

PARTNERSHIP HEALTH CENTER

PATIENT INFORMATION: (Who is being seen today)

Last Name: _____ First Name: _____ Middle Initial: _____
 Address: _____ SSN: ____/____/____ Date of Birth: ____/____/____
 _____ Sex: Male Female
 City: _____ State: _____ Zip Code: _____
 What County do you live in? _____
 Phone#: _____ Driver's License #: _____
 Marital Status: Single Single w/Partner Married Separated Divorced Widowed
 Employment Status: Full-Time Part-Time Unemployed Retired
 Employer: _____ Work Phone#: _____
 Are you a Student? Yes No (If yes: Full-Time or Part-Time)
 Are you a Veteran? Yes No Are you a Seasonal or Migrant Worker? Yes No
 Are you Homeless? Yes No If yes, for how long have you been homeless? _____
 If yes, where do you live? Street Shelter Doubling up Transition Other
 Primary Language: _____ What is your Ethnicity? Hispanic/Latino Non-Hispanic
 Which Race Group(s) do you feel you belong to? American Indian Black Hispanic/Latino Asian
 (check all that apply) White Other _____
 Relationship to Person Responsible for the bill? _____
 Emergency Contact Name and Relationship: _____
 Emergency Contact Phone#: _____
 Do you want to apply for our sliding fee discount? Yes No Family Size: _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL (if other than self):

Last Name: _____ First Name: _____ Middle Initial: _____
 SSN: ____/____/____ Date of Birth: ____/____/____ Sex: Male Female
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone#: _____ Message Phone#: _____ Can we call you? Yes No
 Employment Status: Full-Time Part-Time Unemployed Retired
 Employer: _____ Work Phone#: _____
 Do you want to apply for our sliding fee discount? Yes No Family Size: _____

PATIENT/HOUSEHOLD MEMBERS INFORMATION:

Last Name, First Name, Middle	Relationship	Birth Date	SSN	Sex	Ethnic Group	Insurance

INSURANCE COVERAGE: Must have all insurance cards front and back.		
Check all that apply: None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> HMK <input type="checkbox"/> VA <input type="checkbox"/>		
Primary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
Secondary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	

**PARTNERSHIP HEALTH CENTER
323 WEST ALDER STREET
MISSOULA, MT 59802**

AUTHORIZATION AND ASSIGNMENT

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement for Partnership Health Center (PHC).

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. Also, I authorize PHC to bill my insurance and release information to the insurance company if requested. I understand and agree to communicate to PHC all changes to my income and/or insurance status.

I understand and give consent for my information to be accessed by outside entities for the purposes of auditing the facilities compliance with federal, state and pharmaceutical program business rules.

Signed _____ Date _____

FOR PHC USE: STAFF INITIALS	DATE:	SLIDING SCALE: A B C D E NONE
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FINANCIAL STATUS WORKSHEET

VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)

Family Income	Yes	No	Amount
Wages			
Self Employment			
Unemployment			
Workers Compensation			
Retirement/Pension			
Social Security			
Disability			
Food Stamps			
Child Support			
Alimony			
Other (please indicate)			

TOTAL GROSS INCOME: _____