Patient Name: XXXXXX
HAR: XXXXXX Age: XXXXXX Sex: XXXXX
MRN: XXXX Birth: XXXX

Conditions of Treatment

1. Medical Consent: I hereby consent to the provisions of health care services, including tests and treatments, such as X-rays, exams, immunizations, administration of drugs, behavioral health consultation, lab tests (including HIV), and other services at Community Health Partners, Inc. (CHP) as directed by my provider. I have the right to discuss all treatments with my provider and to refuse any procedure or treatment.
2. Information Privacy: I acknowledge receipt of the CHP Notice of Privacy Practices. I will refer to the CHP Notice of Privacy Practices regarding the release of my health information.
3. 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 childcare 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.
4. This document does not expire unless revoked by the patient. Patients have the right to revoke their consent to treatment or release of information by stating this expectation to staff in writing.
5. Insurance Disclosure: I understand that it is my responsibility to notify my insurance company directly within the time limits of my policy if I am treated at CHP or for pre-authorization of special procedures and/or tests. CHP may submit a separate charge for behavioral health consultation services provided as part of your medical visit.
6. Financial Agreement: I hereby assume full responsibility for charges I incur for services provided by CHP and I agree to pay said charges in full. I have given my insurance information, if any, to CHP. I hereby authorize CHP to bill my insurance carrier on my behalf. I also authorize my insurance carrier to make payments of any benefits I may be entitled to directly to CHP for services rendered. It is my understanding that I will be responsible for any balance not paid by this insurance. If I, or my guarantor, choose not to bill my insurance, I will notify CHP of this at the time of my visit and my visit will be considered self-pay. If I am unable to pay in full, I will contact CHPs Billing Department at (406) 832-6304 to discuss a payment plan to make monthly payments on my account. It is further understood that if I do not pay my account in full or make regular monthly payments on my account, my account may be referred to a collection agency. _____ (Guarantor Initials)
7. Personal Valuables: I understand that CHP shall not be liable for personal items left in our facilities.
8. Teaching Purposes: CHP is a clinical training site. I understand that care may be provided to me by students performing under the supervision of CHP medical staff.
9. All Community Health Partners sites are smoke free. Thank you for not smoking.

I certify that I have read the above information and as the patient, or one who is duly authorized to act in a representative capacity for the patient, that the information has been fully explained, that I understand its content, that it may not be modified and that I may withdraw my consent for services at any time.

Patient/Guarantor Signature: _____ Date: _____

Relationship to Patient: _____

Reason Patient Unable to Sign: _____

Witness: _____ Time: _____ Date: _____

SCAN: Registration/Documents Table
CHP Consent to Treatment

chp COMMUNITY HEALTH PARTNERS

New Patient Information: Welcome!
Please complete all information on both sides of this form.

Appointment Date: _____

Patient's Legal Name:_____

Preferred Name: _____ **Social Security Number:**_____

Gender on Birth Certificate: □ Male □ Female **Date of Birth**:_____
Month/Day/Year

Other names you have used: _____

Legal guardian (if under age 18):_____

Mailing Address _____
Address or P.O. Box **City** **State** **Zip**

Phone _____ **Email** _____

Marital Status:_____ **Preferred Language:**_____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unavailable/Unknown

Country of Origin (In what country were you born?): _____

Race (check all that apply)
□ African-American □ Asian □ Pacific Islander □ White □ Native Hawaiian □ Unknown
□ American Indian/Alaska Native □ Declined

If Employed, Employer: _____ **Employment Status:** □ Full time □ Part time

In the past two years, have you: 1. Moved to a new location to do farm or ranch work? □ Yes □ No
2. Done farm or ranch work on a seasonal basis? □ Yes □ No

In the past year have you lived in a shelter, halfway house, in your vehicle or on the street, or temporarily lived with family or friends? □ Yes □ No

Are you a Veteran? □ Yes □ No

Sexual Orientation:
□ Lesbian, gay or homosexual
□ Straight or heterosexual
□ Bisexual □ Something Else
□ Don't Know □ Choose not to disclose

Gender Identity:
□ Male □ Female □ Other
□ Transgender Male: Female-to-Male
□ Transgender Female: Male to Female
□ Choose not to disclose

Emergency Contact: _____ **Phone Number:** _____

Emergency Contact's Relationship to you: _____

OVER ➡

BusOfficeDoc

SCAN:
Doc Type: Business Office Doc
Doc Desc: CHP Patient Info
E Label

Who is responsible for today's charges? (Adult 18 or older) □ Self □ Other (Family member or employer?)

Only complete this information for the responsible party if you checked "Other" above:

Name: _____ Relationship to you:_____

Address: _____

Social Security #_____Phone: (H) _____ (W) _____

Date of Birth _____ Employer _____
Month/Day/Year

□ **I would like to apply for the CHP sliding scale discount today.**

Do you have insurance that can help pay for today's visit? (Please check ALL that apply)

□ Private Insurance □ Medicaid □ Medicare □ Healthy Montana Kids
□ Workers' Comp □ Auto Coverage

Policy Holder Name: _____ Policy Holder's Birth Date: _____
Month/Day/Year

Insurance Company:_____ Insurance ID Number _____

Policy Holder Address: _____

Please provide your insurance card with this form. If you don't have your insurance card with you today, please bring it in as soon as possible or you will receive a bill for the full charge.

Community Health Partners receives some federal funding. Therefore, we are required to ask the following questions. All information will be kept strictly confidential. This information will be requested one (1) time a year if you are not on a sliding fee discount with us.

What is your annual income?

Family Size	Income Range	Income Range	Income Range	Income Range
1	❑ $0 to $13,590	❑ $13,591 to $20,385	❑ $20,386 to $27,180	❑ $27,181 and over
2	❑ $0 to $18,310	❑ $18,311 to $27,465	❑ $27,466 to $36,620	❑ $36,621 and over
3	❑ $0 to $23,030	❑ $23,031 to $34,545	❑ $34,546 to $46,060	❑ $46,061 and over
4	❑ $0 to $27,750	❑ $27,751 to $41,625	❑ $41,626 to $55,500	❑ $55,501 and over
5	❑ $0 to $32,470	❑ $32,471to $48,705	❑ $48,706 to $64,940	❑ $64,941 and over
6	❑ $0 to $37,190	❑ $37,191 to $55,785	❑ $55,786 to $74,380	❑ $74,381 and over
7	❑ $0 to $41,910	❑ $41,911 to $62,865	❑ $62,866 to $83,820	❑ $83,821 and over
8	❑ $0 to $46,630	❑ $46,631 to $69,945	❑ $69,946 to $93,260	❑ $93,261 and over
9+	How many people are in your household? _____ What is the combined annual income for all members of your household $_____?			
❑ I choose **not** to provide my family income information.				

Signature _____ Today's Date _____

For Office Use Only
Slide Status: Active □ Date Expired _____
Patient Declined Slide □ Will Return Ppwk by: _____
Entered by_____ Date_____
Double Check _____ Date _____

SCAN:
Doc Type: Business Office Doc
Doc Desc: CHP Patient Info
E Label

BusOfficeDoc

BusOfficeDoc

CHP COMMUNITY HEALTH PARTNERS
REAL PEOPLE. REMARKABLE HEALTHCARE.

112 W Lewis St, Livingston, MT 59047

Sliding Fee (Discount) Eligibility

Your household income should be updated:

> Every 3 months if you have no documentation of income due to unemployment/homelessness
> Every 12 months if documentation of income is not your personal tax return
> As soon as filed, but no later than Nov 1 of the next year when providing your tax return information

Total number of people in your household who you share expenses with including yourself, spouse, boyfriend, girlfriend, partner, other family members, and all children _____

	Legal Name	Employed	Male Female	Birth Date	CHP Patient	Relationship
1		□ Yes □ No			□ Yes □ No	Self
2		□ Yes □ No			□ Yes □ No	
3		□ Yes □ No			□ Yes □ No	
4		□ Yes □ No			□ Yes □ No	
5		□ Yes □ No			□ Yes □ No	

List everyone in your household who is employed, including spouse, boyfriend, girlfriend, partner and children 18 years of age and older:

Name	Employer	Gross Monthly Income

List any other monthly income for your household (including Children SSI, TANF and SS Death Benefits):

Social Security $_____ Workers Comp/Disability $_____ Other Income $_____
Veterans $_____ Alimony/Child Support $_____ I am unemployed _____
Unemployment $_____ Interest/Dividend Income $_____ I have no income _____
TANF $_____ Self Employment $_____

Do you pay child support and/or alimony? _____ If documented, we will deduct this from your income when calculating your slide.

All information on this form is a true statement of income at this time. If I give false information, I may be prosecuted under state and federal laws. I agree to report any changes within 30 days of the change.

_____ _____
Signature **Date**

_____ _____
Complete Address: Number & Street (or P.O.Box), City, State, Zip **Phone Number**

Please complete, attach documentation of all income, and return within 30 days of visit

For Office use only:

Weekly:
Total of all checks:

$_____ Divide by 3=

$_____ x 52

$_____ yearly total

Bi-monthly (pd twice/month on set days:
Total of all checks:

$_____ Divide by 3=

$_____ x 24

$_____ yearly total

Yearly (gross)

$_____

SSI/Retirement:
Gross before Medicare Deduction: Gross/month x 12

$_____

Bi-Weekly (pd every 2 weeks):

$_____ Divide by 3=

$_____ x 26

$_____ yearly total

Self Statement of Gross Monthly Income:

$_____ x 12

$_____ yearly total

Slide: _____

Start Date: _____

End Date: _____

Tax Returns:

For sliding fee applications we only accept individual tax returns which will normally be **Form 1040**

For Tax Years 2020 and 2021, please request page 1.

	Tax Year 2020 (exp 11/1/22)		**Tax Year 2021 (exp 11/1/23)**
Adjusted Gross Income	$_____ Page 1, Line 11		$_____ Page 1, Line 11
Plus Untaxed Social Security	$_____ Page 1: 6a minus 6b		$_____ Page 1: 6a minus 6b
Plus Yearly amounts of (per month x 12):			
	$_____	Child Support	$_____
	$_____	VA Disability	$_____
	$_____	Workers Comp Income	$_____
	$_____	TANF	$_____
	$_____	**= Total Yearly Income**	$_____

Calculation of Household Income:

Total yearly income	$_____		$_____
Less Annual Child Support Paid	$_____	(3 payments documented)	$_____
Less Annual Alimony Paid (if tax return not provided)	$_____	(3 payments documented)	$_____
Annual Household Income	$_____		$_____

Entered into F/P Initials: _____

Entered into All Family Members Initials: _____

Entered into Dental Guarantor _____ Initials: _____

Double checked: Math F/P Family Dental Initials: _____

SCAN: E Label
Doc Desc: CHP Sliding Scale