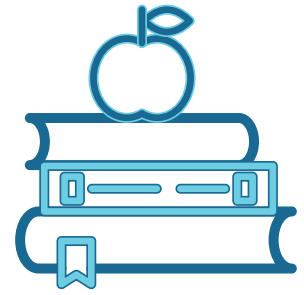




## School-Based Health Centers

→ Coming fall/winter 2024 ←

Get your healthcare at school!



The RiverStone Health Clinic at Billings Senior High is here for you. We've got everything you need, right at school, to keep you feeling your best.

### Need to talk?

Behavioral health services will be open Mon. - Fri. 8 am - 5 pm

### Need to see a medical provider?

Clinic services will be open Mon. - Fri. 8 am - 5 pm



Katie Keith  
Family Nurse Practitioner

## What we offer

Urgent care for when you're not feeling so great

Regular check-ups

Immunizations to stay healthy

Treatment for minor injuries and illnesses

Help managing ongoing health issues

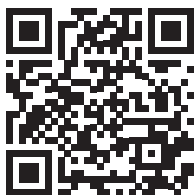
Sports physicals to get you game-ready

Dental education and community referrals

Our counselors are also here to help with mental health, whether it's dealing with anxiety, depression, substance misuse, or if you just need someone to talk to.

We're all about making sure you're okay, inside and out!

## Have ?s



Download patient forms and learn more:

**[RiverStoneHealth.org/SchoolClinics](https://RiverStoneHealth.org/SchoolClinics)**

or call **406.247.3210**

## FAQs

**Do I have to pay?** We care for everyone, regardless of your ability to pay. We accept most insurance plans.

**How do I sign up?** Fill out the enrollment forms before your first visit, or complete them when you come in.



## 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: \_\_\_\_\_



# School-Based Health Clinic Patient Information Form

## STUDENT INFORMATION

Student's Last Name: \_\_\_\_\_

Student's First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

School: \_\_\_\_\_

Sex:  Male  Female Grade \_\_\_\_\_

Student Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ City State Zip Code

Does the student communicate in a language other than English?

No  Yes: Language \_\_\_\_\_

Who is the student's regular doctor?

Name: \_\_\_\_\_

Is the student currently experiencing homelessness?

No  Yes

Racial Group:  White  African American  Native American

Asian  Pacific Islander  More than One Race

Ethnicity:  Hispanic/Latino  Not Hispanic/Latino

## PARENT/GUARDIAN INFORMATION

### Mother

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Cell Phone # \_\_\_\_\_

### Father

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Cell Phone # \_\_\_\_\_

### Legal Guardian, If Applicable

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship of legal guardian to student

Grandparent  Aunt or Uncle  Other: \_\_\_\_\_

### Contact Information for parent or guardian

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Cell: \_\_\_\_\_

### Additional Emergency Contact

Name: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Cell: \_\_\_\_\_

## INSURANCE INFORMATION

Does your child have Medicaid or HMK/CHIP?

No  Yes: Medicaid ID # \_\_\_\_\_

Does your child have coverage through your employer or any other type of health insurance?

No  Yes, Health Plan: \_\_\_\_\_

Member ID/Policy Number: \_\_\_\_\_

If your child does not have health insurance, would you like a Certified Application Counselor to contact you to enroll into health insurance?

No  Yes

## PREFERENCES

Does your child have a regular dentist?

No  Yes: Name \_\_\_\_\_

Preferred Pharmacy:

Name: \_\_\_\_\_

Location: \_\_\_\_\_

Do you wish to apply for our sliding fee scale which is based on income and family size?  No  Yes

If yes: Household Annual Income \_\_\_\_\_

Number of people in home \_\_\_\_\_

RiverStone Health provides high-quality healthcare.  
Everyone is welcome, regardless of ability to pay.

- We are **accepting new patients**
- **Sliding fee scale** based on income & family size
- We **accept** private insurance, Medicare & Medicaid
- **Same-day appointments** for urgent care
- Schedule **TeleHealth** visits from home
- **Pharmacy** offers curbside pickup & mailed prescriptions
- **Dental Clinic** provides dental care for all ages
- **Behavioral Health** for all ages

Did you lose your Health Insurance Coverage? Our care managers can help: **406.651.6540**

**RiverStone Health Clinic**  
Call us: **406.247.3350**



Medical Care



Dental Care



Behavioral Health



Pharmacy

**WIC Signup:** WIC offers help for pregnant women, new moms, infants and kids under 5. **406.247.3370.**

**RiverStone Health Healthcare for the Homeless:** 2424 First Ave. North. Walk-ins welcome. **406.651.6560.**

**Immunization Clinic:** Stay healthy this school year and stay current on infant, childhood and adult immunizations. Schedule an appointment online: [RiverStoneHealth.org/immunizations](http://RiverStoneHealth.org/immunizations) or call **406.247.3382.**

123 South 27th Street, Billings MT • 406.247.3200 • [RiverStoneHealth.org](http://RiverStoneHealth.org)

.....  
Please fill out and return bottom half  
.....



## RiverStone Health Clinic Dental Survey



Child's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Does your child have a dentist?

Yes: Name \_\_\_\_\_  No

Has your child been to the dentist in the last year?

Yes  No

Are you interesting in having your child see Riverstone Health providers for dental exams, cleanings and sealants?

Yes  No



# Patient Health Information School-Based Health Clinic

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Do you have **ANY ALLERGIES** or **SENSITIVITIES**:  Yes  No If yes, please list below:

\_\_\_\_\_  
\_\_\_\_\_

**Medications:** List medicines, birth control pills, herbal supplements or vitamins you take with or without a prescription:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Illnesses:** Please  where you or members of your family (parents, grandparents, siblings) have had the following diseases or problems:

Patient	Family	Who		Patient	Family	Who	
<input type="checkbox"/>	<input type="checkbox"/>	_____	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure/Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney/Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease, Hepatitis, Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mumps, Measles, Chicken Pox
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Disorder or Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Suicide Attempt
<input type="checkbox"/>	<input type="checkbox"/>	_____	Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eczema				
<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema				Other Illnesses:
<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



## RiverStone Health Clinic Patient Bill of Rights & Responsibilities

<b>As a patient, you have the <i>right</i> to:</b>	<b>As a patient, you have the <i>responsibility</i> to:</b>
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**

### 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  
RiverStone Health Dental  
RiverStone Health Healthcare for the Homeless – 2424 1st Ave. N.  
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 406.651.6470  
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  
RiverStone Health - Dental- 406.651.3269  
RiverStone Healthcare for the Homeless 406.651.6575

## Acknowledgement of Receipt of Notice of Privacy Practices

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I acknowledge that I have been offered a copy of RiverStone Health’s Notice of Privacy Practices that is in effect as of August 1, 2024, in electronic or paper form. I understand I can access a copy of our Notice of Privacy Practices at [www.riverstonehealth.org](http://www.riverstonehealth.org)

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Patient Signature

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Date

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Signature of Patient’s Representative

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Date