Missouri Highlands Health Care
PATIENT INFORMATION

As a Federally Qualified Health Care Center, we are required by the Bureau of Primary Health Care to collect data on all our patients annually.

MHHC does not discriminate based on age, sex, race, creed, marital status, religion, national origin, disability, sexual preference, public assistance, or criminal record.

PLEASE PRINT

Patient Name: _____ Social Security No. _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing Address _____

City_____ State _____ Zip_____

Physical Address (if different)_____ County of Residence _____

City _____ State _____ Zip_____

Home Phone_____ Cell/Alternate Phone_____

Legal Guardian (if patient is 17 or under): _____

Employed? ☐ Fill-time ☐ Part-time ☐ No Employer: _____

Student? ☐ Fill-time ☐ Part-time ☐ No Veteran? ☐ Yes ☐ No ☐ N/A (17 or under)

Preferred Pharmacy _____ Location_____

GENDER/SEXUAL ORIENTATION

Gender Identity (circle): Male Female Transgender (f-to-m) Transgender (m-to-f)

Gender Queer/Questioning Other_____ Choose not to disclose

Sexual Orientation (circle): Straight/heterosexual Homosexual/Gay Bisexual

Something else: _____ Don't Know Choose not to disclose

COMMUNICATION

Primary Language: ☐ English ☐ Spanish ☐ Other_____ (Indicate which language)

** Missouri Highlands has resources available to assist patients who may need hearing, vision, or language assistance. If you need such assistance, please check what kind of assistance you require.

☐ Sign Language ☐ Visual Aides ☐ Interpreter for (indicate which language) _____

Preferred method of communication: ☐ Phone ☐ Email ☐ Letter ☐ Patient Portal

ETHNICITY

☐ Hispanic/Latino ☐ Not Hispanic/Latino

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MISSOURI Highlands HEALTH CARE

RACE

Please check ALL that apply: ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to Answer

HOUSING STATUS

☐ Not Homeless

☐ Homeless (Without Permanent Housing)

☐ Transitional (Passing from one place to another)

☐ Other (Hotels/Motels or other day-today paid for housing)

☐ Street (living outdoors, in a car, makeshift housing/shelter)

☐ Public Housing (Senior Living or HUD)

☐ Doubling Up (Staying with others temporarily/housing unstable)

☐ Unknown

ANNUAL INCOME

Check one THEN circle the annual income range on the line beside the household size you have selected.

	Household Size		Annual Income Range			
☐	1	→	$0-14,580	$14,581-19,391	$19,392-24,203	$24,204-29,160
☐	2	→	$0-19,720	$19,721-26,228	$26,229-32,735	$32,736-39,440
☐	3	→	$0-24,860	$24,861-33064	$33,065-41,268	$41,269-49,720
☐	4	→	$0-30,000	$30,001-39,900	$39,901-49,800	$49,801-60,000
☐	5	→	$0-35,140	$35,141-46,736	$46,737-58,332	$58,333-70,280
☐	6	→	$0-40,280	$40,281-53,572	$53,573-66,865	$66,866-80,560
☐	7	→	$0-45,420	$45,421-60,409	$60,410-75,397	$75,398-90,840
☐	8	→	$0-50,560	$50,561-67,245	$67,246-83,930	$83,931-101,120

ACCOUNT TO BE PAID BY: (If someone other than the patient)

Name: _____ D.O.B._____

SS#_____ Relationship to patient_____

Home Address (If different than the patient's) _____

City _____ State _____ Zip _____

Home Phone: _____ Cell/Alternate Phone _____

PLEASE PRESENT YOUR INSURANCE CARD

Thank you for selecting Missouri Highlands Health Care. If you have any questions, please ask us. We will be happy to help.

Missouri Highlands Health Care Patient Consent, Authorization, and Acknowledgement

Consent to Treatment I herby grant permission for Missouri Highlands Health Care to perform those procedures and treatments necessary for complete care of myself or a dependent for whom I am legally responsible.

Authorization and Release I authorize Missouri Highlands Health Care to release any information, including the diagnosis and the records of any treatment or examination provided to me or my dependent during the period of such medical care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Missouri highlands Health Care any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services provided on my behalf or my dependents. If my account balance is sent to an outside agency for collection. I am responsible for collection fees that must be paid to said agency. I authorize the doctor/dentist/nurse practitioner/behavioral health specialist to preform any treatment, medication administration and therapy that may be indicated in connection with my care or the care of my dependent. I understand that before treatment, full explanation of the procedure(s) involved will be given by staff.

Patient's Rights and Responsibilities We have also shared a copy of our Patient's Rights and Responsibilities, to ensure you are aware of your rights and responsibilities.

Photographic Consent I agree that photographs of me or my dependent may be taken by a member of Missouri Highlands Health Care staff. The photograph(s) will be used for medical records and to help in the avoiding identity Theft. All photographs are strictly private and the identity of the patient will not be revealed to anyone outside of Missouri Highlands Health Care unless required by law enforcement.

About Our Notice of Privacy Practices We are committed to protecting your personal health information in compliance with the law. We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice. If you choose to receive information from Missouri Highlands Health Care via email (e.g. appointment reminders), it will be sent through a secure server. However, you will be responsible for the protection of that information once it leaves our server.

Fundraising Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please mark the following box:

☐ Please do not use my information for fund-raising purposes.

Marketing Unless you request us not to, there are some marketing activities for which we may use your name and address to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please mark the following box:

☐ Please do not use my information for marketing purposes.

Patient Name (please print) _____

Patient's Date of Birth _____ Social Security Number _____

Patient/Patient Representative Signature _____

Relationship to Patient _____ Date _____

Witness Signature (MHHC Employee/Representative) _____

This signed consent, authorization and acknowledgement is effective until treatment is terminated in writing by you, the patient, or Missouri Highlands Health Care.

MISSOURI Highlands HEALTH CARE

Patient Authorization to Release Medical Information

Patient Name _____ Date of Birth _____

I understand that my family members or friends may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors/nurses to discuss my medical information in any way with anyone with my expressed written consent. By signing this form, I give Missouri Highlands Health Care permission to discuss my medical information with the people listed below.

I recognize that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I may limit the amount of information that I authorize to disclose. It is my expressed with that ALL medical information may be released. If I have any information that I do not want given, I will list:_____

Individuals to Receive My Medical Information (Please Print)

Name_____ Date of Birth_____

Relationship to patient _____ Phone Number _____

Name_____ Date of Birth_____

Relationship to patient _____ Phone Number _____

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Signature of MHHC Witness Date

Emergency Contact Information (family, friend, or neighbor, not living with you, who can get a message to you)

Name of Secondary Contact _____ Secondary Contact Phone _____

Relationship of Secondary Contact _____

MISSOURI Highlands HEALTH CARE

Appointment Guidelines

Please Review the guidelines below, initial next to each one and sign below.

_____ **Missed Appointments:** If you miss your appointment without proper notice, you will be considered a "No Show". If you have two "No Shows" in a three month period, you will be placed on a probation and not allowed to schedule appointments for one month. You will be considered a "walk-in" only until the one month probation expires.

_____ **Walk-Ins:** Urgent walk-ins are welcome in our office. We will do our best to work you in between scheduled appointments and a wait time is to be expected. Prescribed Controlled Medications will NOT be refilled at a walk-in appointment. These appointments must be a scheduled appointments.

_____ **Late Arrival for Appointment:** Please call the office if you think you may be late for your appointment. If you arrive more than 15 minutes late for a scheduled appointment, your appointment will be handled as a walk in and wait time is to be expected.

_____ **Applying for Slide Fee:** If you are applying for out slide fee at the time of your appointment, you must arrive 30 minutes early. This is necessary so that we may process your applications prior to your appointment time. If you do not arrive 30 minutes before your appointment time, you will be considered a "Late Arrival" (see above). You are welcome to mail or fax you Slide Fee Application to our office before your appointment day. Please speak with the front desk staff for our address and fax number.

I have read and understand the above guidelines.

_____ _____

Patient Signature Date

MISSOURI Highlands HEALTH CARE

Authorization for Release of Health Information

Patient Name_____

Date of Birth _____ Social Security Number _____

Patient Address _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

1. Big Spring Medical Association INC. DBA Missouri Highlands Health Care uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Big Springs Medical Association INC. DBA Missouri Highlands Health Care.
2. This authorization may include disclosure of prescription information related to alcohol and drug use, mental health treatment, and/org confidential HIV related information by SureScript, Inc. to Big Springs Medical Association INC. DBA Missouri Highlands Health Care.
3. I have the right to revoke this authorization at any time by writing to Big Springs Medical Association INC. DBA Missouri Highlands Health Care. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____ _____

Signature of Patient or representative authorized by law Date

_____ _____

Relationship to Patient Interpreter, if utilized

_____

Witness Signature

MISSOURI Highlands HEALTH CARE

Patient Portal Consent

Missouri Highlands Health Care provides patients of the health center with a secure Patient Portal web site. This "portal" is intended to improve access to medical records and enhance patient-provider communications. Patients must be 18 years of age to access the portal and must sign up with the front desk via this form, at the time of their office visit.

The patient portal allows for electronic access to view personal medical history, update personal information, schedule appointments, and ensure patient information is correct and complete. The portal is NOT to be used to communicate Urgent or Emergency issues. **If you are experiencing an emergency, please call 911. 911 can be called in the following counties: Butler, Iron, Reynolds, and Ripley. For emergencies in Carter County please dial 573-323-4510, in Shannon County dial 573-226-3915, and in Wayne County dial 573-224-3219.**

Please read the following carefully:

- **ALL communication via the Patient Portal will be** included in your permanent patient record.
- The Patient Portal is being provided to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the Patient Portal at any time and for any reason.
- Staff members other than your primary care provider will be involved in receiving your messages and directing them to the right person/place. These staff members will be designated and may be medical assistants, billing clerks, or front desk staff.
- Refill requests for controlled substances CANNOT be made through the portal. Please call your primary care provider to set up an appointment.
- Is your responsibility to protect your password from anyone not authorized to access your information. If your password is stolen it is your responsibility to contact us and let us know. You agree to not hold Missouri Highlands Health Care responsible for any violations beyond our control.
- Please refer to our Notice of Privacy Practices for information on how private health information is handled in our office.

Please complete the following information and sign on the signature line below.

_____ _____

Name (please print) Date of Birth

Address (Number): _____

City_____ State_____ Zip Code_____

Email Address: _____

_____ _____

Signature Date

MISSOURI HIGHLANDS HEALTH CARE
BEHAVIORAL HEALTH CONSENT FOR TREATMENT

Patient's Name: _____ DOB _____ Social Security Number _____

Missouri Highlands health Care provides behavioral health services to residents of Iron, Shannon, Carter, Reynolds, and Butler counties. All persons are eligible regardless of age, race, income, or gender status.

Services: Your first appointment with your behavioral health professional is for screening and assessment and usually lasts 45 min-one hour. The goal of the screening and assessment is to determine the best course of treatment for you. You will also discuss options at that time to determine the type and extent of services that are best for you. The follow-up visits usually last between 15-50 minutes. Counseling is a confidential process designed to help address your concerns, better understand yourself, and learn effective personal and interpersonal coping strategies. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive: however the level of satisfaction for an individual is not predictable. Your counselor is available to support you through the counseling process.

Scheduling: If you are unable to make the appointment, please call the receptionist at the clinic to cancel at least 24 hours before the appointment time. If you miss a scheduled appointment and have not cancelled it in advance, you are responsible for re-scheduling another appointment. If you experience a crisis between appointment you can call the clinic (or the MOCARS crisis line after hours: 800-811-8720 (Iron County) or 800-356-5395 for all other areas).

Confidentiality: Information shared in a session is strictly confidential. While the behavioral health professional may at times need to consult with your doctor (or other members of your health team) at the clinic in order to insure you get the best treatment, information about you will never be shared with outside agencies or people without your written permission.

The only time staff can disclose information without your consent are the following:

1. If a staff member has reason to believe that a child under the age of 18 or an elderly or dependent adult is being abused or neglected s/he is required by law to report this to the appropriate state agency
2. If a staff member has reason to believe that you are in danger of harming yourself s/he may have to make an involuntary referral to a hospital and/or contact a family member or a friend to help protect you.
3. If a staff member has reason to believe you are seriously intending to harm another person s/he will have to notify the police and the intended victim as well as seek hospitalization for you to insure the safety of all involved.
4. If records are subpoenaed for a court case you are involved in we may need to release some or all of your record. If this happens, you will be notified before records are released.

By signing the Consent for Treatment, I certify that (1) I have read and understand the information above: (2) I have the legal authority to consent to treatment as the Patient or as the Patient's Legal Guardian: and (3) I understand that this consent is continuing in nature and that it will remain fully effective until it is revoked in writing.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient

_____ _____
Witness Signature Date

_____ _____
Printed Name of Witness Witness Job Title

MISSOURI Highlands HEALTH CARE

Virtual Visit Informed Consent

I, _____, agree to participate as a patient of Missouri Highlands Virtual Delivery System of providers. I will be receiving medical health and/or mental health services through interactive virtual visits. I understand the use of virtual visits is an alternative method of medical and/or metal health care delivery and that my providers will not be physically in the same room with me.

I understand that although Missouri Highlands Health Care providers make every effort to protect my privacy by using a secure server, they cannot guarantee the security of an information I transmit to them over the internet. By using virtual services, I recognize that transmissions over the internet or phone service are at my own risk and that third parties may unlawfully intercept or access the transmissions. I also understand that despite reasonable efforts on the mart of my virtual provider, there are risks and consequences insuring virtual services. The risk included but are not limited to. The possibility that the transmission of sessions could be disrupted or distorted by technical failures. In case of technical failures, my provider will make every effort to re-connect with me through my clinic site.

I also understand that virtual services may not be as complete as services provided via face-to-face, although several benefits of virtual services have been identified including access to specialized services in remote areas, lower healthcare cost, reduced travel, minimizing time off work, and decreased waiting time for services. I have also been notified that if my provider believes I would be better served by another form of service, I will be referred to a provider who can provide such services. Finally, I understand that there are potential risk and benefits associated with an form of medical and/or mental health services and that, despite my efforts and the efforts of my provider, my conditions may not improve and in some cased my even get worse. I understand that my participation in this is voluntary and I may decide to terminate my treatment at any time. My privacy and confidentiality will be protected.

I understand that there will be no recordings of my virtual sessions on any platform. I also agree to not record my own virtual sessions without my provider's knowledge or permission.

I understand that I must confirm my appointment by 4pn on the business day prior to my scheduled appointment. If I do not confirm my appointment, I know my time slot may be forfeited and given to someone else in need.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Witness Signature Date