MO Ozarks
MISSOURI OZARKS COMMUNITY HEALTH

Patient Information

☐ Male
☐ Female

Last Name | First Name | Middle Initial | 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

EMERGENCY CONTACT

Name | Relationship | Phone Number

Name | Relationship | Phone Number

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: _____**

Patient Demographics

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

RACE

Please select the option that best describes your race.

- ☐ White (not Hispanic or Latino)
- ☐ Hispanic or Latino (all ethnicities)
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ More than one Race

ETHNICITY

Please select the option that best describes your ethnicity.

- ☐ Not Hispanic or Latino
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish Origin
- ☐ Unknown or more than one Hispanic, Latino/a, or Spanish Origin

HOUSING STATUS

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

ARE YOU A VETERAN? Yes No

PREFERRED LANGUAGE

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

Do you have a Living Will?

- ☐ Yes
- ☐ No

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Please complete the below area and list person (s) who may obtain health information and appointment information for you (patient). This includes medical, dental, and behavioral health information.

****IF PATIENT IS A MINOR, please list any individuals who may accompany the minor to appointment and make decisions for medical/dental/behavioral health care. These individuals may also receive minor patient's health information.**

****For receipt of medical records, a medical records release form must be completed. ****

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 responsibility 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:** _____

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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).

Missouri Ozarks Community Health
2024 Federal Poverty Guidelines

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	15,060 and below	15,061 18,825	18,826 22,590	22,591 30,120	30,121 and over
2	20,440 and below	20,441 25,550	25,551 30,660	30,661 40,880	40,881 and over
3	25,820 and below	25,821 32,275	32,276 38,730	38,731 51,640	51,641 and over
4	31,200 and below	31,201 39,000	39,001 46,800	46,801 62,400	62,401 and over
5	36,580 and below	36,581 45,725	45,726 54,870	54,871 73,160	73,161 and over
6	41,960 and below	41,961 52,450	52,451 62,940	62,941 83,920	83,921 and over
7	47,340 and below	47,341 59,175	59,176 71,010	71,011 94,680	94,681 and over
8	52,720 and below	52,721 65,900	65,901 79,080	79,081 105,440	105,441 and over

For each additional person, add $5,380 to the income range.

Health Information Exchange Authorization and Consent

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).