

## NEW PATIENT REGISTRATION FORM

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

### PATIENT IDENTIFICATION AND CONTACT (Please Print)

<b>Patient Full Name:</b>					
<b>Legal Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Date of Birth:</b>		<b>Social Security #:</b>	
<b>Residential Address:</b>				<b>Mailing Address:</b> <input type="checkbox"/> Same	
<b>City:</b>	<b>State:</b>	<b>Zip</b>	<b>City</b>	<b>State</b>	<b>Zip</b>

Place a check in the box next to the number you prefer to be called first

<b>Home Phone:</b> <input type="checkbox"/>	<b>Cell Phone:</b> <input type="checkbox"/>	<b>Work / Alternative Phone:</b>
<b>Patient Email Address</b>		
<b>Preferred Method of Communication:</b> <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message <input type="checkbox"/> Email <input type="checkbox"/> Letter <input type="checkbox"/> Patient Portal		
Missouri Highlands Health Care 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.		
<input type="checkbox"/> Sign Language <input type="checkbox"/> Visual Aides <input type="checkbox"/> Interpreter for (indicate which language):		

### CONTACT and GUARDIAN INFORMATION (If patient is under the age of 17)

Contact below is: <input type="checkbox"/> Custodial Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> NA		Contact below is: <input type="checkbox"/> Custodial Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> NA	
<b>Guardian Name:</b>		<b>Guardian Name:</b>	
<b>Guardian Email:</b>		<b>Guardian Email:</b>	
<b>Home Phone:</b> <input type="checkbox"/> Same as Patient	<b>Cell Phone</b>	<b>Home Phone:</b> <input type="checkbox"/> Same as Patient	<b>Cell Phone</b>
<b>Relationship:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grand Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling <input type="checkbox"/> Other (Please Specify)		<b>Relationship:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grand Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling <input type="checkbox"/> Other (Please Specify)	

### EMERGENCY CONTACT

<b>Name:</b>	<b>Home Phone:</b>	<b>Cell Phone:</b>
<b>Relationship:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/> Guardian <input type="checkbox"/> Other		

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<b>Name:</b>	<b>Phone:</b>	<b>Relationship:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/> Other
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### DEMOGRAPHICS










<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Specify)		<b>Race (check all that apply):</b> <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to Answer	
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Partner	
<b>Gender at Birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female			

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**Agricultural Work (You or a Family Member)** This includes work in crop production, animal production, aquaculture, forestry, fishing, or support jobs like planting, picking, feeding, sorting, or caring for farm animals or crops.

☐ Migratory Agricultural Work current or past 2 years and moved from home for this work ☐ Seasonal Agricultural Worker current or past 2 years but DID NOT move from home for this work ☐ Former Migratory Agricultural Worker (Aged or Disabled) stopped work due to age or disability ☐ None of the above apply

**Household Size & Annual Income Range:** Check the household size THEN circle the annual income range on the line beside the household size you have selected.

Household Size			Annual Income Range			
<input type="checkbox"/>	1		\$0-15,650	\$15,651-20,815	\$20,816-25,979	\$25,980-31,300
<input type="checkbox"/>	2		\$0-21,150	\$21,151-28,130	\$28,131-35,109	\$35,110-42,300
<input type="checkbox"/>	3		\$0-26,650	\$26,651-35,445	\$35,446-44,239	\$44,240-53,300
<input type="checkbox"/>	4		\$0-32,150	\$32,151-42,760	\$42,761-53,369	\$53,370-64,300
<input type="checkbox"/>	5		\$0-37,650	\$37,651-50,075	\$50,076-62,499	\$62,500-75,300
<input type="checkbox"/>	6		\$0-43,150	\$43,151-57,390	\$57,391-71,629	\$71,630-86,300
<input type="checkbox"/>	7		\$0-48,650	\$48,651-64,705	\$64,706-80,759	\$80,760-97,300
<input type="checkbox"/>	8		\$0-54,150	\$54,151-72,020	\$72,021-89,889	\$89,890-108,300

**Housing Status:** ☐ Not Homeless ☐ Doubling Up (Staying with others temporarily) ☐ Homeless Shelter ☐ Public Housing (Senior Living / HUD) ☐ Street (Living outdoors, in a car, makeshift shelter) ☐ Transitional (No permanent housing / one place to another) ☐ Other (Hotels/Motels)

**Veteran:** ☐ Yes ☐ No ☐ Decline to Answer

**Occupation:**

### GUARANTOR INFORMATION (To whom statements will be sent)

<b>Guarantor Relation to the patient:</b> <input type="checkbox"/> Patient / Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Specify)		
<b>Guarantor Full Name:</b>		<b>Guarantor DOB:</b>
<b>Guarantor Mailing Address:</b> <input type="checkbox"/> Same as patient		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Guarantor SSN:</b>	<b>Guarantor Phone:</b>	<b>Guarantor Email:</b>

**Preferred Pharmacy** \_\_\_\_\_ **Location:** \_\_\_\_\_

**PATIENT INSURANCE** ☐ Check if uninsured (You will be contacted by a MHHC representative prior to your visit, if checked)

<b>Relation to the Insured:</b> <input type="checkbox"/> Patient / Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Specify)	
<b>Member ID / Policy #:</b>	<b>Group #:</b>
<b>Name of Insured:</b>	
<b>Name of Insurance:</b>	



## NEW PATIENT REGISTRATION FORM

### PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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 any member of my medical care team to discuss my medical information in any way with anyone without 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 be disclosed. It is my expressed wish that ALL medical information may be released. If I have any information that I do not want to give I will list below:

**Individual(s) I authorize to receive my medical information:**

<b>Name:</b>	<b>Phone:</b>	<b>Relation:</b>	<b>DOB:</b>
<b>Name:</b>	<b>Phone:</b>	<b>Relation:</b>	<b>DOB:</b>

**Signature of Patient/Patient Representative**

**Date**

**Signature of MHHC Witness**

**Date**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NEW PATIENT REGISTRATION FORM**

**MISSOURI HIGHLANDS HEALTH CARE PATIENT CONSENT, AUTHORIZATION, AND ACKNOWLEDGEMENT**

**Consent to Treatment:** I hereby 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 for 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 my medical care team to perform any treatment, medication administration, and/or 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.

**SureScripts:** I, or my authorized representative, request the health information regarding my care and treatment be released as set forth on this form. In accordance with Missouri State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 \*HIPAA, I understand that:

1. BIG SPRINGS 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 medical care team and the pharmacy. The information sent between these systems may include details of all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV-related information by SureScripts, 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.

**Patient's Rights and Responsibilities:** I acknowledge that Missouri Highlands Health Care has shared a copy of their 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 the Missouri Highlands Health Care staff. The photograph(s) will be used for medical records and to help in 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 acknowledgment 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 fundraising efforts. If you do not want to participate in fundraising efforts, please mark the following box:  
☐ Please do not use my information for fundraising purposes.
- **Marketing** – Unless you request us not to, we will use your name and address for marketing activities, to provide you with information about services available at our practice. If you do not want to receive marketing communications from our practice, please mark the following box:

☐ Please do not use my information for marketing purposes.

**Patient Name (please print):** \_\_\_\_\_

\_\_\_\_\_

**Name of Representative/Guardian (If applicable):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient/Patient Representative**  
**Date**

\_\_\_\_\_

\_\_\_\_\_  
**Signature of MHHC Witness**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Date**

\_\_\_\_\_

**Delegation of Another Person to Consent for Treatment of a Minor  
Attachment A**

I, (parent/legal guardian), \_\_\_\_\_, cannot accompany my child,  
(child's name) \_\_\_\_\_, to Missouri Highlands Health Care, I give  
permission to the following adult(s) (must be 18 years of age or older):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

I give permission for this person to seek treatment for my child including any type of  
medical/dental care, diagnostic test, mental health care, immunizations, procedure, and  
the administration of local anesthesia determined by a Physician, Nurse Practitioner, or  
Dentist, to be necessary for the welfare of my child, **and provide consent for such  
treatment if attempts to contact me are unsuccessful.** (initial here) \_\_\_\_\_

I give permission for this person to seek treatment for my child including any type of  
medical/dental care, diagnostic test, mental health care, immunizations, procedure, and  
the administration of local anesthesia determined by a Physician, Nurse Practitioner, or  
Dentist, to be necessary for the welfare of my child, **and provide consent for such  
treatment without having to contact me.** (initial here) \_\_\_\_\_

This form will remain in effect until revoked by filling out the Notice to Revoke Delegation  
form

This form is VALID ONLY during the following timeframe:

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

X \_\_\_\_\_

(Signature of parent or legal guardian) (Date and Time signed-REQUIRED)

X \_\_\_\_\_

(Signature of MHHC employee witness) (Date and Time signed-REQUIRED)

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Delegation of Another Person to Consent for Treatment of a Minor  
Attachment A**