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: _____ | SSN: _____

Residential Address: _____

City: _____ State: _____ Zip _____

Mailing Address: ☐ Same

_____

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 ☐ 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 ☐ N/A

Guardian Name: _____

Guardian Email: _____

Home Phone: ☐ Same as Patient _____

Cell Phone: _____

Relationship: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent
☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (please specify)_____

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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**: _____

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, 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

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Employment: Employer_____ Job Title_____ WorkPhone_____
Employment Status: ☐Full-Time ☐Part-Time ☐Unemployed ☐Retired ☐Student
Occupation:_____

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)

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 an MHHC representative prior to your visit, if checked)
Relation to the insured: ☐Patient/Self ☐Child ☐Spouse ☐Other(Specify)_____
Member ID/Policy #:_____Group#_____
Name of Insured:_____

MISSOURI Highlands HEALTH CARE

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:

Name:	Phone:	Relation:	DOB:

Name:	Phone:	Relation:	DOB:

_____

Signature of Patient/Patient Representative Date

_____

Signature of MHHC Witness Date

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

SURESCRIPTS AUTHORIZATION AND ACKNOWLEDGEMENT

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 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 HELATH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____

Printed Name of Patient

_____

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 ("MHHC") 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 MHHC 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 MHHC 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.

Patient's Rights and Responsibilities: I acknowledge that MHHC has shared a copy of their Patient's Rights and Responsibilities, and I am aware of rights and responsibilities under that document.

Photographic Consent: I agree that photographs of me or my dependent may be taken by a member of the MHHC staff. The photographs will be used for medical records and to help avoid identity theft. All photographs are strictly private, and the identity of the patient will not be revealed to anyone outside of MHHC 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 MHHC 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