



Central Montana Family Planning Data Form

505 W. Main Street - Suite #108 - Lewistown, MT 59457 - (406) 535-8811 - http://www.cmtfp.org

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.

1 Name: _____ Birthdate: _____
Mailing Address: _____ Soc. Sec. #: _____
City: _____ State: _____ County: _____ Zip: _____
Home Phone #: _____ Work #: _____ Cell #: _____
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 #: _____

2 How may we contact you? Call Home Call Work Call Cell E-mail Write
May we say "Family Planning"? Yes No
If you are under 21, 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. TO DETERMINE YOUR PAYMENT PLAN, CHOOSE A OR B BELOW:
A. I wish to pay the **FULL CHARGES (Payable at the time of services rendered)**. # in home _____
B. I wish to be evaluated based on household income: Please **COMPLETE** the following:
Household yearly gross income : _____ Number in household: _____
Your work hours per week: _____ Wage: \$ _____/hr. Tips: \$ _____/wk
Partner work hours per week: _____ Wage \$ _____/hr. Other Income \$ _____/wk or month
C. Parents give consent to use their insurance information or yearly gross income (if under 21)
D. I am interested in volunteer work to satisfy any debt.

4 Insurance Information: Medicaid ID # _____ Private Insurance Company: _____
Employer: _____ Subscriber ID: _____ Group #: _____
Subscriber Name: _____ Subscriber SS# _____
Subscriber Date of Birth: _____ Secondary Private Insurance Company: _____
Copy of card on file? Yes No

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

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- I hereby voluntarily request, understand, and consent to Central Montana Family Planning services which include but are not limited to: Examinations, lab work, vaccinations (includes data entry and communication of vaccinations both current and historical with the Web-based Immunization Registry Database [WIZRD]), and treatment from Central Montana Family Planning. (INITIALS) _____
- I am aware of the location of emergency services in Lewistown: CMMC 408 Wendell Ave. 406.535.7711. (INITIALS) _____
- I understand that I will be counseled on the importance for further evaluation and follow-up if/when needed, and that it is my responsibility to comply with the referral(s). I authorize the release of additional information necessary for the referral to the referred provider and for that provider to release records of that referral and corresponding appointments (when applicable) to Central Montana Family Planning for Continuity of Care (per HIPAA). (INITIALS) _____
- I hereby certify that all of the information given is correct. I accept financial responsibility for any debts incurred and authorize the release of any medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Central Montana Family Planning. (INITIALS) _____

Signature: _____ Date: _____
Staff Signature: _____ Date: _____ X3 X19 _____ %
NON TX _____ %