

PERSON(S) WHO MAY OBTAIN HEALTH RECORDS FOR THE LISTED PATIENT. IF THE PATIENT IS A MINOR PATIENT, THE LISTED INDIVIDUALS 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	PERCENT OF POVERTY GUIDELINE				
	A	B	C	D / E	F
	< 100% FPG	101-125% FPG	126-150% FPG	151-200% FPG	> 200% FPG
1	12,880 and below	12,881 16,100	16,101 19,320	19,321 25,760	25,761 and over
2	17,420 and below	17,421 21,775	21,776 26,130	26,131 34,840	34,841 and over
3	21,960 and below	21,961 27,450	27,451 32,940	32,941 43,920	43,921 and over
4	26,500 and below	26,501 33,125	33,126 39,750	39,751 53,000	53,001 and over
5	31,040 and below	31,041 38,800	38,801 46,560	46,561 62,080	62,081 and over
6	35,580 and below	35,581 44,475	44,476 53,370	53,371 71,160	71,161 and over
7	40,120 and below	40,121 50,150	50,151 60,180	60,181 80,240	80,241 and over
8	44,660 and below	44,661 55,825	55,826 66,990	66,991 89,320	89,321 and over

For each additional person, add \$4,540 to the income range.



Health Information Exchange Authorization and Consent Form

Missouri Ozarks Community Health may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, health care operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your health care providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes.

The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STD treatment and test results, and family planning information.

The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be obtained at our front desk or you may call us at 417-683-5739. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).