PUREVIEW Health Center

Printed *Patient* Name _____ Date of Birth ____/____/____

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, Data Agreement and Communications

- 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 to ask for confirmation of payment via receipt.
- 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 authorize PureView Health Center to contact me by phone, text or email. I understand that while PureView will use reasonable safeguards to protect text and email communications, no electronic communication is guaranteed to be secure.
- I authorize PureView Health Center to access prescription history from outside sources including but not limited to Surescripts.
- I authorize the use of smart dictation/voice recognition tools to document my care, with all notes reviewed by my provider and kept confidential under privacy laws.

I certify that the provided 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 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.

imMTrax Consent for Adults and Children

_____ *(Initial Here)* I authorize PureView Health Center to collect and enter my/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/my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my/my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my/my child record removed at any time by contacting my local health department.

No-Show (Missed Appointment) Policy

PureView Health Center has adopted a No-Show (missed appointment) Policy. 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. This policy is in effect separately for each individual department.

- **MEDICAL, MENTAL HEALTH, DENTAL**: 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. Future appointments will be cancelled.

By signing below, the patient is stating that they have read and understand the *PureView Health Center Consent for Treatment, Treatment, Payment, Data Agreement and Communications. imMTrax Consent for Adults and Children and No-Show (Missed Appointment) Policy* as above.

Signature _____ Printed Name _____ Date ____/____/____

(Patient or Guardian if under 18)

(Rev 06/2025)

PUREVIEW Health Center

Today's Date_____

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

Date of Birth

Social Security #

Insurance Information (Please show card at every visit for verification.)

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

May we leave a message?
O Yes O No

Cell Phone

May we leave a message?
O Yes O No

Responsible Party/Relationship (If not self)

Responsible Party Date of Birth (If not self)

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

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

Housing Status O Own/Rent (stable housing) O Homeless Shelter O Doubling Up/Staying with Friends/Couch Surfing
O Transitional (Family Promise/Sober Living/YWCA) O Street/Vehicle O Permanent Supportive Housing O Other _____

Preferred Pharmacy (Low-cost prescriptions available at both Helena PureView Pharmacies)
O Main Clinic O Downtown Clinic O Other (Please List) _____

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 O Already Signed Up

Email Address: O None O Choose not to share

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 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? *

$_____

O No income

How many people, including you, does this income support?

_____

Employment Status:
O Employed Full Time
O Employed Part Time
O Retired
O Unemployed
O Disabled
O Other _____

Racial Group(s) (select all that apply)
O Asian Indian
O Chinese
O Japanese
O Korean
O Vietnamese
O Filipino
O Other Asian
O Native Hawaiian
O Samoan
O Guamanian or Chamorro
O Other Pacific Islander
O American Indian/Alaskan Native
O Black or African American
O White
O Decline to specify

Ethnicity:
O Mexican, Mexican American
O Chicano/a
O Puerto Rican
O Cuban
O Another Hispanic, Latino/a or Spanish Origin
O Hispanic, Latino/a or Spanish Origin Combined
O Not Hispanic/Latino/Latina
O Decline to specify

Preferred Language:
O English
O Español
O Francais
O Portugués
O Other _____

Student Status:
O Student Full Time
O Student Part Time
O Not a Student

Country of Birth:
O USA
O Other _____

Are you a Veteran of the US Armed Forces?
O Yes
O No

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 a Sliding Fee Discount. 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 406.457.0000 to learn more.

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

(Rev 11/2024)

PUREVIEW Health Center

Name:	Last:	First:	MI:
	Today's Date:	Date of Birth:	

1. What is the highest level of school that you have finished?

☐ Less than high school degree ☐ High school diploma or GED ☐ Some college/trade school ☐ College degree

2. In the past year, have you or any family member you live with been unable to get any of the following when needed?

Please check all that apply:

☐ Food ☐ Utilities ☐ Transportation ☐ Job ☐ Clothing ☐ Housing

☐ Childcare ☐ Hygiene kit

3. In the past year, have you or any family member you live with needed additional assistance with:

Please check all that apply:

☐ Medical ☐ Dental ☐ Mental Health ☐ Vision ☐ Medications/Pharmacy Needs

☐ Legal ☐ Other _____

4. In the past year, have you or any family member you live with had a legal issue with:

Please check all that apply:

☐ Housing ☐ Family law ☐ Benefits ☐ Consumer ☐ Employment ☐ Taxes ☐ Immigration

☐ Other _____

5. Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No

6. In the past year, have you been afraid of a family member, your partner, or an ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer ☐ I have not had a partner in the past year

7. In the past year, have you spent more than 2 nights in a row in jail, a detention center, or a juvenile correctional facility?

☐ Yes ☐ No ☐ I choose not to answer.

8. What benefits/resources are you currently receiving?

☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ State/Public Assistance ☐ Unemployment ☐ SSI/SSDI

☐ SNAP ☐ Social Security ☐ Worker's Comp ☐ Veteran's Benefits ☐ Other _____

9. Would you like a member of our Case Management Team to contact you to help with addressing the needs listed above?

☐ Yes ☐ No *(If patient selected 'no', the clinic will provide "Health Resource Guide" to patient.)*