Sage Medical Clinic

820 North Montana Avenue Helena, MT 59601

406-443-7733

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Welcome to our clinic!

We have five providers in our office. They are all separate entities operating in the same clinic; therefore you will receive separate billing statements from each provider that you see. We do our best to schedule you with your chosen provider each time that you need us, but on occasion may offer another provider for your acute needs. Please rest assured that we all share the same electronic medical records, so that each provider here can see your previous visits, along with your medications.

We do save appointments each day, for each provider for acute needs, so please remember to call early in the day if you need to be seen.

Our clinic is open Monday-Friday 8:00 am until 5:00 pm. We do close each day so that we may have lunch from 12:00 pm until 1:20 pm.

We do have a provider available on call for after hour needs. If you call after hours you will receive a call back from one of our providers. Please do not leave messages with the after-hours physician to refill a medication, cancel, or reschedule an appointment. These items can be taken care of during normal business hours.

Our office does request that you call in for medication refills ***<u>72 hours prior</u>*** to needing those medications.

If for some reason you are hospitalized while under our care, St. Peters Health Regional Medical Center uses staff doctors, known as “hospitalists “to provide your care while you are in the hospital. We will usually be contacted as you prepare to discharge from the hospital to schedule a follow-up appointment.

We have enclosed items for your review and to complete prior to your appointment. This information will help you become familiar with our practice and policies. Please have these forms completed prior to your visit so that you and your physician can stay on schedule.

Patient Information Form – This form gathers the necessary data for us to process your electronic medical record and process insurance claims for you.

Patient Medical History Form - This provides information to the physician regarding your current health and past health history.

HIPPA/Emergency Contact – (Health Insurance Portability and Accountability Act) – This form is an authorization to disclose medical health information to your friends, and/or family members. Emergency contact is necessary to provide us with information about who we should contact in case of an emergency.

Billing Policy- This is the billing policy outline for all of the providers in our clinic. We will be happy to file your insurance for you, so please provide us with your current insurance card.

Lab Services- We send out all labs drawn in our clinic. You have a choice about which lab provides that service for you, Labcorp or St Peter’s Health. You will be billed by us for the lab draw (venipuncture) but will receive a separate bill from the lab for those services. Please let us know your preference.

We encourage you to call our office with any questions about the information or forms you have received. We believe strongly that an open line of communication is beneficial to us both. We look forward to meeting you!

SAGE MEDICAL CLINIC
PATIENT INFORMATION FORM

LAST NAME: _______________________________FIRST NAME: ___________________________________ MI________

MAILING ADDRESS: ____ CITY____________STATE______ ZIP_________

SS #:___________________________DATE OF BIRTH: __________________SEX: F M MARITAL STATUS___________

Ethnicity/Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian or other Pacific Islander White Other

Preferred Language: ___________________________ Communication Barriers: Hearing Sight Speech

HOME PHONE: ____________________ Preferred contact #? ☐ Ok to leave confidential messages? YES NO

WORK PHONE: ____________________ Preferred contact #? ☐ Ok to leave confidential messages? YES NO

CELL PHONE: ______________________ Preferred contact #? ☐ Ok to leave confidential messages? YES NO

EMERGENCY CONTACT: ____________________________Relationship:________________ Phone: _________________

RESPONSIBLE PARTY FOR PATIENT:

Name: ____ Relationship to patient: ___________________

Social Security #:______________________________ Date of Birth: ____

Address (if Different):____ Phone #:_____________________

INSURANCE INFORMATION:

PRIMARY INSURANCE: __________________________

SUBSCRIBER NAME: _____________________________

SUBSCRIBER DATE OF BIRTH: ______________________

SUBSCRIBER SS#_______________________________

RELATIONSHIP TO SUBSCRIBER: ____________________

INS. ID: _______________________________________

GROUP: ______________________________________

SECONDARY INSURANCE: _________________________

SUBSCRIBER NAME: _____________________________

SUBSCRIBER DATE OF BIRTH: ______________________

SUBSCRIBER SS#_______________________________

RELATIONSHIP TO SUBSCRIBER: ____________________

INS ID: _______________________________________

GROUP: ______________________________________

Patient Signature (or responsible party, if minor): ____ ________

Today’s Date: _________________________

SAGE MEDICAL CLINIC 820 N. MONTANA AVEHELENA, MT 59601

PHONE: 406-443-7733 FAX: 406-443-8292

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY POLICIES AND PROCEDURES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), The Sage Medical Clinic (Practice) may not use or disclose your personal health information without your authorization.

The Practice has policies and procedures to comply with HIPAA law. Every attempt has been made to keep the process for patients and staff as efficient as possible. However, the requirements are extensive and take time, effort and cooperation to process required tasks.

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms.

Notices of Privacy Practices- This notice describes how medical information about you may be used and disclosed and how you get access to this information.

Authorization for Use or Disclosure of Protected Health Information- The Practice may not use or disclose your health information for purposes other than health treatment, payment or health care operations, without your authorizations. Your signature on this form indicates that you are giving permission to the Practice for the use and disclosure of the health information listed on the form, for purpose(s) listed on the form, to the people/organization(s) listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to the office.

Complaint-You have the right to make a complaint about the Practice's policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

Request to Amend Protected Health Information- You have the right to request that health information that involves you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of protected Health Information- You have the right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that someone other than the person who originally denied the request review the decision. If you request copies of your medical record, the Practice reserves the right to charge you a reasonable fee for the expenses associated with copying the requested information.

Request for Accounting of Disclosures of Protected Health Information- You have a right to request an accounting of all non-routine disclosures of health information that pertains to you. Disclosures of health information associated with treatment, payment and healthcare operations or with prior patient authorization will not be accounted for.

Confidential Channel Communication Request- You have a right to request the communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.
Designation of Personal Representative- You have a right to nominate one or more persons to act on your behalf with respect to

the protection of health information that pertains to you by making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

The goal of the HIPPA privacy act is to assure that individuals' health information is properly protected. In order to keep our patients information protected, we are asking that our patients provide us with the names of the people it will be acceptable to discuss their health information with. This release of information can include such things as: sensitive health information, billing or financial matters, medication refills, and whether you as a patient were here at our office for an appointment or not.

If you are a parent of a minor child, this does not pertain to your children. If your children are 18 years of age or above, they are considered adults and we will need to have your adult children sign a release in order for us to talk to you about their health care. Even if your child is currently living at home, or currently a full time student, we are unable to give you information without a signed consent.

Please list below the people it is acceptable to talk to about your health care. This could include your spouse, children, friends, or other family members.

Please Note: Without a signed release, we will not give any information to anyone who calls on your behalf. I give Sage Medical Clinic the authorization to discuss my health information with those listed below:

PLEASE PRINT CLEARLY

NAME OF PERSON	RELATIONSHIP AND PHONE NUMBER

Patient's Signature:

_________________________________ _______________________________ _________

Print Name **Signature** **Date**

*******I revoke permission to speak with the above named individuals*******

_________________________________ _______________________________ _________

Print Name **Signature** **Date**

INITIAL VISIT RECORD

Your Name: ___________________________________ Age: __________ Date: __________________________________

Reason for your visit today: ____

Is this visit due to an accident? Y N If yes, please explain: ____

Occupation: ____How Long? ____________________

Toxic Exposure: (Fumes, Dust, paint?) ____

Last school grade completed: ___________ Last Physical Exam: __________

Immunizations: Please check any that you have had and the year:

Pneumonia __________ Meningitis __________ Flu __________ Tetanus __________

Hepatitis B ___________ MMR ______________ PPD _________ Hepatitis A __________ Other ____________

Past Medical History- Please check if you or a blood relative has/had any of the following:

	You	Relative		You	Relative
Anemia	___	___	Kidney/Bladder Issues	___	___
Asthma	___	___	Bleeding Tendencies	___	___
Diabetes	___	___	Arthritis	___	___
Stroke	___	___	Tuberculosis	___	___
Epilepsy	___	___	Ulcer/Stomach issues	___	___
Glaucoma	___	___	Heart Trouble	___	___
Gout	___	___	High Blood Pressure	___	___
HIV	___	___	Mental Illness	___	___
Cancer	___	___	Alcohol/Chemical dependence	___	___

Hospitalizations/Surgeries: Please list any surgery or serious illness that you've had which required hospitalization.

MO/YR	Illness/Surgery	Any Complications (Y or N)

Gyn/OB History: Pregnancies: ______ Births: _____ Miscarriages: _____

Pelvic Pain or abnormal discharge: Y or N____

History of abnormal Pap: Y or N ____

Prolonged or abnormal bleeding: Y or N____

Method of birth control: ____

Review of Systems: Please indicate if you've had any recent problems with the following:

	Yes	No		Yes	No
Lumps	____	_____	Hearing	____	_____
Moles	____	_____	Seeing	____	_____
Swelling	____	_____	Smelling	____	_____
Dizziness	____	_____	Digestion	____	_____
Balance	____	_____	Weight Gain	____	_____
Appetite	____	_____	Mood/Feelings	____	_____
Sleeping	____	_____	Breathing	____	_____
Pains/aches	____	_____	Hay Fever	____	_____
Urination	____	_____	Menstruation	____	_____

Other____

Preventive Care Issues:

	Yes	No		Yes	No
Pap Smear	____	_____	Mammogram	____	_____
Bone Density	____	_____	Prostate screening	____	_____
Cholesterol Screening	____	_____	Colonoscopy	____	_____

Medications/Dosage:

____ ____
____ ____
____ ____
____ ____

Depression Screening:

Over the past two weeks, have you felt down, depressed, or hopeless? ____
Over the past two weeks, have you felt little interest or pleasure in doing things: ____

Personal Habits:

Do you smoke? Y or N How much per day: ______________ Do you drink alcohol?: Y or N how many per day?: _____________
How many times in the past year have you had more than Male 5 drinks /day: ____________ Female 4 drinks/day: ____________
Do you use illicit drugs?: Y or N Specify : ____
Do you wear your seatbelt? Y or N
Do you have a living will?: Y or N
Do you have a donor card?: Y or N
Do you practice “safe sex”? Y or N

Previous Healthcare Provider: ____

BILLING POLICY

As a courtesy to our patients we are happy to file your insurance claim with a carrier of your choice. Your insurance will notify you of any charges that they may or may not cover. Although we have filed a claim for you, you may still receive statements each month as long as you carry a balance on your account.

Please pay the appropriate co-pay at the time of service.

The charges you incur are your responsibility. Sage Medical Clinic is not responsible for collecting insurance claims or negotiating settlements on disputed claims.

NOTE: If you do not provide the appropriate insurance information at each visit, we reserve the right to refuse to re-bill outstanding balances to a new carrier. Many insurance companies will not accept claims over 30 days old.

If you are a self-pay patient, a co-pay of $50.00 is expected at each visit. A minimum payment of $40.00 is expected each month on any remaining balance unless other arrangements have been discussed in advance with the clinic manager.

I have read the above statement and understand any charges I incur in this office are my responsibility.

____

Please Print Name:

____ ______________________

Signature of responsible party Date