COMC
MEDICAL · BEHAVIORAL · DENTAL
Your Health.....Our Mission.

Central Ozarks Medical Center
If you need help filling out this form, please let us know.

School Based Medical - Peds Registration

(Please Print)

Today's Date:	COMC Medical Provider:	COMC Dental Provider:

PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:	Social Security Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	State:	Zip Code:	
Mailing Address: ❑ Same as above	If homeless, please state homeless Status: ❑ Doubling Up ❑ Homeless Shelter ❑ Homeless ❑ Other: _____			
Email Address:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )	
May we text you for appointment reminders: ❑Yes ❑ No	Preferred Pharmacy:	Preferred method of contact for reminder calls and messages: □ Cell □ Home □ Work		
❑ Parent/Guardian **OR** ❑ Emergency Contact Name: _____ Number: _____	Address: ❑ Same as above	Primary Phone Number: ( )		

Does the patient have any problems with: ❑ Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:

MEDICAL INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Primary Phone Number: ( )
Occupation:	Employer:		Employer Phone Number: ( )

Patients relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other

Primary Medical Insurance:	❑ Medicare	❑ Medicaid	❑ Blue Cross Blue Shield	❑ Cigna	❑ Other:

Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #:	Group #:	Co-Payment: $
Name of **Secondary Medical Insurance** (if applicable):	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #: Group #:	

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:	Subscriber's Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /

If you are enrolled in Medicare, please provide HIC number and sign below

I request payment of authorized medical benefits be made to Central Ozarks Medical Center, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.
HIC Number: _____
Signature: _____ Date: _____

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Central Ozarks Medical Center. I understand that I am financially responsible for any balance. I also authorize COMC or my insurance company to release any information required to process my claims.

Signature:_____Date: _____

Circle of Care: Please list names of **ALL** providers who are treating you, including - Behavioral Health, Dentists and Specialists		
Name:	**Specialty:**	**Phone:**
1.		
2.		
3.		

Ethnicity	
	Hispanic or Latino
	Not Hispanic
	Unreported /Refused to Report Ethnicity

Race	
	Asian
	Native Hawaiian
	Other Pacific Islander
	Black/African American
	American Indian/ Alaska Native
	White (not Hispanic or Latino)
	More than one race
	Not Reported / Refuse to Report

Primary Language	
	English
	Spanish
	Russian
	Ukrainian
	Other Please Specify:

How did you hear about us?	
	Newspaper/TV/Radio Ad
	Website
	Special Event
	Employee
	Other Organization
	Friend
	Other

Do you identify yourself as:	
	Straight (not lesbian or gay)
	Lesbian or gay
	Bisexual
	Something else
	Don't know
	Chose not to disclose
	Other

Parent's Education	
	Current Student?
	Full Time
	Part Time

Parent's Highest Level of Education	
	Not yet in school
	Pre-School Kindergarten
	Grade School
	Middle School
	High School
	High School Degree/ GED
	Did not complete High School
	Technical Trade School
	College
	College Graduate

COMC is my primary medical home?	
	Yes
	No

What is your current gender identity?	
	Female
	Male
	Transgender Male Female-to-Male
	Transgender Female Male-to-Female
	Gender queer, neither exclusively male nor female
	Other
	Chose not to disclose

Parent's Employment Status	
	Full Time/ Part Time
	Migrant Worker
	Not a Migrant Worker
	Seasonal

Housing
☐Homeless
☐Doubling Up ☐Shelter ☐Other ☐Street ☐Transitional ☐Unknown
☐Public Housing-HUD
☐ Permanent Supportive Housing (PSH)

Is the child adopted?	
	Yes
	No

I am using COMC today for an urgent care need?	
	Yes
	No

What sex were you assigned at birth on your original birth certificate?	
	Female
	Male
	Chose not to disclose

All requested information is for statistical purposes only and is necessary for receipt of federal grants to provide services.

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Central Ozarks Medical Center
Sliding Fee Discount Schedule
Effective June 1, 2020

*****Sliding Fee Discount Program eligibility is based solely on family size and income*****

OFFICE FEE PER VISIT					
Medical	$30	$40	$60	$80	Full Fee
Behavioral Health	$30	$40	$60	$80	Full Fee
Dental	$50	Greater of $75 or 30% of Charges	Greater of $75 or 40% of Charges	Greater of $75 or 50% of Charges	Full Fee
Hospital	$30	Greater of $30 or 40% of Charges	Greater of $30 or 60% of Charges	Greater of $30 or 80% of Charges	Full Fee

FEDERAL POVERTY GUIDELINES (2020)					
Family Size	Level A (0-100% PFG)	Level B (101-133% PFG)	Level C (134-166% FPG)	Level D (167-200% FPG	Level E (Above 200% FPG)
1	$0 - $ 12,760	$12,761 - $ 16,971	$16,972 - $ 21,182	$21,183 - $ 25,520	$25,521 and Above
2	$0 - $ 17,240	$17,241 - $ 22,929	$22,930 - $ 28,618	$28,619 - $ 34,480	$34,481 and Above
3	$0 - $ 21,720	$21,721 - $ 28,888	$28,889 - $ 36,055	$36,056 - $ 43,440	$43,441 and Above
4	$0 - $ 26,200	$26,201 - $ 34,846	$34,847 - $ 43,492	$43,493 - $ 52,400	$52,401 and Above
5	$0 - $ 30,680	$30,681 - $ 40,804	$40,805 - $ 50,929	$50,930 - $ 61,360	$61,361 and Above
6	$0 - $ 35,160	$35,161 - $ 46,763	$46,764 - $ 58,366	$58,367 - $ 70,320	$70,321 and Above
7	$0 - $ 39,640	$39,641 - $ 52,721	$52,722 - $ 65,802	$65,803 - $ 79,280	$79,281 and Above
8	$0 - $ 44,120	$44,121 - $ 58,680	$58,681 - $ 73,239	$73,240 - $ 88,240	$88,241 and Above
9 or more	Add $4,480 for each additional member	Add $5,958 for each additional member	Add $7,437 for each additional member	Add $8,960 for each additional member	Add $8,960 for each additional member

For questions about sliding fee discount program, please contact:
Camdenton - 573.346.4446 Osage Beach - 573.302.7490 Richland - 573.765.5141

Revised 5/8/2020

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Pediatric Medical History

Child's Name: _____ Date: _____
Date of Birth: _____ City and County of Birth:_____
Parent / Guardian 1: _____
Parent/ Guardian 2: _____
Email address: _____
Preferred method of communication: □ Phone □ Text □ Email

Main reason for today's visit:

_____

Where was your child receiving care before?

_____

PREGNANCY & BIRTH: Please fill in the following information about your pregnancy and birth history with this child, as you remember.

PREGNANCY HISTORY:
Prenatal Care: □ Yes □ No Provider: _____

MATERNAL HEALTH PROBLEMS:

□ Pre-eclampsia □ Bleeding
□ Pre-Term Labor □ High Blood Pressure
□ Infections □ Diabetes
□ Abnormal U/S □ Rh Incompatibility
□ Alcohol/Drugs □ Tobacco/Smoking
□ Bleeding/Bruising
□ Infection □ Urine/Stool Problems
□ Birth defects □ Feeding Problems

BIRTH HISTORY:
Birth Location: □ Hospital □ Home □ Other
Hospital Name: _____
Due date: _____ Birth was □ Vaginal □ C-Section
Gestation: □ Term (37+ wks) □ Pre-Term (36 wks or less) Birth
Weight: _____ Birth Length: _____
Circumcision? □ yes □ no
Hepatitis B vaccine? □ yes □ no
BIRTH PROBLEMS:

□ Breach □ Forceps
□ Nuchal Cord □ Low APGARs
□ Jaundice □ Breathing Problems
□ Shoulder Dystocia

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know that you wrote there.

□ **MY CHILD TAKES NO MEDICATIONS** Please list your pharmacy of choice:_____

MEDICATION	DOSE (MG/PILL)	HOW MANY TIMES PER DAY

ALLERGIES:

□ **NO KNOWN DRUG ALLERGIES**

ALLERGIES	TYPE OF REACTION

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PERSONAL MEDICAL HISTORY

Please provide child's past medical conditions:

_____

_____

_____

_____

_____

Please indicate which of the following diseases parents and siblings have had:

√	DISEASE	RELATIONSHIP (Parents and siblings)	COMMENTS
	No significant history known		
	Alcoholism/Drug abuse		
	Alzheimer's Dementia		
	Asthma		
	Autoimmune Disease		
	Bleeding or Clotting Disorder		
	Cancer _____		
	Coronary Artery Disease (Heart attack, Angina)		Age of Onset:_____
	Depression/Suicide/Anxiety		
	Diabetes – Type 1 (childhood onset)		
	Diabetes – Type 2 (adult onset)		
	Emphysema (COPD)		
	Genetic Disorder (explain)		
	Heart Failure (CHF)		
	Hepatitis (A, B, or C)		
	High Blood Pressure (Hypertension)		
	High Cholesterol		
	Hypothyroidism/Thyroid Disease		
	Kidney Disease		
	Migraine Headaches		
	Osteoporosis		
	Stroke		
	Other (please list)		

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Growth/Development:
Do you think your child is growing and developing normally? □ yes □ no

Do you have any concerns about your child's growth?
_____
_____

Do you any concerns about your child's development?
_____
_____

Education:
Grade in school: ___ School Name: _____
Teacher's name: _____
Does your child do well in school? □ Yes □ No
Does your child enjoy school? □ Yes □ No
Is your child concerned about bullying? □ Yes □ No
Is your child concerned about safety? □ Yes □ No

Health Maintenance Screening Tests:
□ Newborn Screening
□ Lead Screening
□ Anemia (Hgb/Hct) Screening
□ Cholesterol Screening
□ Autism Screening (18 months of age)
□ Dentist - Last visit: _____
□ Eye doctor - Last visit: _____

Activity:
Estimated hours of physical activity or active playtime your child engages in each week: _____

Estimated hours of TV, video games, or computer time your child engages in each week: _____

Sport or school activities: _____

Family activities: _____

Diet:
For infants: □ Breastfeeding □ Formula
Balanced Diet? □ yes □ no
Food allergies? □ yes □ no
Special diet? □ yes □ no
Do you have any concerns about your child's nutrition?
_____
_____

Safety:
Type of car seat: □ Rear-facing □ Forward facing

Do you use your car seats or seatbelts consistently?
□ Yes □ No

Do you have your child use a bike helmet?
□ Yes □ No

Home has a working smoke detector?
□ Yes □ No

Is violence in your home a concern for you?
□ Yes □ No

Tobacco / Alcohol / Drug Exposure:
Is your child exposed to any of the following at home, school or other location?
Tobacco □ Yes □ No
Alcohol □ Yes □ No
Drugs □ Yes □ No
Are prescription medications kept locked away from your child at home? □ Yes □ No

Home Environment:
Who lives at home with your child?
_____
_____
_____
Please list siblings names and ages:
_____
_____
_____
Problems or stress at home?
_____
_____
_____

Thank you for taking the time to fill out this important health information.

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Consent for Treatment of a Minor & HIPAA Release

I, _____, consent for treatment of _____.
Printed Name of Parent/Guardian **Printed Name of Minor**

I attest that I have legal responsibility for this patient and the legal right to direct the medical treatment of this patient. This consent allows for treatment today and all future appointments. This record may be given to other providers within COMC to treat this minor as needed with or without a parent or legal guardian present. I also understand that I will be contacted about treatment plans or any changes in treatment.

I hereby authorize the below listed individuals access to my health information:
(If this section is not completed, we will only use your medical record for treatment, payment and healthcare purposes. We will not be able to release your medical information to family members or friends unless they are listed by name below)

Individual	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give COMC consent for treatment of my child for health care services. I understand that services are available without discrimination prohibited by federal and state law. I understand that no treatment will be given without my knowledge or consent unless it is an emergency.

- I understand that the information in my child's health record is confidential and will not be released to any unauthorized person or agency without my consent.
- I authorize COMC to only disclose any portion of my child's health record to school personnel only as it relates to my child's academic success, including scheduling treatment and confirmation that my child is receiving services.
- I authorize COMC to have access to my child's school records only to assist in providing necessary care to my child.

Parent/Guardian Acknowledgment of Receipt of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices (on following page).

Parent/Legal Guardian: _____ Date: _____

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About Our Notice of Privacy Practices

Notice of Privacy Practices: This notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at phone number (573) 836-7112 or amcnulty@centralozarks.org.
Who will follow this notice? :. All COMC employees, temporary or contract staff, students and volunteers.
What is this Notice?: We are required by law to maintain the privacy of your protected health information. We are also required by law to give you this notice of our legal duties and privacy practices regarding your health information. We are required to notify you if there is a breach of your unsecured protected health information. We are required to follow the terms of the current Notice of Privacy Practices.
We may use and disclose your health information for: **Treatment:** We may use and disclose health information for your medical treatment and services. **Payment**: We may use and disclose health information to bill for and receive payment for the services provided to you. **Health Care Operations**: We may use and disclose health information for purposes of health care operations. **Appointment Reminders**: To remind you that you have an appointment scheduled with us. **Treatment Alternatives:** To inform you of treatment options available to you. **As required by Law**: When required to do so by applicable law. **To prevent a Serious Threat to Health or Safety**: To prevent a serious threat to your health and safety or the health and safety of others. **Individuals Involved in your Care:** Unless you object, to friends, family members or others involved in your medical care or who may be helping pay for your care. **Organ and Tissue Donation:** Organ or tissue donation to organizations that handle organ procurement and transplant. **Decedents:** Health records for patients deceased 50 or more years are no longer considered Protected Health Information. **Genetic Information:** Genetic Information is considered Protected Health Information, which may be disclosed with authorization but cannot be used by health plans for underwriting purposes. **Military and Veterans:** If you are a member of the armed forces, as required by military command authority. **Worker's Compensation:** For worker's compensation purposes or similar programs providing benefits for work related injury or illness. **Public Health Activities:** For public health activities such as preventing or control of disease, reporting births and deaths, and reporting child abuse and neglect. **Health Oversight Activities**: To governmental agencies and boards as authorized by law such as licensing and compliance purposes. **Breach Notification:** Uses or disclosures of PHI that are not permissible are now presumed to be a Breach, unless it can be demonstrated a "low probability" exists that your PHI has been compromised or that an exception applies. **Disaster Relief:** Unless you object, to disaster relief organizations to coordinate your care or notify family and friends of your location or condition following a disaster. **Lawsuits and Disputes:** In response to a warrant, court order, or other lawful process. **Law Enforcement:** Pursuant to process and as otherwise required by law. **Coroners, Medical Examiners, Funeral Directors**: As necessary to determine the cause of death or to perform their duties. **National Security and Intelligence Activities**: To authorized federal officials for intelligence and other national security activities as authorized by law. **Protective Services for the President and Others**: To federal officials to provide protection to the President and other authorized persons, or conduct special investigations. **Inmates or Individuals in Custody:** If you are an inmate or in the custody of law enforcement, we may disclose to the correctional institution or law enforcement official as necessary to provide you with health care, to protect the health and safety of you and others, or for the safety and security of the correctional institution. **Research Studies and Clinical Trials:** Authorizations may be combined in the research context subject to certain requirements, and authorizations for future research are also permitted. **Business Associates:** Business Associates are directly liable for violations of the HIPAA/HITECH Act. Subcontractors of a business associate that create, receive, maintain or transmit PHI on behalf of the business associate are likewise HIPAA business associates, and subject to the same requirements that the first business associate is subject to. **Fundraising:** For raising funds. You may opt out of receiving fundraising communications at any time. **Other disclosures:** With certain exceptions, we are not allowed to use or disclose psychotherapy notes without your authorization. We are also not allowed to use or disclose your health information for marketing purposes or sell your health information without your authorization. Other uses and disclosures of your health information not described in this Notice of Privacy Practices or applicable laws will require your written authorization. If you choose to permit us to use or disclose your health information, you can revoke that authorization by informing us of your decision in writing. If you revoke your authorization, we will no longer use or disclose your health information as set forth in the authorization. However, any use or disclosure of your health information made in reliance on your authorization before it was revoked, will not be affected by the revocation.
Your rights regarding your health information: In most cases, **you may make a written request to look at, or get a copy of your health information.** If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you have the right to have that denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review. **If your health information is maintained in electronic format, you have the right to request an electronic copy of your health information.** If your health information is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document. We may charge you a reasonable cost based fee for the labor associated with transmitting electronic health information. If you feel your health information is incorrect or incomplete, **you have the right to request that we amend your information**. You must submit a written request providing your reason for requesting the amendment to the Privacy Officer. Your request to amend your health information may be denied if it was not created by us; if it is not part of the information maintained by us; or if we determine that the information is correct. You may submit a written appeal if you disagree. Your request for amendment will be included as a part of your health information. **You have the right to receive a list of certain disclosures we made of your health information**, for a period of time up to six years prior to the date of your request. The first list you request in a 12-month period is free. If you make more requests during that time, you may be charged our cost to produce the list. We will tell you about the cost before you are charged. **You have the right to a paper copy of this notice.** You may ask us to give you a copy of this notice at any time. **You have the right to request that your health information be given to you in a confidential manner**. You have the right to request that we communicate with you in a certain way or at a certain location, such as by mail or at your workplace. Any such request must be made in writing to the Privacy Officer. We will accommodate reasonable requests. **You have a right to ask that we not disclose your health information to your health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.** Such restricted disclosure must pertain solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full. **You may request, in writing, that we not use or disclose your health information** for treatment, payment or healthcare operations; or to persons involved in your care; when required by law; or in an emergency. All written requests or appeals should be submitted to our Compliance Office listed at the end of this notice. We are not required to agree with the requested restrictions. **You have the right to be notified if there is an unauthorized use or disclosure of your unsecured protected health information unless we determine that there is a low probability that your information has been compromised.**
Complaints: If you believe that your privacy rights may have been violated, you may contact our Privacy Officer, Amy McNulty, at (573) 836-7112 or by email at amcnulty@centralozarks.org. You may write us at Central Ozarks Medical Center Attn: Amy McNulty PO Box 777, Richland, MO 65556. You may also contact Missouri Department of Health, Bureau of Health Facility Regulation: (573) 751-6303 and/or the State Attorney General's Office Consumer Hot Line: 1-800-392-8222. You may file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights at:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html The Office of Corporate Compliance can provide the mailing address. We will not retaliate against you for filing a complaint. If we change our policies regarding our use and/or disclosure of your protected health information, we will change our Notice of Privacy Practices and make the revised notice available to you on our website and our practice locations. You may access our website at http://www.centralozarks.org. You may also request a paper copy of the current Notice of Privacy Practices at any time.