316 N. 3rd Street
Hamilton, MT 59840
Phone: 406-541-0032
Fax: 406-541-0036

We are happy to welcome you to Sapphire Community Health and would like to share some information with you about our clinic. We set high standards for how we care for our patients and aim to improve the health of the valley, reduce costs on services and prescriptions and improve your experience. You will play a critical role in coordinating your care with primary care and with any other services you may need.

Our Promise

Patient-Centered Care

1. We recognize that the patients and families are core care team members and will ensure that you are fully informed when establishing care plans.
2. We will coordinate care across all elements of the broader healthcare system, including specialty care, hospitals, home healthcare, and community services and support. Such coordination is particularly critical during transitions between sites of care, such as when patients are discharged from the hospital. We promise to build clear and open communication among patients and families, your providers, and the broader care team members.
3. We are committed to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision-making with patients and families.

Financial Policy

At Sapphire Community Health, we value our relationship with you and take pride in working for your best interests and optimal health. As part of improving your health care and refining customer services, we converted to a new electronic medical records system at the end of July 2022. As with any new process, there have been a few bumps in the road; one of those bumps being that we have been unable to process patient billing statements until now.
As a gentle reminder; while we will never turn anybody away due to inability to pay at the time of care, we do bill for our services. We are pleased to inform you that we have a multitude of payment options available to our patients, including:

1. Income-based sliding fee scale
2. Flexible payment plans
3. Certified Application Counselor to help uninsured and underinsured patients obtain adequate coverage, and we would be happy to discuss these options with you should you feel it necessary.

Please accept our apologies for any inconvenience this may have caused, and feel free to reach out to our billing department at (406)541-0945 with any questions or if payment arrangements need to be made.

SAPPHIRE COMMUNITY HEALTH
316 N. 3rd Street
Hamilton, MT 59840
Phone: 406-541-0032
Fax: 406-541-0036

As a reminder do the following prior to your appointment:

1. Have your current primary care provider send a new referral to our facility for behavioral health appointments
2. Arrive ***10 minutes*** early to your appointments to ensure all documentation can be completed and we can stay on schedule for the benefit of all patients. (We reserve the right to reschedule your appointment if you do not arrive on time)
3. Please commit to your appointments. Proper planning on your part will ensure your timely arrival. We do understand that emergencies happen and will strive to reschedule you at your earliest convenience.
4. Complete the enclosed paperwork and bring it with you, or deliver it prior, to your appointment.
5. Bring the following additional information with you.

    - Photo ID
    - Insurance card (s)
    - Co-payment that may be due at the time of service
    - Advanced directives
    - Current list of all medications, supplements, and over-the-counter medications you are taking

    Please note- Sapphire Community Health is not a specialty pain clinic and does not routinely prescribe narcotic medications.

Behavior Agreement.

To manage your medical and behavioral health care it is essential that we all work together as a team. Your team includes your provider, your nurse, and the front desk staff you check in with, and our administration. This requires that you participate in a plan of care responsibly and reasonably.

Verbal abuse and profanity are not tolerated in Sapphire Community Health.

Extreme or violent behavior will result in an immediate discharge from our facility.

We ask that you speak to anyone at our facility with calmness and respect and refrain from any violence.

If you choose not to honor this agreement by displaying inappropriate behavior you may jeopardize your relationship with your provider and the clinic. This act could lead to a discharge from Sapphire Community health.

No show/ missed appointment and late appointment policy

- Please cancel your appointment at least 24 hours prior via phone or HealtheLife portal .
- Appointments canceled on the same day will be considered a no-show.
- Arrive at your appointment 10-15 minutes early to allow for completion of the check-in process
- Sapphire Community Health gives a 10-minute grace period for patients running late. After 10-minutes, your appointment will have to be rescheduled and marked a no-show.
- After each no-show you will receive a warning via letter, call, or portal message.
- Repeat no-show appointments may result in discharge from the practice.

I agree to the above agreements and will follow clinic regulations.

_____ _____

Patient name (print) Date of birth

_____

Signature of Patient or Guardian

SAPPHIRE COMMUNITY HEALTH
316 N. 3rd Street
Hamilton, MT 59840
Phone: 406-541-0032
Fax: 406-541-0036

Provider_____ PSR_____

Patient Full Name _____ **DOB**_____

Primary Provider_____ Located at_____
(Please Print Clearly)

Address _____ **City, State, Zip**_____

Physical Address _____ **SS#**_____

Best phone to reach you at _____

Message type: Non-detailed/Detailed (may include health information)

Patient Gender at Birth M F Decline **Patient Identified Gender** M F Other

Marital Status of Patient: Single Married Divorced Widow

Emergency contact _____Relation_____Phone_____

****If someone other than the patient is financially responsible, please complete this section****

Print name _____ **Relation**_____

Mailing address_____**Phone**_____

Please check if patient is…

	Veteran
	Seasonal Worker
	Homeless/ Public Housing
	Migrant
	Hearing, Vision cognitive impairment
	Require interpreter or Language device

	Lesbian/Gay
	Straight
	Bisexual
	Transgender Male to Female
	Transgender Female to Male
	Choose not to disclose/other

	African American
	American Indian/ Alaska Native
	Asian
	Caucasian
	Hispanic or Latino
	Choose not to disclose

How many people are in your household? 1 2 3 4 5 6 7 8+

	$0 - 19,140		$19,141 - 25,520		$25,521 – 34,481
	34,482 – 43,441		43,442 – 50,000		50,001 – 60,000
	60,001 – 65,000		65,001 – 70,000		70,000 and above

How would you like to be reminded of your appointments?

o Phone Call o Text

Insurance information

Company _____
Policy#_____
Address _____
City, State, Zip_____
Insured name _____ DOB / / /

Secondary Company _____
Policy# _____
Address _____
City, State, Zip _____
Insured name _____ DOB / / /

Sapphire Portal: *Healthelife*!

Would you like us to connect you with your provider using our e-portal? o Yes o No

Patient's email address (Minors eligible starting at age 13): _____

Secondary email address for optional Authorized Representative _____

316 N. 3rd Street
Hamilton, MT 59840
Phone: 406-541-0032
Fax: 406-541-0036

SCHC cannot guarantee that the recipient will not re-disclose my health information to a third party. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by HIPAA privacy regulations, unless a State law applies that is more restrictive than HIPAA and provides additional privacy protections. If requested, I will be given a copy of this authorization for my records. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment. I may revoke this authorization at any time by submitting a written notice of revocation to SCHC. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions. By my signature below, I hereby, knowingly and voluntarily, authorize SCHC to disclose my health information.

Consent to Treat

I hereby give my consent for the treatment of myself or _____ (name of patient) (of whom I am the parent or legal guardian) to Sapphire Community Health, Inc and confirm that the above information provided is correct. I understand that I am giving consent for routine treatment, or services, (including behavioral health services, chronic care management, and/or integrated behavioral health services), that are considered necessary or advisable for me, or my dependent. I understand that I am asked to participate in my, or my dependents, care plans and that I have the right to refuse interventions, treatment, care, services, or medications to the extent that the law allows. I understand that the care I, or my dependent, will receive may include tests, medications, injections, etc., that are based on established medical criteria, but not free of risk

Insurance Disclosure

Sapphire Community Health will provide you with information regarding the health plans that your provider(s) accepts. If you choose to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment and financial responsibility for services rendered.

Notice of Privacy

I acknowledge that I was provided or given the opportunity to read a copy of Sapphire Community Health's Notice of Privacy Practices (NOPP).
Initials _____ (located at each check in station.)

May we collect your prescription history from pharmacies?

opt in _____Yes ____ No

Common Well Consent

May we share your medical information to a national database?

opt in _____Yes ____ No

imMTrax Consent

May we share/receive your vaccinations to/from a statewide database?

opt in _____ Yes _____No

ASSIGNMENT and RELEASE

I request that SCH provide me and/or my family with medical and mental health care and hereby accept responsibility to pay for this care. I authorize the use and disclosure of my protected health information to SCH and contracted medical, pharmacy, dental, mental health providers, and any insurance companies I may have. This authorization includes, but is not limited to, my medical history, substance abuse, communicable diseases, mental health records, medication history, and billing information. Furthermore, I hereby designate SCH as my lawful agent and assign to SCH any benefits for medical, dental, or mental health services I may be entitled to. I understand and agree: (1) the disclosure and use of my protected health information, to the entities referenced above, is at my request, (2) the information used or disclosed may be subject to re-disclosure by the individuals/entities receiving it, and would then no longer be protected by federal privacy regulations, (3) my refusal to sign this authorization will not affect my ability to obtain treatment, payment for services or eligibility for benefits, (4) I may revoke this authorization by notifying SCH, in writing, however, SCH requires thirty (30) days to process any such request, (5) SCH may use or disclose my protected health information until such time as I am no longer a patient at SCH.

Patient or Legal Guardian Name (Print): _____ Date_____

Patient or Legal Guardian Signature: _____ Date _____