Kalispell Regional Healthcare - New Patient Registration Form

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name or Initial:	email address:

Mailing Address:	City:	State:	Zip Code:

Physical Address:	City:	State:	Zip Code:

Home Phone: OK to leave message Y N	Cell Phone: OK to leave message Y N	Work Phone: OK to leave message Y N
( ) -	( ) -	( ) -

Date of Birth:	Age:	Gender:	Marital Status:
/ /		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Social Security No:	Employer Name and Address:
- -	

Employment Status:	Student Status:
☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired	☐ Full Time ☐ Part Time ☐ Not a Student

If patient is a minor, please give parent/guardian names and specify relationship to patient:	Race _____ ☐ Other ☐ Unreported/Refused to Report
Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Other _____ Language: ☐ English ☐ Russian ☐ Indian (Includes Hindi & Tamil) ☐ Spanish ☐ Other	Pharmacy Name:
Primary Care Provider:	Referring Provider:

IN CASE OF EMERGENCY

Name of Emergency Contact Person:	Relationship to Patient:	Home Phone No:	Work Phone No:
		( ) -	( ) -

Mailing Address:	City:	State:	Zip Code:

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's Last Name:	First Name:	Middle Name:

Mailing Address, if different from Patient:	City:	State:	Zip Code:

Phone No:	Relationship to Patient:	Date of Birth:	Social Security No:
( ) -		/ /	- -

Employer Name and Address:	Work Phone No:
	( ) -

INSURANCE INFORMATION

Name of Primary Insurance:	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth:
		/ /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Subscriber/Policy No:	Group No:

Name of Secondary Insurance (if applicable):	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth:
		/ /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Subscriber/Policy No:	Group No:

KALISPELL REGIONAL HEALTHCARE

Patient Name: _____ Patient DOB: _____
Please Print

PATIENT CONSENT AND FINANCIAL AGREEMENT

Kalispell, Montana

Welcome to Kalispell Regional Healthcare ("KRH"). Thank you for choosing us for your care and treatment. KRH is an integrated health system that includes a number of organizations and Healthcare Services providers. Your consent covers services provided at the following KRH entities: Kalispell Regional Medical Center, The HealthCenter, Brendan House, The Summit, Northwest Orthopedics and Sports Medicine, Kalispell Regional Behavioral Health, The Newman Center.

Please review this Agreement carefully. Except in cases of emergency care, we must have a signed and dated Patient Consent and Financial Agreement before Healthcare Services (defined below) can be provided to you. If you have any questions about this Agreement, our KRH staff will be happy to answer your questions before you sign.

If, at a later date, you have additional questions about your medical bills or need to make corrections to the information you have provided to KRH, please contact the KRH Patient Accounting office by calling (406) 756-4408, Monday through Friday, except holidays, from 8:00 a.m. through 5:00 p.m.

CONSENT FOR TREATMENT AND CARE

You hereby consent to any Healthcare Services (as defined below in this paragraph) provided by KRH and Healthcare Services providers who are independent from KRH but who are authorized to provide Healthcare Services to you as a KRH patient. These independent, non-KRH-employed providers include, but are not limited to physician and other medical and allied health professional staff members of Glacier Regional Pathology, Ltd.; Clinical Pathology Associates, LLC; Northern Rockies Anesthesia Consultants, PLLC; Northwest Imaging, PC; Silvertip Emergency Physicians, PC (collectively, "KRH Affiliated Providers") and outside reference laboratories. You understand and agree that resident physicians and other Healthcare Services education students may participate in or be observers of the Healthcare Services you receive at KRH. These residents and students will be supervised by qualified instructors and KRH staff. You can decline care by supervised resident physicians and Healthcare Services education students by discussing it with your provider(s) prior to care being rendered. Your Healthcare Services may include, but are not limited to, hospital inpatient, outpatient, and/or emergency services; physician office services; diagnostic procedures; transportation; nursing care; and other Healthcare Services and products. You acknowledge that no guarantees have been made regarding the outcome of these Healthcare Services. If you are not able to sign this Agreement personally, then the consent for your care and treatment: (1) may be given by your representative(s) who are legally authorized to make decisions and sign this Agreement on your behalf, or (2) shall be implied in cases of emergency.

REPORTING OF IMMUNIZATION RECORDS

The Montana Department of Public Health and Human Services (DPHHS) has requested that we seek your consent to share your/your child's immunization data with the DPHHS Immunization Information System (IIS). DPHHS may release IIS data to other public health agencies as well as to your/your child's healthcare providers to assist in your/your child's medical care and treatment. In addition, DPHHS may release IIS data to schools in order to comply with immunization requirements. You can always choose to opt out at a later time and/or have your/your child's immunization record removed at any time by contacting your county's health department. You understand that any such revocation will not be effective as to uses and/or disclosures already made prior to opting out.

THIS IS NOT A CONSENT TO RECEIVE ANY IMMUNIZATION, IT IS ONLY A CONSENT TO REPORT YOUR/YOUR CHILD'S IMMUNIZATION DATA TO DPHHS IIS. If you are OPTING OUT and do not wish for your/your child's immunization data to be provided to DPPHS, check the box, sign and date in the area below.

☐ **OPT OUT** OF THE DPHHS IMMUNIZATION INFORMATION SYSTEM

_____ ___/___/___
Name of Patient Date

_____
Signature of Patient/Parent, Authorized Representative or Guardian, if applicable

FINANCIAL AGREEMENT

Agreement to Pay Charges and Billing Statements – In consideration of the Healthcare Services provided to you, you and/or any individuals who are directly responsible for your medical bills, such as a parent or guardian, (collectively, "Guarantors") agree to pay KRH's billed charges related to those Healthcare Services ("Charges"), minus any contractual reductions from the Charges agreed to by KRH with your Health Plan Payor (if applicable) and any other reductions to which you may be entitled, such as under the KRH financial assistance policy. You understand and agree that: (1) any KRH Affiliated Providers that provide Healthcare Services to you in connection with your care and treatment at KRH may have separate billing and collection practices that result in one or more separate bills for which Guarantors are responsible to pay; (2) the terms of this Agreement prevail over any conflicting terms and conditions in any other contract or plan to which you claim to be a party or a beneficiary; (3) it is possible that your Health Plan will determine that Healthcare Services provided to you are not Covered Services and that you will be responsible for paying for those Healthcare Services; and (4) the terms of this Agreement are governed by the laws of the State of Montana.

Financial Assistance – KRH has a Financial Assistance policy available to patients who qualify. If you are interested in learning more, please ask our staff for a copy of the policy. The Financial Assistance Policy is available on the Kalispell Regional Healthcare website under the heading "Pay Bill."

PATIENTS WITH OUT-OF-NETWORK INSURANCE/OTHER HEALTH PLAN PAYOR/HEALTH SHARE PRODUCT – **You understand and agree that except when prohibited by applicable law, KRH may collect its charges from guarantors when KRH does not have a written contractual agreement with an insurance company, other health plan Payor or health share product outlining an agreed upon rate of payment for the Healthcare Services provided (called "out-of-network"). You understand and agree that when receiving Healthcare Services from KRH on an out-of-network basis, Guarantors may also be required to make payment at the time of service.**

Payment – Guarantors may make payment to KRH: (1) at the time Healthcare Services are provided to you; (2) in accordance with billing statements received from KRH; or (3) in accordance with a payment arrangement schedule that is agreed upon by both KRH and Guarantor(s). If Guarantors fail to

see other side

make any scheduled payment when due, you understand and agree that: (1) KRH may declare the entire balance to be immediately due and payable, and (2) Guarantors will be responsible for all costs associated with collection of the owed charges, including reasonable attorney's fees. You acknowledge and agree that payments to KRH Affiliated Providers must be made to them in accordance with their payment rules. No partial payment of the amount owed by Guarantors to KRH (whether the payment says it is in full payment or not) will be treated as full payment without a specific separate written agreement between Guarantors and KRH that is signed by both parties. KRH may also assign past due accounts to third party collection agencies.

Third Party Liability – In the event that any third party is or could be liable for part or all of the charges for the Healthcare Services provided to you (such as due to an automobile accident), you acknowledge that Guarantors remain responsible for the portion of the Charges that you are responsible to pay, but KRH is also legally authorized to bill for and recover from that third party the full charges for the Healthcare Services. KRH may do this whether or not KRH has also submitted a bill for the services to any federal, state, or private healthcare insurance/health benefits plans (collectively a "Health Plan Payor") covering you. Guarantors will not be responsible for any amounts in excess of the portion of the charges that you are responsible to pay, but KRH may recover from the third party an amount that permits KRH to receive up to the full charges for the Healthcare Services provided. Guarantors also acknowledge that KRH may submit a Healthcare Provider/ Facility Lien, as allowed by Montana Code Annotated Title 71, Chapter 3, Part 11, to the third party.

Overpayments – **Please let us know if your address changes so that we can contact you in the event that your account is overpaid and you are entitled to a refund in accordance with this paragraph.** ***If your account is overpaid by less than $15.00,*** you agree that the amount is too small to refund and that we may take either of the following actions in the following order: (1) apply the overpayment amount to any other outstanding accounts that you have with us, or (2) if you do not have any other outstanding accounts with us, we may write off the overpayment amount. ***If your account is overpaid by $15.00 to $49.99,*** we will attempt to contact you and provide you with a refund of the overpayment amount. If, after one year, we have not been able to contact you, you agree that we may take either of the following actions in the following order: (1) apply the overpayment amount to any other outstanding accounts that you have with us or, (2) if you do not have any other outstanding accounts with us, we may write off the overpayment amount. ***If your account is overpaid by $50.00 or more,*** we will attempt to contact you and provide you with a refund of the overpayment amount. If, after three years, we have not been able to contact you, then pursuant to Montana's Unclaimed Property Act, we will send the overpayment amount, minus a statutorily allowed dormancy charge of $10 per year, to the Montana Department of Revenue.

AUTHORIZATION

Without waiver or limitation of the above Financial Agreement, you hereby: (1) authorize KRH, on your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and other responsible third party providing coverage for, or who may be otherwise liable for, payment of any of the charges for the Healthcare Services provided to you ("Responsible Third Parties"); and (2) direct those Health Plan Payors and Responsible Third Parties to which KRH submits a claim for payment to make payment(s) directly to KRH. You understand and agree that KRH: (1) is not required to submit a claim for payment to anyone other than Guarantors; but (2) may choose to submit a claim to one or more of your Health Plan Payors and Responsible Third Parties. This authorization is limited only to the rights, on your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and Responsible Third Parties. It does not entitle KRH to any other rights or bind KRH to any responsibilities that you may have under any Health Plan Payor agreements, third party liability agreements or policies or any other theories of coverage or liability. You hereby consent also to KRH providing notice of this authorization to your Health Plan Payors and other Responsible Third Parties.

APPOINTMENT OF KALISPELL REGIONAL HEALTHCARE (KRH) AS AUTHORIZED REPRESENTATIVE

I understand that KRH may assist in pursuing a claim or appeal of a denied claim. I authorize and appoint KRH to act on my behalf and/or on behalf of my covered child/ dependent (under 18 years of age) as my authorized representative with any insurance carrier with whom valid insurance coverage exists for medical services. I further direct that any payment made by any insurance carrier as a result of a successful appeal is to be paid directly to KRH. This authorization and appointment will remain valid until such time as I revoke this authorization and appointment in writing to KRH.

RELEASE OF INFORMATION

You acknowledge that KRH and KRH Affiliated Providers are authorized by law to release medical and account information necessary for the purposes of treatment, payment, and healthcare operations. This information may be released to Health Plan Payors, liability insurance companies, billing companies, collection agencies, attending/consulting healthcare providers, governmental programs or medical review organizations and otherwise as permitted or required by law.

CONSENT TO CONTACT

You agree that, in order for KRH and/or KRH Affiliated Providers to request your feedback about the Healthcare Services provided to you, to service your account, or to collect any amounts you may owe, KRH, KRH Affiliated Providers and their business associates, including without limitation any independent contractors, account management companies or collection agencies, may contact you by telephone, SMS text message or email at any cellular or residential telephone number or email address provided during your registration process. These methods of contact may include auto-dialed, prerecorded and/or artificial voice message calls or texts as permitted by law.

PERSONAL VALUABLES

You acknowledge that KRH maintains a safe for securing money and/or other valuables. KRH shall not be liable for the loss of or damage to your money, valuables, articles of unusual value, or any other personal property if not deposited with KRH for storage in KRH's safe.

BY SIGNING BELOW, YOU CONFIRM THAT YOU: (1) UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT, (2) HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS AGREEMENT AND (3) HAVE RECEIVED AND REVIEWED AND, IF NEEDED, COMPLETED THE FOLLOWING:

- **FEDERAL TRUTH IN LENDING ACT NOTIFICATION**
- **PATIENT BILL OF RIGHTS & RESPONSIBILITIES**
- **KRH JOINT NOTICE OF PRIVACY PRACTICES**
- **AN "IMPORTANT MESSAGE FROM MEDICARE FOR MEDICARE BENEFICIARIES" or "IMPORTANT MESSAGE FROM TRICARE FOR TRICARE BENEFICIARIES" (Medicare and Tricare Inpatients, only)**
- **ADVANCE DIRECTIVE** – You have been advised of your right to formulate and execute an Advance Directive and have been provided with written information regarding the same.

_____ _____

Patient Signature/Authorized Representative/Guarantor Date

If an Authorized Representative/Guarantor, the nature of the relationship to the Patient: _____

_____

Patient Name _____ Acct # _____

Witness _____ MRN # _____

GLACIER VIEW
PLASTIC SURGERY
RENEW • REFINE • TRANSFORM

I _____ would like to give authorization to Glacier View Plastic Surgery to discuss my medical care with the following persons. Please include any friends or family. I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual(s) Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Printed Name:_____

Patient Signature:_____ Date:_____

60 Four Mile Drive, Suite 10, Kalispell, MT 59901
Tel 406.756.2241 | GlacierViewPlasticSurgery.com | Fax 406.756.4151

GLACIER VIEW
PLASTIC SURGERY
RENEW • REFINE • TRANSFORM

AUTHORIZATION AND CONSENT FOR CONFIDENTIAL COMMUNICATIONS VIA EMAIL/MAIL, TELEPHONE AND TEXT MESSAGING

PATIENT: _____ DOB: _____

EMAIL: _____

SSN: _____ PHONE: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have the right to make reasonable requests to receive confidential communications of my protected health information from Glacier View Plastic Surgery ("Practice") by alternative means or at alternative locations. By completing and signing this form, I am authorizing Practice communicate with me via email at the address above.

I acknowledge and agree to the following:

- I have received and reviewed the "Important Information About Email" notice; had an opportunity to ask questions and have had such questions answered to my satisfaction; and understand the information contained within the notice.
- Despite the possibility that my email system may not be encrypted or secure and there are no assurances of confidentiality, I consent to the Practice communicating with me via email.
- The email address above is accurate and it is my responsibility to update the Practice of any changes.
- I may withdraw this consent at any time by delivering written notice to the Practice.

Please mark the ways that you consent to us communicating with you:

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call or do not leave a message

Method	Voicemail	OK to Leave Message with Another Person	Preferred Contact Method(s	Best time to Call*
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
Ok to send Email ?				
Email Appointment Reminders		☐ Yes ☐ No		
Email Medical Info/Communicate with Staff		☐ Yes ☐ No		
Email Office Specials/News		☐ Yes ☐ No		
Ok to send Regular Mail? ☐ Yes ☐ No				
Ok to send Text Message for Appointment Reminders? ☐ Yes ☐ No **-if yes, please list cell phone carrier** (e.g., AT&T,Verizon):				

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) DATE

_____ _____

PRINTED NAME PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

60 Four Mile Drive, Suite 10, Kalispell, MT 59901
Tel 406.756.2241 | GlacierViewPlasticSurgery.com | Fax 406.756.4151

GLACIER VIEW PLASTIC SURGERY

RENEW • REFINE • TRANSFORM

Name (Please Print): _____ Date: _____

How did you hear about Glacier View Plastic Surgery?

- ☐ www.glacierviewplasticsurgery.com
- ☐ RealSelf
- ☐ Facebook
- ☐ Radio
- ☐ Doctor referral from_____
- ☐ Friend referral from_____
- ☐ Instagram
- ☐ Magazine (which one)_____
- ☐ Television
- ☐ Google

Can we Contact your significant other for your birthday or anniversary?

- ☐ Yes When is your Anniversary? _____ Who Should we contact and how? _____
- ☐ No

Are there any other areas that you may be interested?
Please check all that apply: (We offer surgical & non-surgical options)

Surgical Options

- ☐ Facelift
- ☐ Neck Lift
- ☐ Brow Lift
- ☐ Upper Eyelid Surgery
- ☐ Lower Eyelid Surgery
- ☐ Rhinoplasty (nose reshaping)
- ☐ Cheek Implants
- ☐ Chin Implants
- ☐ Mommy Makeover
- ☐ Breast Reduction
- ☐ Breast Augmentation
  - ☐ Gummy Bear Breast Implants
- ☐ Breast Lift
- ☐ Nipple Surgery
- ☐ Arm Lift
- ☐ Thigh Lift
- ☐ Buttock Lift
- ☐ Liposuction
- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Labiaplasty
- ☐ Gynecomastia (Male Breast Reduction)
- ☐ Skin Cancer Treatment
- ☐ Scar Treatment and Revision
- ☐ Earlobe Repair

Non-Surgical Options

- ☐ Skin Care
  - ☐ Advice and Product
  - ☐ Chemical Peels
  - ☐ Skin Cancer Treatments
  - ☐ Acne Treatment
    - ▪ Accutane
- ☐ Botox, Dysport, & Xeomin
- ☐ Juvederm Products
- ☐ Restylane Products
- ☐ Sculptra
- ☐ Kybella
- ☐ Spider Vein Therapy
- ☐ Liquid Facelift
- ☐ Lip and Cheek Augmentation
- ☐ Hand Rejuvenation
- ☐ CoolSculpting "Freeze the Fat"
- ☐ Laser Treatments
  - ☐ Hair removal
  - ☐ Tattoo removal
  - ☐ Skin resurfacing
  - ☐ Discoloration
    - ▪ Brown spots

Please return this form to the front desk

Michelle A. Spring, MD, FACS | Michael V. Hromadka, MD| Kristy Ehrmantraut PA-C
60 Four Mile Drive Suite 10 | Kalispell, MT 59901 | P: 406.756.2241 | F: 406.756.2241
www.glacierviewplasticsurgery.org