PUREVIEW Health Center

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.

Date of Birth Month Day Year / /

Social Security #

Insurance Information

Primary Medical Insurance: ______________________________

Secondary Insurance: ______________________________

Tertiary Insurance: ______________________________

Dental Insurance Only: O Yes ______________________________

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

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

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

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

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

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

Email Address: O None O Choose not to share

Are You a Veteran? O Yes O 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? O Secure Patient Portal (Must be signed up.) O Letter O 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:**
$__________ O No income **How many people, including you, does this income support?** __________	O Employed Full Time O Employed Part Time O Student Full Time O Student Part Time O Retired O Unemployed O Disabled O Other ____________________	O Asian O Native Hawaiian O Other Pacific Islander O Black/African American O American Indian/Alaskan Native O White O Decline to specify	O Hispanic/Latino/Latina O Not Hispanic/Latino/Latina O Decline to specify **Country of Birth:** O USA O Other ____________________
Preferred Language: O English O Español O Francais O Portugués O Other ____________________	**Marital Status:** O Married O Partnered O Single O Divorced O Widowed O Legally Separated	**Referral Source:** O Self O Friend/Family O Advertisement O Other ____________________	**Please Turn Over**

*PureView Health Center offers Sliding Fee Discounts. 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 406.500.2113 to learn more.

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

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 and Data Agreement

- 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 for obtaining a receipt for all payments I make in person at any PureView Health Center location.
- 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 certify that the above 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 (1) one appointment, it will result in all pending appointments being cancelled and patients can only use the Dental Walk In clinic for (1) one year.
- **MENTAL HEALTH:** If a patient misses 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 and Data Agreement and No-Show (Missed Appointment) Policy* as above.

Signature ______________________________ **Printed Name** __________________________ **Date** ____/____/____

PureView Health Center

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

Date of Birth	Month Day Year / /

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

Please give to your medical, dental or mental health team when complete.