MONTANA

WHOLE HEALTH

Montana Whole Health Policies

Please read and initial one of the following two statements that applies to you/your child.

_____ For **children** with Medicaid (Healthy Montana Kids Plus), uninsured or underinsured (insurance that does not cover vaccinations):

Payment for each vaccine is $21.32 due at the time of the vaccine visit. Montana Whole Health charges this minimal administration fee because naturopathic physicians are unable to bill Medicaid directly.
Remember that you can receive vaccines at no cost by visiting the local Health Department. Montana Whole Health provides this service as a courtesy to patients who would rather not visit the health department for each vaccine visit. You are in no way obligated to continue the entire immunization schedule at Montana Whole Health. Returned checks are subject to a $35 non-sufficient funds charge from Montana Whole Health.

_____ For insured patients (including Healthy Montana Kids, non-Medicaid):

Please fill out an insurance form prior to the vaccine administration. **Patients are responsible for confirming insurance eligibility and reimbursement, and for the payment of any amount not covered by their insurance.** Returned checks are subject to a $35 non-sufficient funds charge from Montana Whole Health.

_____

Patient name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____

Patient Signature (Parent/guardian signature if minor) Date

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Consent for Treatment:

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Montana Whole Health to administer the vaccine(s) I have requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Montana Whole Health, as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: I understand the purposes/benefits of my state's immunization registry ("State Registry"). I acknowledge that, depending upon my state law, I may prevent, by using a state-approved opt-out form ("Opt-Out Form"): (a) disclosure of my immunization information to the State Registry; or (b) the State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry. Montana Whole Health, as applicable, will, if my state permits, provide me with an Opt-Out Form. Unless I provide Montana Whole Health, as applicable, with a signed Opt-Out Form, I elect to participate fully in, and consent to Montana Whole Health, as applicable, reporting my immunization information to the State Registry.

I authorize Montana Whole Health, as applicable, to (1) release my medical or other information, including my communicable disease (excluding HIV) to my healthcare professionals, or other third-party payer as necessary to effectuate care or payment, (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to Montana Whole Health, as applicable, with respect to the above requested items and services. **I further agree to be fully financially responsible for any cosharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits.** I understand that any payment for which I am financially responsible is due at the time of service or, if Montana Whole Health invoices me after the time of service, upon receipt of such invoice.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

_____	_____
Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
_____	_____
Guardian/Personal Representative's Signature	Patient's Signature
_____	_____
Relationship/Representative's Authority	Date

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Insurance Form

If you are requesting Montana Whole Health to submit a claim to your insurer, please fill out the following form.

Patient Name:	Date of Birth:
Address:	Phone Number: *Please circle preferred contact number* Cell: Home: Work:
Primary Insurance Company:	Policy Number:
Name of Insured:	Insured's DOB:
Insured's Relationship to Patient:	Group Number:
Send Claim To:	Deductible: Individual: Family:
Insured's Employer:	
Policy Notes:	