Richland County Family Planning
1201 West Holly St Suite #1
Sidney, MT 59270
(406) 433-2207 phone & fax (406)433-6895

ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR PERMISSION. HOW EVER THE LAW REQUIRES ALL SUSPECTED CHILD ABUSE AND POSITIVE RESULTS FOR SOME SEXUALLY TRANSMITTED INFECTIONS BE REPORTED TO THE APPROPRIATE AUTHORITIES. WE MUST ALSO COMPLY WITH LEGAL SUBPOENAS FOR MEDICAL RECORDS. IF YOUR LIFE IS IN DANGER, APPROPRIATE REFERRALS WILL BE MADE.

**1**

NAME_____MAIDEN NAME_____BIRTH DATE_____AGE_____

MAILING ADDRESS_____
CITY STATE ZIP CODE

HOME PHONE_____CELL PHONE_____WORK PHONE _____

Do you have a Primary care provider? ☐ YES ☐ NO

IN CASE OF A **MEDICAL EMERGENCY**, WHO MAY WE CONTACT?

NAME_____RELATIONSHIP _____

ADDRESS _____PHONE _____

**2**

**PLEASE ACKNOWLEDGE WE NEED TO REACH YOU REGARDING LAB RESULTS AND MONTHLY STATEMENTS?** ☐YES ☐ NO

**PREFFERED METHOD OF CONTACT** ☐SEND MAIL ☐TEXT CELL ☐CALL CELL ☐CALL HOME ☐CALL WORK

**MAY WE SAY FAMILY PLANNING** ☐YES ☐ NO **MAY WE LEAVE A VOICE MESSAGE?** ☐YES ☐ NO

*IF YOU ARE UNDER 18, ARE YOUR PARENTS AWARE OF YOUR VISIT? ☐YES ☐ NO

**3**

WE RECEIVE PARTIAL FUNDING FROM FEDERAL AND STATE GRANTS. OUR CONTINUED SERVICES RELY HEAVILY ON YOUR FEES AND DONATIONS. TO HELP DETERMINE YOUR FEES PLEASE CHOOSE A , B 0R C.

- **I live with** ☐MY PARENTS ☐A PARTNER/SPOUSE ☐MY CHILDREN ☐FRIENDS/ROOMMATES ☐ALONE
- **Are they financially supportive?** ☐ **YES** ☐**NO**
- **People supported on this income** (INCLUDING YOURSELF) **#** _____
- **Primary** Wage $ _____ /hour Hours _____ /week -OR- $_____ Annually
- **Secondary** Wage $ _____ /hour Hours _____ /week -OR- $_____ Annually

**Initial A , B OR C**

_____ **A** I elect to pay the full charges
_____ **B** I wish to be evaluated for a discount based on my income
_____ **C** I have had a hysterectomy or I am menopausal

**OFFICE USE ONLY**

MONTHLY TOTAL FEE Level _____

$ _____ Pay Percentage _____%

**4**

**Insurance Information** ☐None ☐Medicaid/Access to Health ☐Plan First ☐Private _____

**CONSENT TO BILL INSURANCE** ☐ YES ☐ NO

NAME OF CARDHOLDER _____ DATE OF BIRTH _____

POLICY #_____ GROUP # _____

**5**

THE FEDERAL GOVERNMENT REQUIRES THE STATISTICAL INFORMATION ASKED BELOW. ALL INFORMATION IS CONFIDENTIAL & ANONYMOUS. DCFP COMPLIES WITH APPLICABLE FEDERAL CIVIL RIGHTS LAWS & DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY OR SEX.

**SEX** ☐ FEMALE ☐ MALE **ETHNICITY** ☐ Hispanic ☐ Non-Hispanic

**RACE** WHAT BEST DESCRIBES YOU? ☐ Caucasian ☐ American Indian or Alaskan Native ☐ African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

**PRIMARY LANGUAGE** ☐ENGLISH ☐ SPANISH **DO YOU NEED A TRANSLATOR? (LEP)** ☐ YES ☐ NO

**6**

I hereby voluntarily request and consent to Family Planning Services including but not limited to examinations & treatment from Dawson County Family Planning. I confirm that the above information is true. I accept financial responsibility for any debts incurred and authorized the release of any medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Dawson County Family Planning.

SIGNATURE DATE