PATIENT REGISTRATION

Sawtooth Mountain Clinic
Together Through Life
a 501©(3) not-for-profit organization

PATIENT INFORMATION

First Name _____ MI _____

Last Name _____

Preferred/Nickname_____

Mailing Address _____

City/State/ZIP _____

Local Resort/Motel/Camp_____

Phone _____ [ ] Home [ ] Cell

Phone _____ [ ] Home [ ] Cell

Email _____

Sex [ ] Male [ ] Female Date of Birth _____

Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Other

Soc Sec # _____

Preferred Language [ ] English [ ] Other _____

Employer _____

Employer's Phone _____

[ ] Retired [ ] Unemployed [ ] Other

EMERGENCY CONTACT & PHARMACY

Name / Relationship / Phone # of Emergency Contact

_____

_____

Local Pharmacy Preference _____

GUARANTOR - FOR MINOR PATIENTS

Guarantor's Info (Person Responsible for Billing):

Name _____

D.O.B. _____ SS# _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Company _____

ID # _____

Policy Group # _____ Co-pay $ _____

SECONDARY INSURANCE

Company _____

ID # _____

Policy Group # _____

DEMOGRAPHIC INFORMATION (OPTIONAL)

For Community Health Center Grant statistics, race/ethnicity, income range, gender identity, and sexual orientation are reporting requirements

RACE (Mark all that apply)

[ ] Asian
[ ] American Indian/Alaska Native
[ ] Black/African American
[ ] Native Hawaiian/Other Pacific Islander
[ ] White

ETHNICITY

[ ] Hispanic or Latino
[ ] Not Hispanic or Latino

VETERAN

[ ] Yes
[ ] No

FAMILY SIZE _____

INCOME

[ ] $21,999 or less
[ ] $22,000—$34,999
[ ] $35,000—$49,000
[ ] $50,000 or more

SEXUAL ORIENTATION

[ ] Lesbian or gay
[ ] Straight (not lesbian or gay)
[ ] Bisexual
[ ] Something else
[ ] Don't know
[ ] Choose not to disclose

GENDER IDENTITY

[ ] Male
[ ] Female
[ ] Transgender Male (Female-to-Male)
[ ] Transgender Female (Male-to-Female)
[ ] Genderqueer (neither)
[ ] Other
[ ] Choose not to disclose

PRONOUN PREFERENCE

[ ] He/Him
[ ] She/Her
[ ] Other _____

The **Sliding Fee Scale** program is a federal program that permits Sawtooth Mountain Clinic to reduce the normal costs of medical, dental, mental health, and other services for patients who qualify. All patients are encouraged to apply, whether or not they have insurance and regardless of immigration status.

Ask at the Front Desk for more information.

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GENERAL CONSENT & AUTHORIZATION

In order for Sawtooth Mountain Clinic (SMC) to treat you, we ask you to sign below indicating your consent:

Medical Treatment I give my consent to SMC providers, healthcare workers, and behavioral health staff to perform exams, treatments, assessments, procedures, and administer medicine that they believe is necessary or helpful to my health.

Payments for Treatment I authorize payment from Medicare, Medicaid, insurance companies, and any other entities who are financially responsible for my medical care and treatment to be paid directly to SMC. I understand that it is my responsibility to comply with the requirements of my insurance policies. I authorize the release of any/all of my necessary medical records to these entities for the purpose of payment of the services rendered.

I consent to pay any charges not covered by insurance, government medical assistance programs, or other funds such as SMC's Sliding Fee Scale program. I further agree to pay reasonable attorney fees and all costs of collection in the event my account is turned over to an attorney or collection agency. I understand that it is my responsibility to negotiate for the payment of a claim that is disputed by the payer. I understand that co-pays are expected at the time of service.

Release of Information I understand that SMC will release my health information: (1) to any requesting health care provider for my further diagnosis, care, or treatment; or for that provider's payment, or health care operation purposes; (2) to any person or entity which is or may be responsible to SMC for all or part of SMC's charges, including but not limited to insurance companies; (3) to any agency or organizations responsible for the oversight of SMC, such as CMS (Centers for Medicare & Medicaid) and HRSA (Health Resources & Services Administration); (4) for SMC's normal health care operations.

I understand that SMC may access information from any pharmacy from which I have filled prescriptions.

Accidental Exposure to Blood I understand that while I am receiving care, a healthcare worker may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens. I understand that the test results will become a part of my medical record and will be released to the exposed healthcare worker and a positive result must be reported to the state by law.

Contact Regarding Medical Care I understand that SMC may need to contact me by phone or email in regard to my medical care. This includes the use of pre-recorded messages and texts.

Notice of Privacy Practices I acknowledge that a copy of the current Notice of Privacy Practices (HIPPA) has been provided to me, and a copy can be made available to me, or can be viewed on the SMC website www.sawtoothmountainclinic.org.
I understand that this authorization ends one (1) year from the date signed, except for the purposes of payment and research.

_____	_____	_____
Patient Name - printed	Patient Date of Birth	Today's Date
_____	_____	
Signature	or: signature of Witness / Court Appointed Guardian / Auth. Rep.	