MISSOURI Highlands HEALTH CARE

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)

Patient Full Name:					
Legal Sex: ☐ Male ☐ Female		**Date of Birth:**		**Social Security #:**	
Residential Address:			**Mailing Address:** ☐ Same		
City:	**State:**	**Zip**	**City**	**State**	**Zip**

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

Home Phone: ☐	**Cell Phone:** ☐	**Alternative Phone:**
Patient Email Address		
Preferred Method of Communication: ☐ Phone Call ☐ Text Message ☐ Email ☐ Letter ☐ 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. ☐ Sign Language ☐ Visual Aides ☐ Interpreter for (indicate which language):		

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

Contact below is: ☐ Custodial Parent ☐Legal Guardian ☐ Caretaker ☐ NA		Contact below is: ☐ Custodial Parent ☐Legal Guardian ☐ Caretaker ☐ NA	
Guardian Name:		**Guardian Name:**	
Guardian Email:		**Guardian Email:**	
Home Phone: ☐ Same as Patient	**Cell Phone**	**Home Phone:** ☐ Same as Patient	**Cell Phone**
Relationship: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (Please Specify)		**Relationship:** ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (Please Specify)	

EMERGENCY CONTACT

Name:	**Home Phone:**	**Cell Phone:**
Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Cousin ☐ Guardian ☐ Other		

NEXT OF KIN

Name:	**Phone:**	**Relationship:** ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Cousin ☐ Other

DEMOGRAPHICS

Primary Language: ☐English ☐ Spanish ☐ Other (Specify)	**Race (check all that apply):** ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to Answer
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Partner
PCP:	**PCP Phone Number:**

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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

Employment: **Employer**_____ **JobTitle**_____ **WorkPhone**_____
Employment Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Unemployed** ☐ **Retired** ☐ **Student**

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				
☐	1	→	$0-15,960	$15,961-21,227	$21,228-26,494	$26,495-31,920	$31,921 +
☐	2	→	$0-21,640	$21,641-28,781	$28,782-35,922	$35,923-43,280	$43,281 +
☐	3	→	$0-27,320	$27,321-36,336	$36,337-45,351	$45,352-54,640	$54,641 +
☐	4	→	$0-33,000	$33,001-43,890	$43,891-54,780	$54,781-66,000	$66,001 +
☐	5	→	$0-38,680	$38,681-51,444	$51,445-64,209	$64,210-77,360	$77,361 +
☐	6	→	$0-44,360	$44,361-58,999	$59,000-73,638	$73,639-88,720	$88,721 +
☐	7	→	$0-50,040	$50,041-66,553	$66,554-83,066	$83,067-100,080	$100,081 +
☐	8	→	$0-55,720	$55,721-74,108	$74,109-92,495	$92,496-111,440	$111,441 +

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)

Agricultural Worker: ☐ Migrant ☐ Seasonal ☐ Decline to Answer | **Veteran?** ☐ Yes ☐ No ☐ Decline to Answer

GUARANTOR INFORMATION (To whom statements will be sent)

Guarantor Relation to the patient: ☐ Patient / Self ☐ Child ☐ Spouse ☐ Other (Specify)			
Guarantor Full Name:			**Guarantor DOB:**
Guarantor Mailing Address: ☐ Same as patient			
City:		**State:**	**Zip:**
Guarantor SSN:	**Guarantor Phone:**	**Guarantor Email:**	

Preferred Pharmacy:_____ **Location:**_____

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

Relation to the Insured: ☐ Patient / Self ☐ Child ☐ Spouse ☐ Other (Specify)	
Member ID / Policy #:	**Group #:**

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Name of Insured:

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:

Name:	**Phone:**	**Relation:**	**DOB:**
Name:	**Phone:**	**Relation:**	**DOB:**

_____ / _____ _____ / _____

Signature of Patient/Patient Representative **Date** **Signature of MHHC Witness** **Date**

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.

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NEW PATIENT REGISTRATION FORM

Patient Name (please print): _____

Name of Representative/Guardian (If applicable): _____

_____ _____

Signature of Patient/Patient Representative **Date**

_____ _____

Signature of MHHC Witness **Date**

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 a virtual visit is an alternative method of medical and/or mental health care delivery and that my provider will not be physically in the same room with me.

I understand that although Missouri Highlands Healthcare providers make every effort to protect my privacy by using a secure server, they cannot guarantee the security of any 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 part of my virtual provider, there are risks and consequences in using virtual services. The risks include, 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 costs, 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 risks and benefits associated with any form of medical and/or mental health services and that, despite my efforts and the efforts of my provider, my condition may not improve and in some cases may 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 4pm 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/Legal Guardian Date

_____ _____

Witness Date

MISSOURI HIGHLANDS HEALTH CARE
BEHAVIORAL HEALTH CONSENT FOR TREATMENT

Name_____ DOB_____ Soc Sec #_____

Behavioral Health Services are available to all Missouri Highlands Health Care patients. All persons are eligible regardless of age, sex, race, or income.

Services: Behavioral Health Consult: A consult is a 16 – 30-minute appointment with a behavioral health consultant providing brief behavioral interventions to improve chronic health conditions. The behavioral health consultant works with your primary care team to help with a variety of issues, such as physical health conditions, behavioral health problems, medication and treatment plan adherence and brief coaching for substance use disorders.
Therapy: The initial 1 – 3 appointments with your behavioral health provider is for assessment and treatment planning. Each visit usually lasts 45 – 60 minutes. We will discuss what brought you to therapy, your goals for therapy, personal concerns, history, and symptoms during the initial visits. We will also discuss options to determine the type and extent of services that are best for you. Psychotherapy is a confidential process designed to help address your concerns, better understand yourself, and learn effective personal and interpersonal coping strategies. Psychotherapy has both benefits and risks. Risks may include uncomfortable feelings such as sadness, guilt, anxiety, anger, or helplessness. However, the benefits of psychotherapy can lead to reduction of symptoms, increased coping skills, increased satisfaction of interpersonal relationships, greater self-awareness, and resolutions to specific problems. Your therapist is available to support you throughout the psychotherapy process.
Scheduling: If you are unable to attend your appointment, please call the clinic to cancel the appointment by the end of the business on the day prior to the appointment. A "no-show" is a failure to cancel or reschedule an appointment by end of business on the day prior to the patient's scheduled appointment. Patients seeing Behavioral Health providers will be placed on a restricted scheduling status after 3 no-shows in a three-month period. Patients on restricted scheduling status can only schedule same day appointments or are welcome to walk-in and wait for a same day opening. Patients who have 3 no-shows in a three-month period with our Behavioral Health medication providers will be evaluated for a referral to an outside facility for further treatment. All decisions regarding referrals to outside facilities or being placed on restricted scheduling status will be at the provider's discretion.
If you experience a crisis between appointments you can call the clinic to speak to a behavioral health provider. However, if a behavioral health provider is not available Missouri's Suicide & Crisis Lifeline is available 24 hours/day. Call or Text the number: 988. Videophone and chat are available at missouri988.org.
Confidentiality: Information shared during behavioral health visits is strictly confidential. While your behavioral health provider may at times need to consult with your primary care team at the clinic in order to ensure you get the best treatment, information about you will not be shared with outside agencies or people without your consent.
In general, there are some limits to confidentiality including but not limited to:

- If there is reason to believe that a child under the age of 18, an elderly person or a disabled adult is being abused or neglected the staff member is required by law to report this to the appropriate state agency.
- If there is reason to believe that you are in danger of harming yourself the staff member may have to make an involuntary referral to a hospital and/or contact a family member or friend to help protect you.
- If there is reason to believe that you are seriously intending to harm another person the staff member will have to notify the police and the intended victim as well as possibly seek hospitalization for you to ensure the safety of all involved.
- If records are subpoenaed for a court case Missouri Highland Health Care will be required to release your records.

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 a 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