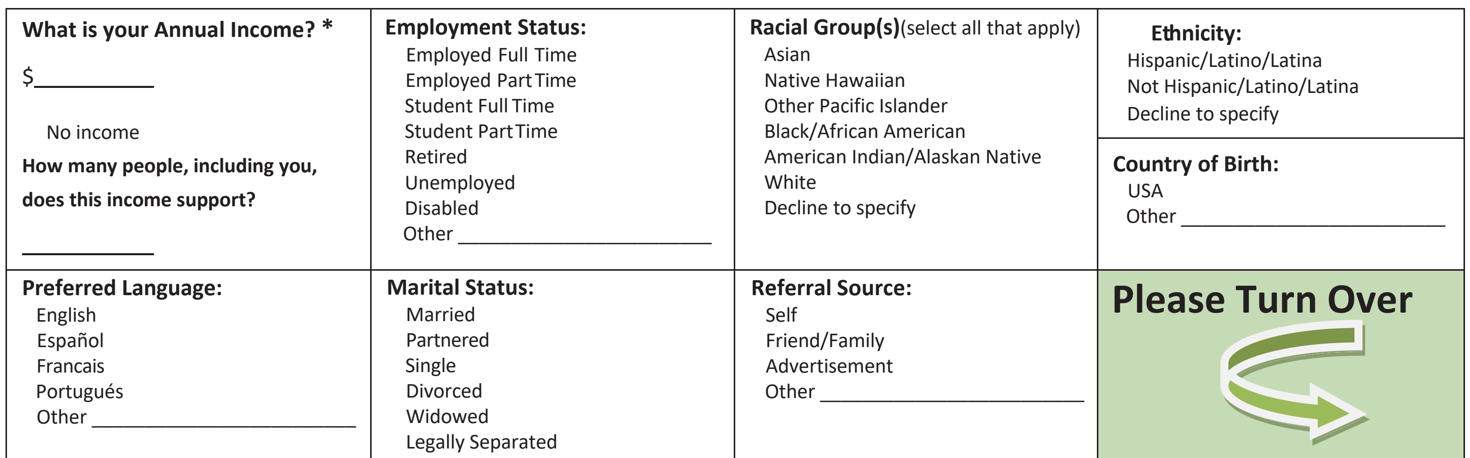
If you are under the age of 18 we require that you provide parent/guardian contact information

Parent/Guardian Name:	**Phone #**	**Relationship to You:**

PureView Health Center may send certain lab and diagnostic imaging results.

How would you like to receive this correspondence? Secure Patient Portal (Must be signed up.) Letter Other

PureView Health Center is federally funded. The personal information you provide in the section below is to be compliant with federal regulations. We are **required** to collect the following information from our patients. This will not impact the care you receive.



What is your Annual Income? *	**Employment Status:**	**Racial Group(s)**(select all that apply)	**Ethnicity:**
$__________	Employed Full Time	Asian	Hispanic/Latino/Latina
No income	Employed Part Time	Native Hawaiian	Not Hispanic/Latino/Latina
How many people, including you, does this income support?	Student Full Time	Other Pacific Islander	Decline to specify
__________	Student Part Time	Black/African American	**Country of Birth:**
	Retired	American Indian/Alaskan Native	USA
	Unemployed	White	Other ______________
	Disabled	Decline to specify	
	Other ______________		

Preferred Language:	**Marital Status:**	**Referral Source:**	**Please Turn Over**
English	Married	Self	
Español	Partnered	Friend/Family	
Francais	Single	Advertisement	
Portugués	Divorced	Other ______________	
Other ______________	Widowed		
	Legally Separated		

*PureView Health Center offers a Sliding Fee Discount. Based only on household size and income, you may qualify. Anyone can apply, even if you have insurance. Please speak with the scheduling staff or call the Billing Office at 406.457.0000 to learn more.

NO ONE WILL BE DENIED CARE DUE TO AN INABILITY TO PAY

PureView Health Center

PureView Health Center is federally funded. The personal information you provide in the section below is to be compliant with federal regulations. We are **required** to collect the following information from our patients. This will not impact the care you receive.

Do you think of yourself as:	What was your sex at birth?:	Gender Identity:
Lesbian or Gay Straight (not lesbian or gay) Bisexual Something else Don’t know Choose not to disclose	Female Male	Female Male Transgender Male/ Female-to-Male Transgender Female/ Male-to-Female Other Choose not to disclose

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1930 9th Ave, Helena, MT 59601 | 406.457.0000 | PureViewHealthCenter.org

AUTHORIZATION FOR RELEASE, DISCLOSURE, AND EXCHANGE OF INFORMATION

Name of Student: ____ DOB: ___________________

Address (city/state/zip): ____ Phone: _________________

Name of Parent/Legal Guardian: ____

I hereby request, consent to, and authorize the mutual disclosure and exchange of information and records concerning the above-named student by and between PUREVIEW HEALTH CENTER and the HELENA SCHOOL DISTRICT, 1325 POPLAR ST, HELENA, MONTANA 59601.

If applicable, I, additionally, request, consent to, and authorize the mutual disclosure and exchange of information and records concerning the above-named student by and between PureView Health Center and the organizations that I have placed my initials next to below:

Parent Signature	Organization

The purpose for the disclosure and exchange of information is to facilitate the delivery of services, including care coordination and case management. Please note that information will only be shared on an as-needed basis.

THE INFORMATION THAT I HEREBY AUTHORIZE FOR RELEASE AND EXCHANGE IS AS FOLLOWS (Please place your initials next to the types of information that you ARE AUTHORIZING for release / exchange):

_____ Education _____ Drug/Alcohol Info/Treatment ______Medical Care

_____ Psychiatric/Behavioral Health _____ AIDS/HIV/STD _____ All

_____ Other Client Information: ____

My consent and authorization to this mutual disclosure and exchange of information and records is being granted with the following understandings on my part:

- That this consent and authorization is not valid without the required signature below;
- That my consent and authorization is being provided voluntarily, and that it will expire no later than **one year** from the date below unless I revoke it in writing prior to that time;
- That I have the right to revoke this authorization at any time in writing, except to the extent that information may have already been disclosed pursuant to this consent and authorization;
- That I have the right to request a copy of this form after I sign it, and may have the right to inspect or copy any information shared or disclosed in accordance with this consent and authorization to the extent allowed for by state and federal law;
- That I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from at least certain of the providers outlined above. I also understand, however, that there may be consequences attendant to

a decision on my part to not authorize the disclosure and sharing of information, i.e., that at least some of the organizations listed above may not be able to effectively provide services without it;

- That some of the information shared between the organizations listed above may be subject to various state and federal privacy laws, including but not limited to HIPAA, FERPA and/or the alcohol and drug abuse privacy regulations (42 C.F.R. Part 2), and that all of the organizations listed above agree to comply with those regulations to the extent they apply to their respective activities, including but not limited to any restrictions or allowances for the any further disclosure of information shared or provided to them in accordance with this consent and authorization;
- That when certain types of my information are used or disclosed pursuant to this authorization, they may be subject to re-disclosure by the recipient to others without my knowledge or further authorization, in which event applicable privacy laws may no longer protect my information;
- That, to the extent I am authorizing the disclosure of information above that specifically relates to alcohol or drug abuse, the entities to whom such disclosure and sharing has been authorized above ARE PROHIBITED from making any further disclosure of that information to any person or entity outside the group identified above, unless otherwise authorized permitted by 42 C.F.R. Part 2 or they receive express written consent for such further disclosure;

____ Date: ____________________

Parent/Legal Guardian /Student[1] Signature

Please check applicable box if signing on behalf of patient and provide a copy of authorizing document for items marked below with an asterisk (*)

□ Parent of minor child □ Legal Guardian* □ Power of Attorney* □ Other Personal Representative*

REVOCATION OF AUTHORIZATION / CONSENT

I hereby REVOKE the foregoing Authorization and Consent to Disclosure and Exchange of Information in its entirety.

____ *Date:* ____________________

Parent/Legal Guardian/Student[1] Signature

[1] Minors are authorized by Montana law (§ 41-1-401, et seq., MCA) to both (1) consent to the provision of health care services and (2) control access to protected health care information under certain limited circumstances (i.e., pregnancy, sexually transmitted disease, or substance and alcohol abuse). Any utilization of this form based on the signature of a minor student should be carefully reviewed by the agency to ensure such circumstances are applicable.