New Patient Registration Information

Patient's Full Legal Name	**Last:**	**First:**	**MI:**	**Today's date:**
Previous Name(s):		**Pronouns:**	**Preferred Name:**	
Mailing Address:		**City**	**State**	**Zip**
Street Address *(if different):*		**City**	**State**	**Zip**
Social Security Number:	**Date of Birth** (MM/DD/YYYY):	**Email Address:** *(To receive secure patient information)*		

Preferred Message Type/s: ☐ **Text** ☐ **Voicemail** ☐ **Both**

Landline:	( )	**Work:**	( )
Cell:	( )	**Extension:**	

Emergency Contact	**Name** *(Last, First):*	**Home:**	**Relationship to patient:**
		Cell:	

Responsible Party	**Relationship:** ☐ **Self** *(If Self, skip to Insurance section)* ☐ **Spouse** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other:** _____	**Home:**
		Cell:
	Name *(Last, First):*	**Mailing Address (if different):**
	Date of Birth (MM/DD/YYYY):	**Social Security #:** *This may be needed if responsible party is also the insurance subscriber*

Health Insurance

Do You Have Health Insurance?

☐ **No**
I would like to talk with a RiverStone Care Manager about possible health insurance options. Please skip to the next section ↓

☐ **Yes** *Please present your insurance card to the registration clerk and continue below* ↓

Type of Coverage: ☐ **Medicaid** ☐ **Medicare**

☐ **Private Insurance:** _____
Name of insurance Company

How did you hear about RiverStone Health?

☐ **Billboard**	☐ **Radio**	☐ **Pre-Release: Alpha House or Passages**
☐ **Bus Bench**	☐ **Self/Walk-In**	☐ **Another Patient** (Please list their name and phone number below)
☐ **Friend/Family**	☐ **Signage on Building**	_____
☐ **HCH**	☐ **Social Media**	☐ **Another Provider** (Please list the provider's name below)
☐ **Newspaper**	☐ **Television**	_____

Annual Demographic Information

Our goal at RiverStone Health is to help address all the factors that can affect your wellbeing and help connect you to a healthy life. However, you do not need to answer any of these questions, and it will not affect your care here.

Patient's Name: _____ **Date of Birth**: _____ **Today's Date**: _____

Pronouns (ex. she, them, he, they, etc.): _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow/Widower ❑ Partnered ❑ Other

Preferred Language (Choose one) ❑ English ❑ Español ❑ Other _____ ❑ I need an interpreter (no cost)

Racial Group(s): Check all that apply

❑ Asian Indian
❑ Chinese
❑ Japanese
❑ Korean
❑ Vietnamese
❑ Filipino
❑ Other Asian

❑ Native Hawaiian
❑ Samoan
❑ Guamanian or Chamorro
❑ Other Pacific Islander

❑ American Indian or Alaska Native
❑ Black or African American
❑ White
❑ Other _____
❑ Declined to Specify

Ethnicity:

❑ Mexican, Mexican American, or Chicano/a
❑ Puerto Rican
❑ Cuban
❑ Another Hispanic, Latino/a or Spanish origin
❑ Not Hispanic, Latino/a or Spanish Origin
❑ Unreported/ Choose Not to Disclose

Employment Status: ❑ Employed full-time ❑ Employed part-time ❑ Not employed ❑ Retired ❑ Self Employed ❑ Other _____

Student Status: ❑ Student part time ❑ Student full time ❑ Not a student

Have you ever served in the armed forces? ❑ Yes ❑ No
(Air Force, Army, Coast Guard, Marines, Navy, Space Force, Commissioned Officer of the Public Health Service, National Oceanic Atmospheric Administration or **active-duty** National Guard or Reserves)

Housing Status:

❑ Own/Rent (stable housing)
❑ Perm. Supportive Housing (Not available in Yellowstone County)
❑ Living on the street/Vehicle
❑ Other/Hotel
❑ Shelter
❑ Doubling up/Staying with friends/Couch Surfing
❑ Transitional/Temporary (Sober living, Family Promise, Independence Hall)
❑ Unknown
❑ Decline to answer

Employment Type: ❑ Migrant ❑ Seasonal ❑ Not migrant or seasonal

Household income level (See chart on back): ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ No income ❑ Choose not to answer

What was your sex assigned at birth? ❑ Female ❑ Male

What is your sexual orientation? ❑ Lesbian or Gay ❑ Bisexual ❑ Choose Not to Disclose ❑ Straight (Not Lesbian or Gay) ❑ Something else ❑ Don't know

What is your gender identity? ❑ Male ❑ Transgender to Female ❑ Genderqueer ❑ Unknown ❑ Other _____ ❑ Female ❑ Transgender to Male ❑ Choose not to disclose

RiverStone Health Clinics
Income Level Attestation

See if you qualify for a discount in your healthcare fees!

****You may qualify for discounted services even if you have Insurance, the discount would be applied to insurance co-pays and deductibles****

Directions:

1) Find your family size in the left column; follow that row to your amount of total monthly family income.
2) Circle the number at the top of that column (1, 2, 3 or 4)
3) A Patient Access Specialist will let you know if you qualify for a discount.

Family Size	1		2		3		4	
	From	**To**	**From**	**To**	**From**	**To**	**From**	**To**
1	$0	$1,304	$1,305	$1,956	$1,957	$2,608	$2,609	& Over
2	$0	$1,763	$1,764	$2,644	$2,645	$3,525	$3,526	& Over
3	$0	$2,221	$2,222	$3,331	$3,332	$4,442	$4,443	& Over
4	$0	$2,679	$2,680	$4,019	$4,020	$5,358	$5,359	& Over
5	$0	$3,138	$3,139	$4,706	$4,707	$6,275	$6,276	& Over
6	$0	$3,596	$3,597	$5,394	$5,395	$7,192	$7,193	& Over
7	$0	$4,054	$4,055	$6,081	$6,082	$8,108	$8,109	& Over
8	$0	$4,513	$4,514	$6,769	$6,770	$9,025	$9,026	& Over

❑ I am **declining** your request for income details. By declining to provide income details, I am also declining the option to apply for RiverStone Health Clinic's medical/dental sliding fee scale program. I am accepting financial responsibility for the entire bill, including any fees that are **not** covered by my insurance plan and I agree to pay any balance in full.

Updated for calendar year 2025

MONTHLY INCOME

As a patient, you have the *right* to:	As a patient, you have the *responsibility* to:
Have access to information about your rights and responsibilities. Your family or guardian may exercise your rights if you are judged incompetent or are a minor.	Provide correct and complete information about your medical problems, past illnesses, medications, advance directives and other health issues. Keep the agency informed of changes in name, address, phone number or financial information
Be treated without regard to race, color, religion, sex, handicap, gender preference, national origin, or decision regarding advance directives.	Agree to accept all caregivers without regard to race, color, religion, sex, handicap, gender preference, or national origin.
Be given information about charges for services, including your eligibility for sliding fee scale with income verification.	Be complete and honest in providing income and insurance information. Keep your financial commitments.
Not be physically abused or exploited. Be treated with respect, consideration, dignity and privacy.	Treat staff and other patients with respect and consideration.
Be given information about services available and participate in decisions regarding your care.	Participate in your care. Let your provider know if you do not understand something. Ask questions.
Be given name and job title of each staff member who provides services to you.	Let us know ahead of time if you are unable to keep an appointment.
Participate in decisions regarding your care including decisions about your treatment. You have the right to refuse to participate in experimental research.	Follow your treatment plan. Let your provider know if you are unable to keep your plan.
Be told of the consequences of your actions, if you communicate to your provider that you are refusing treatment.	Accept the consequences if you refuse treatment or if you choose not to follow your treatment plan.
Have protected health information be handled in a private manner and be able to receive a copy of your clinical record if requested.	If you request a copy of your record, there is a fee for this service.
Choose your provider or change your provider at RiverStone Health. Choose or change the provider you are referred to outside of RiverStone Health.	Follow your treatment plan as agreed with your provider. Take medications as directed by your provider. Keep your provider informed of changes in your health.
Voice complaints or suggestions without discrimination or fear of reprisal. Complaints may be made orally or in writing to the Program Manager.	Let the agency know of any problems or if you are unhappy with care or services.
Be informed about making an advance directive (what you want to happen at end of life if you are unable to express your wishes).	Give your provider a copy of your advance directives.
Know what to do in an emergency or after hours.	Take steps to maintain your health when you can. Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider

I have received a copy of the Patient Bill of Rights.

_____ _____

Patient Signature or Guardian Date

RiverStone Health Clinic
Patient Bill of Rights & Responsibilities

Service Locations:

RiverStone Health Clinic- Billings
RiverStone Health Clinic- Bridger
RiverStone Health Clinic- Joliet
RiverStone Health Clinic- Worden
Medicine Crow School Clinic
Orchard School Clinic
Billings Senior High School Clinic
RiverStone Health Dental
RiverStone Health Healthcare for the Homeless – HCH Base Clinic
RiverStone Health Healthcare for the Homeless – St. Vincent DePaul

After Hours:

After hours coverage is available for special problems by calling 406.247.3350 and following the instructions given. Patients with medical emergencies should call 911 or go to a local Emergency Room.

Questions or Concerns Regarding Services:

If you have questions or concerns regarding the care or services you received, you have the right to contact the following:

RiverStone Health Clinic- Billings 406.651.6513

RiverStone Health Clinic- Bridger 406.247.3264

RiverStone Health Clinic- Joliet 406.247.3264

RiverStone Health Clinic- Worden 406.247.3286

Medicine Crow School Clinic 406.651.6424

Orchard School Clinic 406.651.6424

Billings Senior High School Clinic 406.651.6424

RiverStone Health - Dental 406.651.6470

RiverStone Healthcare for the Homeless 406.651.6575

RIVERSTONE HEALTH CLINIC
CONSENT FOR TREATMENT /ASSIGNMENT OF BENEFITS

Patient Name: _____ Birthdate: _____

I consent, request and authorize RiverStone Health Clinic to assess, evaluate, and provide care and treatment, including behavioral health ("Treatment") to the patient listed above, including any Treatment rendered via telehealth. Documentation of my Treatment will be a part of my RiverStone Health medical record. I understand that a licensed clinical pharmacist may also participate in my care and as part of my care team providing drug therapy management and other related benefits. Additionally, a Care Manager may assist with coordinating services and resources as outlined in my treatment plan. I may also receive Treatment from students and residents of academic programs who are receiving training at RiverStone Health, including, but not limited to, medical or dental students and medical or dental residents who may participate in my care under applicable supervision requirements. If I do not wish to receive Treatment from a resident or student, I understand it is my responsibility to communicate this wish to my provider. During the course of treatment, I understand that Artificial Intelligence (AI) capabilities may be used.

_____ (Initial Here) I authorize my health care provider and public health agency to collect and enter immunization records into the Montana Department of Public Health and Human Services' confidential Immunization Information System registry. 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 medical care and treatment. In addition, children's immunization information may be released to childcare facilities and schools to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

I authorize RiverStone Health to access prescription history from outside sources, including but not limited to SureScripts.

I further understand that I am responsible for the costs of my care. I understand that RiverStone Health Clinic offers a Sliding Fee Scale based on family income; if I qualify for the Sliding Fee Scale, I acknowledge that I remain responsible for the remaining balance for my care. I hereby assign any of my health insurance benefits to be paid directly to RiverStone Health Clinic. I authorize the release of medical information related to the payment of those insurance benefits.

I acknowledge that RiverStone Health Clinic is a Patient Centered Medical Home. I will be asked to select a primary care provider and understand that I will be an active participant in my care.

Signature: _____

Date: _____

Updated 2024.08.01

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of RiverStone Health's Notice of Privacy Practices that is in effect as of January 1, 2023, in electronic or paper form. I understand I can access a copy of our Notice of Privacy Practices at www.riverstonehealth.org

Patient Signature _____ Date _____

Signature of Patient's Representative _____ Date _____