PATIENT INFORMATION

Name: _____ **Birth Date:**_____ **Age:**_____
Last First M.I MM/DD/YEAR

Mailing Address:_____ ☐M ☐F ☐Other
(Street or PO.Box)

City, State, ZIP:_____

E-mail address:_____

Phone:_____ **SSN:** _____ - _____ - _____

Employer_____; **Phone:**_____

Emergency Contact:_____ _____ _____
Name Phone Relationship

POLICY HOLDER/GUARANTOR

If different from above

_____ _____
Name (Last, First, MI) Relationship

_____
Address City, State, Zip

(_____)_____ _____
Phone Date of Birth

PAYMENT IS DUE AT TIME OF SERVICE

EMMC is participating with BC/BS of MT, Allegiance/Cigna, United Healthcare, Pacific Source, Montana Health Co-op, and health plans administered by First Choice Health and Interwest Health. For all other insurance we will provide you with documentation to file your own insurance claim.

For all visits in the next 12 months I authorize medical treatment and the release of medical information necessary to receive treatment, records from other physicians and/or insurance payment. I understand that I am responsible for all charges incurred, and that payment is due at time of service. I certify this information is true and current to the best of my knowledge.

SIGNATURE:_____ **DATE:**_____
Patient or Parent/Guardian

HIPAA Disclosure Document
for
East Main Medical Clinic

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, East Main Medical Clinic (EMMC) is required to provide patients with information regarding our privacy practices with respect to your personal health information (PHI). The following is a brief summary; further details may be obtained online at http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of EMMC, the information belongs to you. You have the right to:

- Copy and/or inspect your PHI.
- Request in writing that your PHI be amended or corrected.
- Receive an accounting of disclosures.
- Request restrictions on uses and disclosures.

EMMC may use your PHI for:

- Treatment at EMMC and/or referral to speciality physicians and outpatient resources.
- EMMC professional healthcare operations, i.e., accreditation, licensing, peer review, etc.

EMMC may use your PHI to:

- Speak with **family and friends** you have designated to be involved in your care (list below).

Name:_____ Relationship:_____

Name:_____ Relationship:_____

- Contact you by phone regarding test results, treatment options, followup, etc.
- Inform you of products and services believed necessary for your treatment.
- Perform necessary services with our business associates, i.e., legal services, accreditation, auditing, etc.

EMMC may be required to release your PHI without your authorization for:

- Any purpose required by law.
- Public health activities, reporting of disease, birth, death, etc.
- Victims of abuse, neglect or violence.
- Work-related illness or injury.
- Organ donation, threat to safety or health, etc.

All requests concerning your health information must be made in writing and sent to East Main Medical Clinic at 1104 E Main St, Bozeman, MT 59715. If you believe your privacy rights have been violated, you can file a complaint with East Main Medical Clinic or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. If you have a question and/or would like additional information, please contact East Main Medical Clinic at 406-587-3788.

I, _____ , have read the EMMC HIPAA disclosure document.
Patient name, please print

_____ _____
Signature of Patient or parent/guardian Date