RiverStone Health Clinic
Authorization for Release of Protected Health Information

Full Name of Patient: ____________________

Address: ____________ City: ____________ State: ____________ Zip: ____________

Phone No.: ____________ Date of Birth: ____________

I authorize **RiverStone Health Clinic** to disclose the following protected health information ("my protected health information") for:
(check one) ☐ the previous 12 months (from date of signature below) ☐ from the time period beginning ____________ and ending on ____________.

(Please initial) | *(Please initial)*

- ☐ Medical Summary ____________
- ☐ Progress Note(s) ____________
- ☐ Lab Results ____________
- ☐ Mental Health Information ____________
- ☐ Chemical Dependency ** ____________
- ☐ X-Ray Reports ____________
- ☐ Consultations ____________
- ☐ Immunizations ____________
- ☐ AIDS/HIV ____________
- ☐ Other (Please Specify and Initial) ____________

☐ If this box is checked, RiverStone Health Clinic may discuss my protected health information with the individual or agency named below.

TO:

Name of Individual(s) or Agency: ____________ Fax: ____________

Address: ____________ City: ____________ State: ____________ Zip: ____________

I authorize the release of my protected health information for the following purpose(s):

☐ At the request of the individual ☐ Other (Please Specify) ____________

By signing this authorization, I understand that I am authorizing RiverStone Health Clinic to use or disclose my protected health information for the purpose(s) I have identified. I understand I can revoke this Authorization in writing and doing so will stop future use or disclosure of my protected health information; but I understand that RiverStone Health Clinic can act on this Authorization until either I revoke my authority in writing or until the expiration date in this Authorization. If I want to revoke this Authorization, I will send my written notice of revocation to RiverStone Health Clinic as follows:

ATTN: Chief Privacy Officer
RiverStone Health Clinic
123 South 27th Street
Billings, MT 59101
Fax: 406.247.3389

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that should I decide to not sign this Authorization there will be no retaliation from RiverStone Health Clinic nor will there be any effect on my treatment or payment for services RiverStone Health Clinic provides, unless this authorization is required in order for me to participate in a research project or clinical trial, in which case I realize I may not be eligible for such project or clinical trial unless I authorize the use or disclosure of my protected health information. I understand I can see and copy my protected health information as described in RiverStone Health Clinic's Notice of Privacy Practices Policy. I understand RiverStone Health Clinic cannot control any further disclosure of my protected health information by those who receive it after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection under federal law once it is received by the recipient.

I understand that I will receive a copy of this Authorization after it is signed. Photocopies or faxed copies of this signed Authorization shall be treated as executed originals.

Unless I indicate an earlier time, this Authorization expires thirty (30) months from the date I sign ____________.
I also authorize the recipient of this Authorization to speak with me about the patient.

*Patient/or Legal Representative Signature: ____________ Date: ____________

Explanation if Not Signed By patient: ____________

*The signature must be that of PATIENT. A parent or guardian must sign if the patient is a minor (under 18) or under guardianship proceedings; (if signed by a guardian or under legal authority to act for the patient, or if this Authorization is signed by a personal representative of a deceased patient, proof of authority to act is required.)

**NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records, the confidentiality of which is protected by Federal Law. Federal regulations (42 CRF Part 2) prohibit any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Dental Health History

Preferred Name:	First:	Last:	MI:	Pronoun:	Date of Birth:

Tobacco Use	☐ Non-Tobacco User	☐ Former Tobacco User How long ago? ________ What age did you start using tobacco? ________	☐ Current Tobacco User ☐Cigarettes ☐Vape ☐ Cigar ☐ Other:__________ ☐ Smokeless Tobacco Type: _______________ Frequency per day? ______________________________ Are you interested in quitting? ☐ NO ☐ Yes

Medications

Please list the names of any prescription or over-the-counter medications you are taking or have recently taken:

_____________________________ _________________________________ _______________________________

_____________________________ _________________________________ _______________________________

_____________________________ _________________________________ _______________________________

_____________________________ _________________________________ _______________________________

Medical History:

Have you ever had any of the following?

(Check all that apply)

☐ AIDS / HIV	☐ Chemical Dependency	☐ Hemophilia	☐ Rheumatic Fever
☐ Arthritis	☐ Chronic Swollen Gums	☐ Hepatitis A, B or C	☐ Sinus Problems
☐ Bleed Heavily	☐ Circulatory Problems	☐ High Blood Pressure	☐ Stroke
☐ Bruise Easily	☐ Diabetes	☐ Low Blood Pressure	☐Heart Attack/M.I.
☐ Cancer	☐ Seizures	☐ Mitral Valve Prolapse	☐ Swollen Neck Glands
If yes, please explain:	☐ General Allergies	☐ Osteoporosis	☐ Thyroid Disease
____________________	☐ Headaches	☐ Ulcer	☐ Tuberculosis
____________________	☐ Heart Murmur	☐ Psychiatric Care	☐ Other:
	☐ Respiratory Disease	☐ Radiation Treatment	____________________

Are you allergic to, or have you had a reaction to the following?

☐ Local Anesthetic ☐ Codeine or Narcotics ☐ Aspirin
☐ Penicillin or other antibiotics ☐ Other:

Do you have, or have you ever had, any joint replacement?
☐ NO ☐ Yes
If yes, what joint? ___________________________________
How many years ago? _________________________________
Have you been told to take a Pre-med prior to dental visits?

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ NO ☐ Yes
If yes, please explain:

Do you have Diabetes? ☐ NO ☐ Yes **Type:** ____________
If yes, what was your last HbA1c? _____________ Date:

Are you currently taking a blood thinner (i.e., Warfarin, Heparin, Eliquis, Coumadin, Xarelto)? ☐ NO ☐ Yes
If yes, what was your last INR? ___________ Date: ____________

Are you taking, or have you ever taken, any medications to treat your bones for osteoporosis, bone cancer or Paget's disease (i.e., Reclast, Boniva, Fosamax, Zometa, Actonel, Aclasta, Atelvia, Alendronate)?
☐ NO ☐ Yes

Any Recreational drug use? ☐ NO ☐ Yes
If yes, what? ____

Do you have, or have you ever had any of the following cardiac conditions (heart conditions)? ☐ NO ☐ YES
☐Prosthetic heart valve or valve repair
☐Congenital heart disease or defect
☐History of infective endocarditis
☐Heart Transplant

Do you have a medical Primary Care Provider(PCP) or a medical doctor or advanced practice provider? ☐ NO ☐ Yes
Doctor's name: ____________________________________
Location: ____
If yes, for what are condition(s) are treated? ________________
____

Women Only: Are you Pregnant? ☐ NO ☐ Yes If yes, months pregnant? __________ Nursing: ☐ NO ☐ Yes
Taking birth control pills or hormone replacement? ☐ NO ☐ Yes

Patient or Guardian Signature: ____ Date: __________________

Guardian Relationship to Patient (please print): ____

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 to provide, among other benefits, drug therapy management. 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.

_____ (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 child care 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 2019.01.07

RiverStone Health Clinic

Patient Bill of Rights & Responsibilities

RiverStone Health Copy

Please sign below and return

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

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

New Patient Registration Information

Patient's Legal Name	Last:	First:	MI:	Today's date:
Previous Name(s):			Social Security #:	

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*

Do You Have Health Insurance?

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	______________________________

RiverStone Health Clinic

Sliding Fee Discount Program Enrollment

(Only complete if you are enrolling in the Sliding Fee Program)

Patient Name ____ Date of Birth ____________________
(Please Print)

Does the patient have any form of health, medical or dental insurance, including Healthy Montana Kids, Medicaid or Medicare? ❑ YES ❑ NO

If yes, list the company and policy number _________________________________

Attach copy of current insurance card.

Number of People in Family (*including self*) ____________________________

Please list people in family or dependents:

	NAME	DATE OF BIRTH
1.	_______________________________________	_______________________
2.	_______________________________________	_______________________
3.	_______________________________________	_______________________
4.	_______________________________________	_______________________
5.	_______________________________________	_______________________
6.	_______________________________________	_______________________

Gross (before taxes) Monthly Income Amount $_________________

Type of Documentation of Income: (Attach Copy)

- ❑ Copy of Pay Check Stub Date _______________________
- ❑ Copy of W-2 or Income Tax Form Date _______________________
- ❑ Child Support Date _______________________
- ❑ Other ___________________________________ Date _______________________

The information I have listed above is true and complete. I understand that if it is later found that I did not truly qualify for the sliding fee scale that I may be responsible for repayment of any discounts that I received but was not entitled to. I understand that a person who obtains or attempts to obtain, by fraudulent means, services to which they are not entitled, may be prosecuted under applicable state and federal laws. **I agree to report any changes in the above information.**

Patient Signature: _________________________________ Date: _______________________

Please fax, mail or bring to RiverStone Health Clinic, 123 South 27th Street, Billings, MT 59101.
Fax – 406.247.3334

Dental Patient Responsibilities

Thank you for choosing RiverStone Health Dental for your dental care needs. We look forward to providing you with excellent dental care. To best serve you and our other patients, we would like to have your agreement with the scheduling guidelines below.

Courtesy Reminders:
Appointment reminder calls/texts are made for patients who have current phone numbers. Patients will be reminded of their upcoming scheduled appointment 1-2 business days prior to the scheduled appointment. Patients who are signed up with the RiverStone Health web portal will also receive an appointment notification via the portal. The patient will be instructed to notify dental if they are unable to keep a scheduled appointment. Dental clinic staff will call patients the day prior to a reserved dental appointment to receive a verbal confirmation if appointment has not already been confirmed.

Cancellations:
We require a 24-hour advance notice if you are unable to make your appointment. Please call us (406) 247-3333, so other patients seeking treatment can have the opportunity to be scheduled. If we do not receive a 24-hour notification for cancellations the appointment will be considered a No-Show Late visit.

Missed appointments:
Patients who miss scheduled appointments will be considered a "No-Show". After the second "No-Show" of a dental appointment within a 6-month period, patients can access Walk-In care for the next 3-months. Once the 3-month time is up the patient can call to reserve dental appointments. Extenuating circumstances of the patient will be taken into consideration.

Patients who have failed a third appointment and have already been asked to wait 3 months prior to rescheduling, will not be scheduled for a reserved dental appointment for 6 months. Extenuating circumstances will continue to be considered by the Dental Clinic Manager. If Patients continue to have repeat failure for missed appointments dental care may be limited to walk-in care only. Patients who may be experiencing scheduling barriers can always contact a Care Manager at 406.651.6540.

Multiple Family Appointments:
We schedule family members together as a courtesy. If you miss these appointments or fail to cancel at least 24 hours prior, we will be unable to give you future family "group" appointments.

Late Patients:
We make every effort to be on time for all our appointments. Unfortunately, when one patient arrives late, it affects other scheduled patients' treatment. If you arrive later than 10 minutes for your scheduled appointment, the visit will be considered a No-Show Late appointment. The dental team will determine if treatment can still be completed, you can choose to access our Walk-In Dental Care Clinic or reschedule the visit to another appointment time.

Walk-In Dental Clinic:
If you should need urgent or emergent dental care, walk-in availability will be offered to all patients. Based on clinic capacity there could be an unexpected wait time.

Questions and comments:
Should you have any questions or comments, please ask to speak to the Dental Clinic Manager.

______________________________ ______________________________

Patient Signature (18 yrs. or older)/ Date **Parent/Guardian Signature/ Date**