MISSOULA URBAN INDIAN HEALTH CENTER
406.829.9515
830 West Central, Missoula MT 59801
www.micmt.com

Welcome to Missoula Urban Indian Health Center

The following documentation is required to complete your registration with MUIHC.

Missoula Urban Indian Health Center required documents include:

Date Rcv'd / Initials

- MUIHC Registration Form (completed)
- Proof of Tribal Enrollment **or** Descendancy (up to 2nd degree)
- Photo ID (i.e. Valid Driver's License, State ID, etc.)
- Insurance Information (Private, Medicare, Medicaid, etc.)

Optional & Extended Services:
Additional documents required for ***Confederated Salish-Kootenai Tribes-Tribal Health & Human Services*** *Registration include:*

- *CSKT THHS Registration Forms (completed entirely)*
- *Birth Certificate*
- *Social Security Card*
- *Proof of Residency (Form required for THHS)*

For Office Use Only:
☐ Release of Information/Assignment of Benefits *(if applicable) – signed/dated*
☐ Notice of Privacy Practices & Recipient Acknowledgements – *signed/dated*
☐ MUIHC Registration – *completed* / Initials of screener:__________Date:______/______/20______
☐ *THHS Registration – completed* ☐ *forwarded to THHS / By:________Date:______/______/20______*
☐ Follow-up req'd:
____
____
☐ Follow-up completed: / Initials of screener:__________Date:______/______/20______

MISSOULA URBAN INDIAN HEALTH CENTER PATIENT REGISTRATION FORM

RPMS #

Patient's Legal Name: ____
Last *First* *Full Middle Name*

[ ] Address: ______________________ ______________ ______ ______
Physical Street Address or PO Box *City* *State* *Zip*

[ ] Phone: [ ]( )______________ [ ]( ) ______________ [ ]( ) ______________
Home *Work* *Cell/Message*

Birth date:____/____/____City & State of Birth:________________When did you move here?____/____

Sex: ☐ M ☐ F Social Security Number ______--_____--_______ Marital Status:
[ ] DIVORCED
[ ] MARRIED (Common Law)
[ ] NEVER MARRIED
[ ] SEPERATED
[ ] SINGLE
[ ] WIDOW(ER)

[ ] E-MAIL ADDRESS:______________________@____________________

We may use your Email address to send you announcements of events you may have an interest in or when attempts to reach you by phone or postal mail have failed. [**PLEASE CHECK PREFERRED METHOD OF CONTACT**].

IF PATIENT IS UNDER AGE 18:

*Guardian:*__________________________*Relationship to Patient:*__________________

Address (if different): ______________________________________
City *State* *Zip*

*Telephone: ( )*______________*( )*______________*( )* ______________
Home *Work* *Cell/Message*

*Father's Employer:*____________________*Mother's Employer:* ____________________

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 #:______________Quantum: ________**

What is your Religious Preference? ______________________

Fathers Name:____________________Mothers Maiden Name: ____________________
Last *First* *Last* *First*
Fathers City/State of Birth:________________Mothers City/State of Birth: ________________

Patient's Employer:________________________________**Status:** ☐ FT ☐ PT ☐ Other: ________
Company Name

____ **Phone:** ______________
Address *City* *State/Zip*

Emergency Contact: Name:__________________________Phone:________________

Address:__________________________City:______________State/Zip: __________

Relationship to patient: ____

Next of Kin: Name:__________________________Phone: ________________

Address:__________________________City:______________State/Zip: __________

Relationship to patient: ____

RPMS #

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.

Financial Responsibility: Do you have Insurance? ☐ Yes ☐ No ***(If Yes, please check all that apply)***

☐ Private ☐ Medicare ☐ Medicaid ☐ Dental ☐ Optical ☐ Prescription ☐ CHS-Tribe: ______________________

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

____ ____________________ ________

Policy Holder's Full Name / Relationship to Patient | Date of Birth | Sex

Policy #:____________________________Group #:____________________Effective Date:_____/_____/_____

Please provide your insurance card(s) so we may make a photocopy.

Are you a US Veteran? ☐ Yes ☐ No Service Branch:______________________ Entry Date:____/____/____ Discharge Date:____/____/____

Are you Service Connected? ☐ Yes ☐ No

Do you have VA benefits? ☐ Yes ☐ No VA Claim #:_____________________Effective Date:_____/_____/_____

Do you have an Advance Directive? ☐ Yes ☐ No ***If YES***, is it a: Living Will or Power of Attorney or 5Wishes

Ethnicity:

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

Race:

[ ] American Indian/Alaska Native [ ] Asian [ ] Black or African American

[ ] Declined to Answer [ ] Native Hawaiian or Pacific Islander

[ ] Unknown [ ] White

What is your primary language you speak?_______________What other languages do you speak? ______________

Do you need an interpreter? ☐ Yes ☐ No What is your preferred language? ____________________________

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 ☐ Other

Do you have Internet Access? ☐ Yes ☐ No Do we have permission to contact you via email? ☐Yes ☐No

If yes, where? ☐ Home ☐ Work ☐ School ☐ Clinic ☐ Library ☐ Community Center

Income Information:

Number in Family_____________Monthly Income $___________________**or** Annual Income $_________________

Release of Information / Assignment of Benefits: MUIHC has my permission to release information, as needed, for insurance processing and for my Insurance to release payment to MUIHC. Furthermore, I accept financial responsibility for services provided to me according to the fees established. I understand and agree to provide MUIHC with information of any change in my household income or insurance status.

I certify the above information is accurate, to the best of my knowledge. I HEARBY AUTHORIZE TREATMENT.

Signature of Client or Guardian:____Date: _______________

Printed Name: ____

Present: Photo identification, Proof of Tribal Enrollment, & Insurance Card(s).

Initials of Screener:

Date:

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RPMS #

RECIPIENT PRIVACY RIGHTS (Public Law 93-579) I understand that the information given to me and/or collected is necessary for MUIHC to provide for my well-being. Furthermore, I have been informed that my records shall not be disclosed to any other agency or person without my signed consent. I acknowledge that I have received a photocopy of the Notice of Privacy Practices (NPP) from MUIHC, which provides a description of uses and disclosures of Protected Health Information (PHI).

ASSIGNMENT OF BENEFITS (AOB) I understand MUIHC has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. This AOB authorization is in effect until revoked by recipient in writing. Further, I understand that MUIHC may bring a claim or cause of action against third party for recovery of such medical expenses.

Therefore, I agree as follows:

1. To assign to MUIHC any claim of cause action against the third party to the extent of the medical expenses paid, or any portion thereof;
2. To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted by or against a third party;
3. To notify MUIHC of a settlement with, or an offer of settlement, for myself or my dependents;
4. The AOB authorization is in effect until revoked by Recipient.

I hereby authorize MUIHC to furnish information to insurance carriers and other third-party payers concerning my illness and treatment, and hereby assign all payments for medical services rendered to myself or my dependents.

COORDINATION OF BENEFITS I understand IHS is the "payor of last resort," and is not an insurance, this means it is vital to be accurate and complete in obtaining information, eligibility, and enrollment for other sources of health care coverage or benefits. I acknowledge **I must apply for and accept all medical benefits and/or alternate resource coverage when available**.

FRAUD STATEMENT Any person who knowingly and with intent to defraud and insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty for each violation.

RELEASE OF INFORMATION (ROI) I authorize MUIHC to collect information on behalf of myself and my dependents. I understand that information received by MUIHC will be kept confidential and used for professional purposes only in terms of facilitating services for me and my dependents.

CONSENT TO SERVICES Recipient hereby consents to any services provided in connection with recipient's treatment by MUIHC providers and by independent providers affiliated with MUIHC.

________________________________ ____________________
Signature of Client | Date

Signature of Parent/Guardian/Legal Representative | Date

Relationship to Client

Client Printed Name

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HIPAA EMAIL CONSENT

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- Information regarding email consent between providers and patients is available on HHS.gov - *https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html*
- The guidelines state that patients may initiate communications with a provider using e-mail. If this situation occurs, the health care provider can assume (unless the patient has explicitly stated otherwise) that e-mail communications are acceptable to the individual. If the provider feels the patient may not be aware of the possible risks of using unencrypted e-mail, or has concerns about potential liability, the provider can alert the patient of those risks, and let the patient decide whether to continue e-mail communications.

___ (Initial here) **I allow the Missoula Urban Indian Health Center to send me generic health information and notices regarding classes and other promotional events. I may unsubscribe at any time by written request.**

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Missoula Urban Indian Health Center to send me personal health information via unencrypted email

________________________ ___________ _________________________ ____________________________

Signature **Date** **Printed Name** **Please print email address**

(parent or guardian if patient is a minor)

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

________________________ ___________ _________________________

Signature **Date** **Printed Name**

(parent or guardian if patient is a minor)