Hill County Family Planning

1

Name: Birthdate:

Mailing Address: Soc. Sec. No: - -

City: State: County: Zip:

Home Phone No: Work No: Cell No:

Email:

Please list a person NOT living with you in case of a MEDICAL EMERGENCY, an unpaid account, or call backs when you are not available.

Name: Relationship:

Address: Phone No:

2

How may we contact you? ☐ Call Home ☐ Call Work ☐ Call Cell ☐ E-mail ☐ Text ☐ Mail

May we send mail to the above address? ☐ Yes ☐ No

If you are under 18, Are your parents aware of your visit? ☐ Yes: Who? _____ ☐ No

3

We receive partial funding from Federal and State grants. Our continued services rely heavily on your payments and donations. **You will never be denied services because of an inability to pay.** To determine your payment plan, choose A or B below:

Household yearly gross income : _____ # in home _____

weekly X 4.33= total

A. ☐I wish to pay the **FULL CHARGES (Payable at the time of services rendered)**.

B. ☐ I wish to be evaluated based on household income: Please COMPLETE the following:

Date: Your work hours per week: _____ Wage: $_____/hr. Other Income: $ _____/wk

_____ Partner work hours per week: _____ Wage$_____/hr. Other Income: $ _____/wk Total_____

4

Insurance Information: ☐Don't bill ☐Medicaid ☐HMK ☐ Private Insurance _____

Employer: _____ Subscriber ID:_____ Group #: _____

Subscriber Name: _____Subscriber SS#_____

Subscriber Date of Birth: _____ ☐ Secondary Private Insurance_____ _____

Copy of card on file? ☐ Yes ☐ No ***I have No insurance Coverage ☐***

5

The Federal Government requires the statistical information asked below.

Sex: ☐Female ☐ Male

Ethnicity: Are you Hispanic/Latino? ☐ Yes ☐ No☐ Unknown

(Mexican, Puerto Rican, Cuban, Central, Or South American, or Spanish Culture or Origin)

Race: What best describes you? ☐ Caucasian ☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Multi-Racial ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown

Do you have limited English Proficiency (Do you need a translator?)? ☐ Yes ☐ No

If you need language assistance services, free of charge, please talk to the receptionist.

6

I hereby voluntarily request, understand, and consent to Hill County Family Planning Services including but not limited to: Examinations, lab work, vaccinations (which includes data entry and communication of vaccinations both current and historical with the Montana Immunization System [imMTrax]), and treatment from Hill County Family Planning. I hereby certify that all of the information given is correct. I accept financial responsibility for any debts incurred and authorized the release of any medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Hill County Family Planning.

Signature: _____ Date: _____

Staff Signature: _____Date: _____

ALL INFORMATION IS CONFIDENTIAL and will not be released without your permission. HOWEVER, the law requires all suspected child abuse and positive results for some Sexually Transmitted Infections. We must also comply with legal subpoenas for medical records, if your life is in danger, and appropriate referrals when indicated.

Hill County Family Planning

Office use only: _____ _____
_____ _____
_____ _____

weekly X
4.33= total

Date: _____ Address_____
Phone #_____
Your work hours per week: _____ Wage: $_____/hr. Other Income: $ _____/wk
Partner work hours per week: _____ Wage$_____/hr. Other Income $ _____/wk
in household_____ Total_____
Insurance information: Subscriber ID:_____ Group #: _____
Subscriber Name:_____SubscriberSS#_____
Insurance Company_____

Date: _____ Address_____
Phone #_____
Your work hours per week: _____ Wage: $_____/hr. Other Income: $ _____/wk
Partner work hours per week: _____ Wage$_____/hr. Other Income $ _____/wk
in household_____ Total_____
Insurance information: Subscriber ID:_____ Group #: _____
Subscriber Name:_____SubscriberSS#_____
Insurance Company_____

Date: _____ Address_____
Phone #_____
Your work hours per week: _____ Wage: $_____/hr. Other Income: $ _____/wk
Partner work hours per week: _____ Wage$_____/hr. Other Income $ _____/wk
in household_____ Total_____
Insurance information: Subscriber ID:_____ Group #: _____
Subscriber Name:_____SubscriberSS#_____
Insurance Company _____

Date: _____ Address_____
Phone #_____
Your work hours per week: _____ Wage: $_____/hr. Other Income: $ _____/wk
Partner work hours per week: _____ Wage$_____/hr. Other Income $ _____/wk
in household_____ Total_____
Insurance information: Subscriber ID:_____ Group #: _____
Subscriber Name: _____Subscriber SS#_____
Insurance Company _____