Flathead Community Health Center
Patient Registration Form

PATIENT INFORMATION (Please Print)			
Patient's Last Name:	**First Name:**	**Middle Name:**	
Mailing Address:	**City:**	**State:**	**Zip Code:**
Physical Address: (if different than mailing address)	**City:**	**State:**	**Zip Code:**
Home Phone: **OK to leave message?** Y N ( ) -	**Cell Phone:** **OK to leave message?** Y N ( ) -	**Sex at birth:** **Male** **Female**	
Date of Birth: / /	**Age:**	**If patient is a minor, provide parent/guardian name(s) and specify relationship to patient:**	

CONSENT

_____ Initial

Patient consents to the services that may be provided in connection with his/her treatment from Flathead Community Health Center. **Patient acknowledges that no guarantees have been made regarding the outcome of the care.** If patient is unable to sign, consent for treatment is given by his/her duly authorized representative or, in cases of emergency, shall be implied if such representative is not available. For purposes of this agreement, the term "patient" includes any representative(s) of patient authorized to make decisions and sign this agreement on patient's behalf.

NOTICE OF PRIVACY PRACTICES (HIPAA)

_____ Initial

This notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (HIPAA) and by the amendments to the HIPAA Privacy Rules made by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act). I acknowledge that I have been provided with Flathead Community Health Center's (FCHC) Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this content. I understand that FCHC reserves the right to change its Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. By signing this form, I consent to FCHC use and disclosure of my health information for treatment, payment, and health care operations.

Montana DPHHS Consents:

_____ Initial:

I authorize the Montana Department of Public Health and Human Service (DPHHS) to perform testing on my (or my child's/dependent's) specimen. I understand that processing the specimen and results may take up to one week. The Montana Department of Public Health and Human Services (DPHHS) will release the results of my test to the FCHC. I understand my (child's/dependent's) test results will be disclosed to the county and state health entity as required by law. I understand that a patient relationship with DPHHS is not created by participating in testing. I understand the testing unit is not acting as my or (my child's/dependent's) medical provider. Testing does not replace treatment by a medical provider. I will take appropriate action with regards to my (child's/dependent's) test results. I will seek medical advice, care and treatment from my (child's/dependent's) medical provider with questions or concerns, or if a health condition worsens. I hereby consent for myself (child/dependent), my (child's/dependent's) heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily agree to have my sample taken and analyzed and hereby waive any and all rights, claims, or causes of action of any kind whatsoever arising out of my participation in this activity, and do hereby release and forever discharge DPHHS and its agents for any injury that I may suffer as a direct result of my participation in this activity, including traveling to and from any location related to this activity.

SIGNATURE

Patient or Responsible Party:_____ Date:_____