Helena Indian Alliance / Leo Pocha Memorial Clinic

501 Euclid Avenue, Helena, MT 59601 • (406) 442-9244 • hia-mt.org

RPMS #

PATIENT REGISTRATION FORM

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Patient's Legal Name _____
Last *First* *Full middle name*

Sex: M / F Social Security Number_____ Marital Status _____

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

Date of Birth _____ City & State of birth _____ When did you move here? _____

Phone ( ) _____ ( ) _____ ( ) _____
Home/Cell *Work* *Cell/Message*

Employer_____ Email: _____

Fathers Name _____ Mother's Maiden Name _____
Last *First* *Last* *First*

IF PATIENT's legal guardian is not a parent

Guardian: _____ *Relationship to Patient:* _____

Do you have a court order for treatment? Yes _____ No _____

Where do you receive medical care? Name: _____

Do you see a mental health professional? Name: _____

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a **copy** of your membership documentation. **Tribe**_____ **Enrollment no.**_____

Emergency Contact/Next of Kin

Name _____ Phone _____

Address _____ Relationship to patient _____

As a Federally Qualified Health Center and to keep our services affordable, we receive grant funding. To qualify for these resources, we must collect the following information on all our clients. Please support us by answering all these questions.

(Please check)

Gender Identity

[ ] Identifies as Male [ ] Identifies as Female [ ] Nonconforming Gender
[ ] Transgender Male [ ] Transgender Female [ ] Do not know
[ ] Declined to Answer [ ] Other _____

Do you have a preferred name you would like to use? Yes / No

Preferred name: _____

Sexual Orientation

[ ] Straight/Heterosexual [ ] Bisexual [ ] Lesbian/Gay/Homosexual
[ ] Do Not Know [ ] Something Else [ ] Declined to Answer

Financial Responsibility

Do you have Health Insurance? (Please circle) Yes / No

Medical_____Dental_____Vision_____ or Medicare_____ Medicaid _____

If you are a dependent on someone else's insurance we will need the following to verify eligibility and to bill the insurance

_____ _____ _____
Insurance Card Holders Full Name Date of Birth Sex

Be sure to provide insurance card(s) so we may make a photocopy.

>Are you a US Veteran? Yes / No >Do you have VA benefits? Yes / No - Branch _____ Discharge Date _____

>Do you have an Advance Directive? Yes / No - If YES, is it in the form of a "**Living Will**" or "**Power of Attorney**"?
(Please circle)

Indicate your ethnicity

[ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Unknown

Indicate your race(s)

[ ] American Indian/Alaska Native [ ] Asian [ ] Black or African American
[ ] Hispanic or Latino [ ] Filipino [ ] Native Hawaiian or Pacific Islander
[ ] White [ ] Other _____

What is your primary language (the language you speak at home)? _____

What other languages do you speak? _____

What is your preferred language? _____ Do you need an interpreter?_____

What is your religious preference? _____

Are you a migrant agricultural worker? Yes / No Are you a seasonal agricultural worker? Yes / No

Are you currently homeless? Yes / No
If yes, please indicate if you are staying in a shelter? _____ In a transitional living arrangement? _____
Doubling Up? _____ Living on the street? ____

Do you have access to the Internet? YES / NO *Where:* Home / Work / School / Clinic / Library / Community Center

Income Information

Number in Family _____Monthly/Hourly Income $_____ or Annual Income $_____

I HEARBY AUTHORIZE TREATMENT: Release of Information/Assignment of Benefits HELENA INDIAN ALLIANCE has my permission to release information for insurance processing and inform my insurance to release payment to HELENA INDIAN ALLIANCE.

Signature of
PATIENT, PARENT OR GUARDIAN

Printed
Name & Date

_____ _____

Present: Photo ID, Native Documentation, & Insurance Card(s)
Please present additonal information to prove Native American descendance such as birth certificate and parents Certificate of Indian Blood/Tribal enrollment.

Date Entered in RPMS
_____

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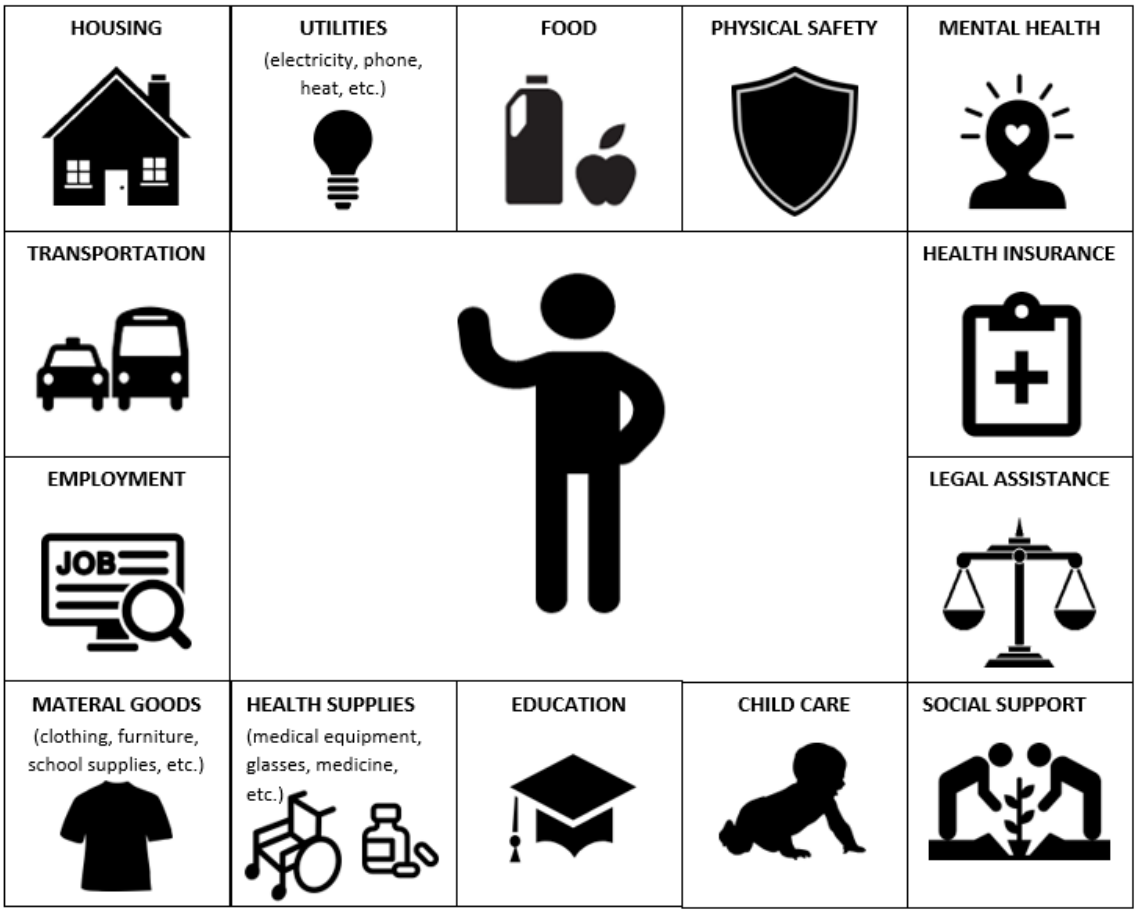
PATIENT NEEDS ASSESSMENT

Welcome to the Helena Indian Alliance. Health starts long before illness in our homes, schools, and jobs. The more we know about you the better health care we can provide. We want to support your health and wellness.

Please circle the areas you would like assistance with. **We cannot guarantee assistance in all areas**, but will do our best to respond to your priorities and put you in touch with local resources.

I am having a hard time getting access to and/or paying for: (please circle all that apply)



Would you like to be contacted by a member of our Patient Advocacy team regarding these resources?
Yes / No

Patient Name _____ Phone: _____

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NOTICE OF PRIVACY PRACTICES

Private information: The Leo Pocha Clinic provides medical services, mental health services, Licensed Addictions Counseling, immunizations, and Montana Breast and Cervical Program Coordination. The LPC has records related to the above services that include your medical information. This may include name, date of birth, contact information, identifiable number for insurance billing and services received (such as immunizations or home visit assessments). Federal Law permits this information to be shared among personnel and parties that need that information to provide these services to you. These services may include, but are not limited to, billing of insured patients, scheduling appointments, coordinating immunizations, and facilitating enrollment in other programs. This notice is to inform you of what and how information is shared. Each of the above programs above programs within the clinic has a privacy policy and you may ask to read those policies.

Where and how is information stored? All personal and medical information is securely stored in electronic form and electronically recorded and retained. Information pertaining to insurance claims is both hard copy and electronically recorded in various insurance claims filing software.

Who sees and shares my medical information? Our office sends claims to insurance companies or government programs for payment of medical, mental health and immunization services. Those claims contain all of the information about the services you were provided and information they need to process the claim, such as name, date of birth, address, social security number or other identifiable number. In the event a patient pays full for a service out of pocket, the patient now has the right to request clinic to not disclose treatment information for this service to a health plan. Immunization information is shared with all parties who have provided you or your child vaccinations to prevent too many or too few vaccinations being given and to provide for a consolidated vaccine record. We may also use your health and demographic information to contact you about appointment reminders of immunizations due or treatment options. We only share the minimum information that is needed at the time by that provider or agency.

May I see my health information? Yes, you have access to your personal records unless it's part of a legal case, or if your healthcare provider decides it would be harmful for you to see the information.

What if my health information needs to go to another location? You will be asked to sign a Release of Information Form allowing your health information to be sent to another location. This would be used if your healthcare provider provides it to another location or if you request that we send it to another individual or healthcare provider for you. This form gives the name and address that we are to send your medical information you wish to be provided.

Note: If you are under the age of 18 your parents or guardians will be required to sign a Medical Release of Information for you, unless by law, you are able to consent for your own healthcare. If you are, then it will not be shared with them unless you sign an authorization form.

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NOTICE OF PRIVACY PRACTICES

Could my information be released without my authorization? We adhere to laws that provide specific instances when medical information must be shared, even if you do not sign a Release of Information Form. We always report:

1. Communicable diseases we are required by Montana Law to report reactions and problems with medicines;
2. To the police when required by law or when the courts so order (such as abuse/neglect cases);
3. To the government for audits and reviews of our programs;
4. To a provider or insurance company to verify your enrollment in one of our programs;
5. To Workers' Compensation for work related injuries;
6. Birth, death and immunization information;
7. To the federal government if required to investigate any matter pertaining to the protection of our country, the President or other government workers.

May I have a copy of this notice? This Notice is yours. If the information changes, you will be provided a copy of the updated Notice. If you have any questions concerning this Notice, please ask the individual providing it. You may contact Leo Pocha Clinic if you have further concerns at 406-449-5796.

Hours of Operation:
8am -5pm, Monday- Thursday
8am – 4pm Fridays; Closed on all Federal Holidays

Leo Pocha Clinic - PH# 406-449-5796 Fax# 406-449-5371
Behavioral Health – PH# and Fax# 406-449-5772
Administrative Office - PH# 406-449-9244 Fax# 406-449-5797

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CONSENT TO THE USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I understand that as part of my healthcare, Helena Indian Alliance and Leo Pocha Memorial Clinic creates and maintains health records describing my health history. I understand that the Clinic may use this information as a:

1. Basis for planning my care and treatment;
2. Method of communication among many hearth professionals who contribute to my care;
3. Means by which third-party payers can verify that services billed were actually provided; and
4. Tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been made aware of Helena Indian Alliance and Leo Pocha Memorial Clinic's Notice of Privacy Practices, which provides a description of potential uses and disclosures of my health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the Clinic reserves the right to change its notice and practices. If the Clinic changes the notice, I can obtain a revised copy from the Clinic. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations.

Signature of Patient/Guardian _____ Date _____

Printed Patient Name _____

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POLICY AND PROCEDURE

CANCELLATION, NO SHOW AND LATE ARRIVAL POLICY

In order to reduce the number of cancellations, no-show and late arrivals, the following policy will be followed:

1. All appointments will be confirmed in person or by phone the day previous to the scheduled appointment or on Friday for a Monday appointment.
2. The patient will be instructed to arrive fifteen minutes early for established patients and ½ hour early for new patients. The patient will be reminded to bring insurance, Medicaid information and co-payment if applicable.
3. Cancellations should be made 24 hours in advance or as early as possible on the day of the appointment. Patients calling in to cancel before their appointment will be rescheduled if desired.
4. Court ordered patients who attempt to cancel the same day will be recorded as no show.
5. Patients who fail to keep a scheduled appointment without notifying the office will be recorded as and show.
6. All no-shows and cancellations shall be noted in the patient's chart.

A patient arriving more than 15 minutes late for a 1-hour scheduled appointment or more than 5 minutes late for a half-hour scheduled appointment will be given one of the following options:

1. Reschedule their appointment.
2. Wait for another opening in the schedule on a walk-in basis.

If significant mitigating circumstances are brought to light, the receptionist will notify the Clinic Manager and in collaboration with the provider will have the discretion to remove the no-show status of the missed appointment.

A patient recording two no-shows within a six-month period will not be allowed to make another scheduled appointment for six months. The patient can still be seen for care on a time available, walk in basis but must realize that scheduled patients and emergencies will take priority.

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: Date of Referral:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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HEALTH HISTORY REVIEW OF SYSTEMS & PAST HEALTH PROBLEMS

Please indicate if you have experienced any of the following health problems:

Illness:	Yes	No
Glaucoma	___	___
Cataracts	___	___
Ear Trouble	___	___
Deafness	___	___
Thyroid Trouble	___	___
Bronchitis	___	___
Emphysema	___	___
Pneumonia	___	___
Hay Fever	___	___
Asthma	___	___
Tuberculosis	___	___
High Blood Pressure	___	___
Hardening of the Arteries	___	___
Heart Murmur	___	___
High Cholesterol	___	___
Ulcer	___	___
Bowel Problems	___	___
Gallbladder	___	___
Mental Health Problems	___	___
Alcoholism/Drug Problems	___	___

	Yes	No
Hemorrhoids	___	___
Kidney or Bladder	___	___
Prostate	___	___
Headaches/Migraines	___	___
Head Injury	___	___
Stroke	___	___
Convulsions/Seizure	___	___
Arthritis	___	___
Gout	___	___
Psoriasis	___	___
Eczema	___	___
Cancer/Tumor	___	___
Bleeding Tendency	___	___
Blood Transfusion	___	___
Polio	___	___
Depression	___	___
Diabetes	___	___

If yes how long have you had Diabetes? _____

OTHER _____

_____

_____

MEDICATIONS:

_____

MEDICATION ALLERGIES:

_____

Tobacco Use _____ Alcohol Use _____ Marital Status _____

HOSPITALIZATIONS & OPERATIONS

Year	Reason	Hospital and City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Patient Signature/ Date

_____

Reviewed by Provider/ Date

Patient Name:_____
Date of Birth:_____
Chart Number:_____