MOOzarks
MISSOURI OZARKS
COMMUNITY HEALTH

Patient Information

☐ Male
☐ Female

Last Name | First Name | Middle Initial | Social Security Number | Sex

Mailing Address | City | State | Zip Code

Home Phone | Cell Phone | Work Phone

/ /
Date of Birth | Email Address | Marital Status

Guarantor Information

Person Responsible for Bill (If self, please indicate so and skip the rest of this section) | Relationship to Patient

/ /
Date of Birth | Address (Street, City, State, Zip) ☐ Same as Patient | Phone Number

PARENT/LEGAL GUARDIAN OR SPOUSE INFORMATION

Name | Relationship | Phone Number

Name | Relationship | Phone Number

Please provide the following information to assist MOCH and our associated federal programs in serving you best.

RACE
- ☐ White (not Hispanic or Latino)
- ☐ Hispanic or Latino (all races)
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one Race

ETHNICITY
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Ukrainian
- ☐ Other:

HOUSING STATUS
- ☐ Not Homeless
- ☐ Doubling Up
- ☐ Street
- ☐ Transitional
- ☐ Homeless Shelter
- ☐ Public Housing (Income Based)
- ☐ Other:

ARE YOU A VETERAN? Yes No

Living Will?
- ☐ Yes
- ☐ No

CONSENT FOR TREATMENT & PRIVACY POLICY: I, the undersigned, do consent for treatment as deemed necessary by the attending health care provider. I also consent to treatment by MOCH dental providers and/or students from UMKC School of Dentistry and Missouri School of Dentistry & Oral Health. In the event the patient is a minor, by signing below I represent that I am the parent and/or legal custodian of the patient being presented today for treatment. By signing below, I am acknowledging that I have read and agree with the MOCH privacy statement and understand that at any time, upon request, I may obtain a copy of the MOCH Statement of Privacy Practices.

Signature of Patient/Legal Custodian:____ **Date:**________________

PERSON(S) WHO MAY OBTAIN HEALTH RECORDS FOR THE LISTED PATIENT. IF THE PATIENT IS A MINOR PATIENT, THE LISTED INDIVDIUALS MAY ACCOMPANY THE MINOR AND MAKE DECISIONS FOR MEDICAL/DENTAL TREATMENT OF THE PATIENT.		
Name:	Relationship to Patient	Phone Number
1.		
2.		
3.		
4.		
5.		
6.		

By providing information above, I understand that I am authorizing the listed individuals to seek care for this minor patient and/or to receive protected health information regarding my care or the care of this minor patient.

Signature of Patient/Legal Custodian:____ Date:_______________

PATIENT FINANCIAL POLICY:

All payments are due at the time of service unless other arrangements have been made prior to the visit. I authorize assignment of benefits for services received to be paid directly to Missouri Ozarks Community Health (MOCH). I understand that I am financially responsible for any balance, including but not limited to copays, deductibles, and self-pay balances. I authorize MOCH to release any medical information necessary to process claims and further authorize payment of medical, dental, and behavioral health benefits payable directly to MOCH. I understand that MOCH will file and complete the necessary steps to collect my insurance payment. However, if my insurance does not cover my service(s), I understand that I may be responsible for the charges associated with these services. I further understand that MOCH may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons. *I understand that it is not the responsible of MOCH to verify insurance benefits under my specific insurance plan and that I am encouraged to contact my insurance provider directly prior to receiving services.*

- Our **Sliding Fee Discount Program** is designed to help you pay for medical, dental, and behavioral health services provided by MOCH. If you would like to apply for our sliding fee discount program, please ask the front desk for a sliding fee program application or request an appointment with one of our Care Coordinators. You must complete the application and provide proof of income to qualify for the sliding fee discount prior to any appointment that you would like the sliding fee to apply to, unless prior arrangements have been made.
- Your child may be eligible for a Medicaid program so please ask for an appointment with one of our Care Coordinators to discuss further.
- Your payment today may be in the form of cash, check, credit card, or debit card. Your minimum co-pay is due at the time of check-in unless other arrangements have been made prior to the visit. Please ask to speak to a Supervisor if you have questions.
- If you participate in a health insurance network, MOCH will be happy to file the insurance claim on your behalf. It is your responsibility to pay the balance of any fees for services not covered under your insurance plan upon receipt of the bill or as agreed upon in your payment plan. Should you foresee needing financial assistance to pay this balance, you must complete the sliding fee application and provide proof of income before the time of service to be qualified for the slide at that time, unless prior arrangements have been made.
- If you do not participate in a health insurance network and if you have household income over 200% of the federal poverty guideline, payment is required in full for services you are receiving today. If there are any additional charges that are not collected at the time of service it is your responsibility to pay the balance of any fees for services upon receipt of the bill or as agreed upon in your payment plan.

Missouri Ozarks firmly believes that a good provider/patient relationship is based upon understanding and good communications. The above information is provided to avoid any misunderstandings. Questions about financial arrangements should be directed to our billing office at 1-417-683-5739. By signing below as the patient or legal custodian, you acknowledge that you have read this Patient Financial Policy sheet and agree to the terms stated above.

Signature of Patient/Legal Custodian:____ Date:_______________

FAMILY SIZE AND INCOME

Patient Name:___________________________________ **Chart Number:**___________________

Instructions: Please select the **family size** in the far left column. Then circle your **income range** to the right of your selected family size (in the same row).

Family Size	HOUSEHOLD INCOME RANGE				
	A	B	C	D / E	F
1	12,060 and below	12,061 15,075	15,076 18,090	18,091 24,120	24,121 and over
2	16,240 and below	16,241 20,300	20,301 24,360	24,361 32,480	32,481 and over
3	20,420 and below	20,421 25,525	25,526 30,630	30,631 40,840	40,841 and over
4	24,600 and below	24,601 30,750	30,751 36,900	36,901 49,200	49,201 and over
5	28,780 and below	28,781 35,975	35,976 43,170	43,171 57,560	57,561 and over
6	32,960 and below	32,961 41,200	41,201 49,440	49,441 65,920	65,921 and over
7	37,140 and below	37,141 46,425	46,426 55,710	55,711 74,280	74,281 and over
8	41,320 and below	41,321 51,650	51,651 61,980	61,981 82,640	82,641 and over

For each additional person, add $4,180 to the income range.

Health Information Exchange Authorization and Consent Form

Who is this form for?
It is for patients who want to allow their health information to be shared with their health care providers through a secure, electronic health information exchange network so that their doctors and other caregivers can provide you with the best care.

What are you agreeing to by signing this form?

- To give consent that allows your healthcare providers to share your health records electronically, through their computers, to better care for you.
- That you have received information about sharing your health records with the health information exchanges that MO Ozarks Community Health participates.

Please read the statements below.
(If you are a patient's legal representative, "me", "my", or "I" refer to the Patient)

1. By signing this form, I understand and agree that MO Ozarks Community Health participates in one or more health information exchange networks. I understand that agree that the health information networks and all health care providers and organizations that participate in the health information exchange networks: Will share my health data with providers who are treating me.
2. Will be able to see all of my health records from both before and after today's date.
3. May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
4. May share all of my health records with providers who are treating me; this includes but is not limited to sensitive data such as: Alcohol or substance abuse problems, genetic (inherited) diseases or tests, HIV/AIDS status, mental health and developmental disabilities, family planning information (including abortions), sexually transmitted diseases, and head/spinal cord injuries.
5. May copy or include my health data in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them. This is the current law.
6. Have penalties in place for anyone sharing my data in the wrong way.
7. The health information exchange networks will keep track of who views my health records to make sure they are secure. I can ask my doctor or the health information exchange network for a list of who has looked at my records.

If I suspect or learn that my data was shared or accessed in the wrong way, I should contact MO Ozarks Community Health immediately.

I also understand and agree that: Using this data for marketing or advertising purposes, or to determine insurance or employment eligibility, is strictly prohibited. My consent will remain in effect until the day I cancel my account by "Opting Out" or MHC no longer exists, whichever comes first. My consent to join MHC is voluntary. I can cancel my consent at any time. I may ask for a copy of this form after I sign it.

By signing this form, I give all MHC participating providers the right to share all of my health records, including sensitive data, through MHC's Network for purposes of providing care to me. MHC has the right to contact me for identity verification.

______________________________	______________________________
Patient Full Name (Print)	**Name of Legal Representative**
______________________________	______________________________
Signature	**Signature of Legal Representative's Signature**
______________________________	______________________________
Date of Signature	**Patient Date of Birth**