Acknowledgement
Notice of Privacy Practices for Patients

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Department. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

We need you to be fully informed and actively involved in your care.

By my signature below I acknowledge receipt of the Notice of Privacy Practices for Patients form.

_____

Signature of patient, client or authorized representative Date

_____

Printed name if signed on behalf of patient or client Relationship (parent, legal guardian, personal representative, etc.)

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:	**Initials:**	**Reason:**

Effective Date: 01-02-04, revised 05/22/18

imMTrax Consent Form for Children

Child's Name:_____ Sex: M___ F___ Date of Birth:_____

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Parent/Guardian Signature: _____

Date: _____

Revised 10/2017

GLACIER COMMUNITY HEALTH CENTER
New Patient Registration
Demographic Information

Patient's Name: (Last, First, MI)			**Current Doctor:**
Mailing Address:			**City, State, Zip**
Date of Birth: / /	**Age**:	**Social Security #:** _____ - ____- _____	**Marital Status** (circle one): Single / Mar / Div / Sep / Wid
Spouse Name: (Last, First, MI)		**Spouse Social Security #** _____ - ____- _____	**Spouse Date of Birth:** / /
Home phone: ( ) - OK to leave message? ☐ Yes ☐ No			**Cell phone:** ( ) - OK to leave message? ☐ Yes ☐ No
Gender (circle one): M F Trans (F to M) Trans (M to F)			**Orientation** (circle one): Straight / Lesbian/Gay / Bisexual / Other / Unknown
Race (circle one): Asian African-American Native American White More than 1 race			
Ethnicity (circle one): Hispanic Not Hispanic			**Language Preferred** (circle one): English Spanish Other_____
Have you ever been a member of the armed forces? ☐ Yes ☐ No			**Email**: ☐ **Interested in the online patient portal (check box)**
Occupation: _____ **Employer**:_____			**Work Phone:** (_____) _____ - _____ OK to leave message: Yes ☐ No ☐

If the Patient is a minor (under the age of 18) please provide information for the parent/legal guardian.
Parent/Legal Guardian Name:_____Date of Birth:_____Gender: M F

Social Security #: _____ - ____- _____ Preferred phone #: (_____) _____ - _____

☐ Parent ☐ Legal Guardian

Insurance Information:
Primary Medical Insurance: _____
Secondary Medical Insurance: _____
Dental Insurance: _____

Billing Information:
Person responsible for the bill: _____Relationship:_____
Billing address (if different): _____
Preferred Phone Number: (_____) _____ - _____

Emergency Contact:
Relative or friend not living with you that we may contact in case of emergency:
Name: _____ Relationship: _____ Phone: (___)_____

Treatment, Assignment & Release: I hereby request and authorize Glacier CHC and its providers to treat me for health problems or conditions identified in the course of assessment and evaluation. I also hereby authorize direct payment of benefits to be paid directly to the provider. I understand and agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider or insurance company to release any medical, dental or incidental information that may be necessary for either medical or dental care or in processing applications for payment benefits for services rendered.

Patient/Guardian Signature: _____ **Date**:_____

GLACIER COMMUNITY HEALTH CENTER

Patient Registration

Medical History

Name:	**Date of Birth:**	**Today's Date:**

Medicines you are taking (prescription AND non-prescription): ☐ None

Pharmacy:

Allergies/Intolerances (list the allergy and the reaction you have to each):

Surgeries (include date and where each was done):

Other providers: Do you see other health care providers for any conditions? ☐ Yes ☐ No
If yes, please list them and the reason you see each:

Illnesses: Please check beside the illness(es) that you or members of your family have had. Please include parents, siblings, grandparents, uncles and aunts. *** **F** = father's side; **M** = mother's side

You	F	M		You	F	M	
			Alcoholism				Hemorrhoids
			Anemia				Hepatitis or Liver Disease
			Arthritis				Hernia
			Asthma				High Blood Pressure
			Bleeding Disorder				Kidney or Bladder problems
			Cancer				Low Blood Pressure
			Chronic Bowel/Intestine disease				Mental Illness, Nervous Breakdown
			Lung Disease (such as COPD)				Ulcer
			Diabetes				Pneumonia or bronchitis
			Drug Abuse				Rheumatic Fever
			Depression				Sleep Apnea
			Eczema, Hives, Rashes				Stroke
			Epilepsy/Seizures				Suicide Attempt
			Eye problems/Glaucoma				Thyroid Disease
			GERD, Acid Reflux				Tuberculosis
			HIV/AIDS				Sexually Transmitted Infection
			Headaches				Whooping Cough
			Heart Attack				Croup, RSV, Influenza
			Heart Failure				Menstrual (Period) Problems
			Heart Arrhythmia				Other

Screenings with date done and where: Mammography_____ Pap_____Colonoscopy_____

Patient/Guardian Signature: _____ **Date**: _____

GLACIER COMMUNITY HEALTH CENTER

Patient Registration

SOCIAL HISTORY

"You" on this page refers to the patient, not the parent/guardian.

If the patient is under the age of 12, fill out only highlighted section.

Name:	**Date of Birth:**	**Today's Date:**
Do you use tobacco? No ☐ Yes ☐ If yes, cigarettes ☐ chew ☐ Vape ☐ How much and how often		
Have you had sex in the last 12 months? No ☐ Yes ☐ If yes, with:__ men __ women Did you use protection? No Yes		
Do you have reliable transportation? No ☐ Yes ☐		
When was your last dental cleaning and at what dental clinic?		
Do you have any hearing issues? No ☐ Yes ☐ Do you have vision problems? No ☐ Yes ☐ If yes, what		
Do you get regular exercise? No ☐ Yes ☐ If yes, How often?_____ minutes_____days per week		
Do you use caffeine? No ☐ Yes ☐ If yes, pop / coffee / energy drinks How many servings/day?		
What kind of diet do you have (examples no red meat, gluten free)?		
Do you feel physically and emotionally safe where you currently live?		
Do you believe you have been the victim of abuse, neglect or assault? No ☐ Yes ☐ If yes, which?		
Do you have emotional barriers such as anxiety or depression? No ☐ Yes ☐ If yes, what?		
Do you have pets? No ☐ Yes ☐ If yes, what kind(s)?		
Do you have a smoke detector in your home? No ☐ Yes ☐		
What do you do for work? Any hazards at your work?		
What is the highest level of education you completed?		
How do you learn best? (Check all that apply) Reading ☐ seeing drawings ☐ hearing it ☐ hands on ☐		
Do you have any religious beliefs? No ☐ Yes ☐ If yes, what?		
What country are you from? Have you traveled outside the US in the last year, if so where?		
Have you been in a Jail/Prison/Detention Center in the last year? No ☐ Yes ☐		
Do you have an advance directive or living will? No ☐ Yes ☐ If yes, please provide a copy to receptionist.		

Patient/Guardian Signature:_____ **Date**:_____

Updated 03/11/2024

GLACIER
Community Health Center

Glacier Community Health Center and Glacier Dental Clinic are federally funded government programs. This allows us to provide healthcare services to individuals regardless of their ability to pay. Because we receive federal grants, we are required to gather information on household size and income for the patients we serve.

Please note: Your personal information is confidential. It is not disclosed to anyone and is only used to develop statistics regarding our use of federal funds.

In what level does your family income fall (1 – 4)?

Find your family size on the left column, then follow that row to your amount of family income; circle that column.

PLEASE CIRCLE 1, 2, 3, OR 4 FOR INCOME OF HOUSEHOLD.

Federal Schedule of Income 2024

Family Size		1		2		3		4	
		From	To	From	To	From	To	From	To
1	Yr	$0	$15,060	$15,061	$22,590	$22,591	$30,120	$30,121	and over
2	Yr	$0	$20,440	$20,441	$30,660	$30,661	$40,880	$40,881	and over
3	Yr	$0	$25,820	$25,821	$38,730	$38,731	$51,640	$51,641	and over
4	Yr	$0	$31,200	$31,201	$46,800	$46,801	$62,400	$62,401	and over
5	Yr	$0	$36,580	$36,581	$54,870	$54,871	$73,160	$73,161	and over
6	Yr	$0	$41,960	$41,961	$62,940	$62,941	$83,920	$83,921	and over
7	Yr	$0	$47,340	$47,341	$71,010	$71,011	$94,680	$94,681	and over
8	Yr	$0	$52,720	$52,721	$79,080	$79,081	$105,440	$105,441	and over

For family units of more than 8 members, add $5,380 for each additional member.

If you circled columns 1, 2, or 3, you may be eligible for our sliding fee discount program. You can get between 20% and 100% off your health care bill, with only a $20 co-pay per visit. The next step is to complete the Financial Worksheet and provide the necessary proof of income.

Please Select Option and Sign Below:

_____ Yes, I'm interested in applying for sliding fee.

_____ No, I'm not interested in applying for sliding fee.

I realize that if I do not qualify for the sliding fee discount or choose not to apply for it, I will be responsible for making full payment. I know that I may apply for the sliding fee discount at any time I receive service.

Patient Signature:_____ Date:_____

Glacier Community Health Center / Glacier Dental Clinic
Appointment Agreement

It is important for patients to keep their appointments, because broken appointments result in lost time that could have been used to treat other patients.

Rescheduling Appointments

We understand that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call the clinic as soon as you know that you will not be able to keep the appointment, preferably at least 24 hours before the appointment time.

Broken Appointments

If you miss a scheduled appointment or cancel it less than two hours prior, a broken appointment will be recorded in your chart. If you are 15 minutes late from your designated arrival time, a broken appointment will also be recorded, and you may have to be rescheduled if there is not enough time to complete your visit. It is not fair to keep other patients waiting because someone showed up late.

If you have three broken appointments during the past six months, you will not be able to make a regular appointment for a period of six months from the date of the third broken appointment. If you require medical, dental or mental health services during those six months, you may come and wait for an open appointment.

I understand this Appointment Agreement and agree to follow the terms of the broken appointment policy.

_____

Patient Name (please print) Date

_____

Patient or Guardian Signature

GLACIER
Community Health Center

To: All Parents or Guardians of our pediatric patients

Re: Pediatric Patient Consent

In most cases, a parent or guardian must consent to medical treatment for minors in the State of Montana. Sometimes other family members or friends bring children to our center for care. We need, however, to insure your consent before we can administer care to your child.

A proxy is an adult that fills in for you if you cannot come yourself. If you want another adult to serve as proxy and bring your child in for medical, mental health, or dental care, you must let us know by filling out and signing our consent form. When you fill out this form, you are telling us who you trust to bring your child in for medical care.

Please take a few moments to fill out the form and hand it back to the front desk staff or nurse. We will scan it in your child's chart.

We can no longer see children without the appropriate adult except to treat medical emergencies.

GLACIER COMMUNITY HEALTH CENTER / GLACIER DENTAL CLINIC

Authorization to Consent to Routine and Emergency Treatment of My Minor Child

Child's Name_____ **DOB:**_____

____I give my child permission to schedule his/her own appointment.
- ____Medical
- ____Mental Health
- ____Dental

____I do not give permission for my child to schedule his/her own appointment.

____I give permission for my child to come alone for routine care.
Phone # at which I can be reached during appt: _____

____Child does not have permission to come alone.

PROXY DECISION MAKER

I hereby authorize and grant permission to the following persons ("Proxy Decision Makers") to make decisions about and consent to the provision of routine care and acute treatment by Glacier Community Health Center to my minor child.

The following person(s) are allowed to make basic decisions about routine and acute treatment by Glacier CHC for my child:

Name	Address	Phone	Relationship to Child	Access to Medical Record
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N

The Proxy Decision Maker shall only be acknowledged and accepted by Glacier Community Health Center upon production of appropriate photo identification, such as a driver's license.

I hereby fully and irrevocably release and discharge Glacier Community Health Center from liability for all appropriate medical care provided to my minor child based upon reliance on this Authorization.

I understand that I may revoke this Authorization, in writing, at any time.

CONTACT INFORMATION

If the nature of the medical, mental health, or dental care to be provided to my child is *not routine or acute care but is emergent and requires immediate medical attention*, please provide such care and then contact me regarding the emergent treatment at the following telephone numbers. If I am unable to be reached, Glacier Community Health Center may rely on the person(s) noted above to consent to all care for my minor child.

Parent's Name:_____

Phone: _____(daytime)_____(evening) _____(cell)

IN WITNESS WHEREOF, the undersigned has executed this Authorization as of _____.
(date)

_____
Signature of Parent or Legal Guardian of Minor

Patient Support Questionnaire

Patient Name:_____ Date: _____

What is the best way to contact you? Phone_____ Email_____

Health starts in our homes, schools, and jobs. When we know more about you, we can provide better care to support your health and wellness. **Please put a check mark in the box next to the areas with which you would like more information and/or assistance.** GCHC staff can use this information to assist with connecting our patients with resources which may be of assistance in your quality of life. *We cannot guarantee help in all areas, but will do our best to respond to your priorities.*

- ☐ Available Housing
- ☐ Social Support
- ☐ Transportation
- ☐ Medication Costs
- ☐ Employment
- ☐ Health Insurance
- ☐ Material Needs (clothes, glasses, diapers, furniture, etc.)
- ☐ Medical, Dental or Behavioral Health Appts
- ☐ Education
- ☐ Food Supply
- ☐ Childcare
- ☐ Utilities
- ☐ Home Care
- ☐ Stress

GCHC Authorization to RELEASE INFORMATION

GLACIER Community Health Center

Authorization for access to the records of:

Name Last	First	Middle	Date of Birth

PATIENT ID NUMBER	SS# / OTHER ID NUMBER	FORMER NAMES	LOCATION OF SERVICE

Request information FROM / TO (please circle one):

Dr. or Clinic Name:	Phone Number:	Fax Number

ADDRESS	CITY	STATE	ZIP CODE

FROM / TO (please circle one):

ORGANIZATION OR AFFILIATION

GLACIER COMMUNITY HEALTH CENTER, INC.

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	
(406) 873-5670	**(406) 873-5675**	

ADDRESS	CITY	STATE	ZIP CODE
519 E. Main St.	**Cut Bank**	**MT**	**59427**

REASON FOR RELEASE

AUTHORIZATION FOR RELEASE:

I authorize the following release of information from my records. I understand that information may be provided orally, by mail, fax, or hand delivery. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Check all that apply:

- ☐ Medical Record
- ☐ Progress and treatment notes
- ☐ X-ray and/or Imaging Reports
- ☐ Laboratory Results
- ☐ Billing Statements
- ☐ Pathology Reports
- ☐ Prescriptions (Pharmacy records)
- ☐ Other

All records from this Date:_____

To this Date:_____

I give my permission to release the following records (Initial all that apply):

_____HIV/AIDS and STD test results, diagnosis or treatment records MCA 50-16-1000
_____Genetic testing information
_____Mental health records
_____Chemical Dependency (CD) records (42 CFR Part 2)

I understand that all health care information, whether generated by you or by any other source may be released to me or to the designated person above for the purpose given. I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. This consent is valid for ninety (90) days or upon expiration date stated in the authorization, whichever is earlier. A copy of this form is valid to give my permission to release records. MCA 50-16-531 GCHC may charge to provide copies of its records. MCA-50-16-816

PRINT NAME	DATE SIGNED	TELEPHONE NUMBER (INCLUDING AREA CODE)

AUTHORIZED BY (SIGNATURE)

If I am not the person whose records are being released. I am authorized to sign because I am the:

- ❑ Parent
- ❑ Legal Guardian (attach copy of court order)
- ❑ Other

To those receiving information under this authorization: Federal and state laws and regulations protect the information disclosed to you. You may not release it to any other person or entity without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.