CENTRAL OZARKS MEDICAL CENTER

COMC

ELDON SCHOOL CLINIC

Child's Name: _____

Dear Parent/Guardian:

Central Ozarks Medical Centers (COMC) is excited to announce we have partnered with the Eldon School District to provide Medical, Dental and Behavioral Health Services during the 2023-24 academic year! This partnership will allow COMC to expand access to convenient care to ensure your child stays healthy throughout the school year. COMC is a local, non-profit organization that has worked to meet the healthcare needs of your community and surrounding areas since 1979.

Open all year, even during the summer and school breaks, COMC's School-Based Clinic offers many services. Jillynn and her Medical Team provide school and sports physicals, care for colds, flu, immunizations, rapid labs, treatment for health problems like asthma, diabetes, and many other health concerns. Dr. Currey and her Dental Team provide access to students, staff, faculty, and the Eldon community for all dental needs. The Dental Clinic is located across the hallway from Medical Services.

In addition to Medical and Dental Services, our Behavioral Health Staff can work with your child to provide access to Counseling Services for issues such as depression, body image, peer pressure and any other challenges that your child may be experiencing. Students served by our School-Based Therapists have direct access in a convenient and confidential setting while they are at school. This limits absences from the classroom, ensures appointments are kept and creates a less intimidating environment for the student.

COMC's School-Based Services are available to any child who completes registration information and makes financial arrangements. COMC accepts Medicaid, Private Medical and Dental Insurance. We also offer a Sliding Fee Scale based on household size and income. We have dedicated staff to assist in eligibility for our Slide Scale and to identify if your student is eligible for the Missouri Medicaid Program. If your child is insured, please attach a copy of the front and back of their insurance card to the completed packet or email a copy of the front and back of the insurance card to: comc.clinic@eldonmustangs.org.

We look forward to working with you to provide the best healthcare experience for your child. If you have questions or concerns, please call: (573)392-8056 for Medical, (573)557-4220 for Dental, or send us an email to: comc.clinic@eldonmustangs.org.

If you would like for your child to be seen by COMC, please complete the attached registration packet and return it to school at your earliest convenience.

Indicate below, which services you would like for us to provide your child:

□ Medical □ Dental □ Behavioral Health

Sincerely,

Kelly Miller, CEO

Your Health... Our Mission

CENTRAL OZARKS MEDICAL CENTER
COMC
ELDON SCHOOL CLINIC

Central Ozarks Medical Centers
School Based Healthcare Services
Patient Registration

Grade: _____

Teacher: _____

If you have questions or need assistance filling out any of these forms, please call: (877) 406-2662

PATIENT INFORMATION (Please Print)

Patient's First Name:	Middle Initial:	Last Name:	Gender at Birth: ❑ Male ❑ Female	Social Security Number: (optional)	Birth Date: / /
Street Address:		City:	State:		Zip Code:
Mailing Address: ❑ Same as above			Home Phone Number where messages can be left: ( )		
Email Address:			Cell Phone Number where messages can be left: ( )		
Preferred Pharmacy:			Preferred Pharmacy City & Street:		
Does the patient have any problems with: ❑Vision ❑Hearing ❑Reading ❑Speaking Explain:					

PARENT/LEGAL GUARDIAN/GUARANTOR INFORMATION

Name:	DOB:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Guarantor ❑ Guardian (Specify): _____
Name:	DOB:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Guarantor ❑ Guardian (Specify): _____

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN

Name:	Phone Number:	Relationship to Patient :
Name:	Phone Number:	Relationship to Patient :

PROTECTED HEALTH INFORMATION

Person(s) who may obtain medical and/or dental health information. This may include verbal and/or copies of records unless specified by you. I also give consent for the following individuals to attend and give consent for services received by COMC and to make treatment decisions for my child in my absence. (This does not include psychiatry or behavioral health records)

Name:	Phone Number:	Relationship type:
Name:	Phone Number:	Relationship type:

If your student is uninsured, a Community Health Worker will be reaching out to you to discuss obtaining insurance for your family and Sliding Fee options

Please provide the best contact number: _____

_____ (Initial) ***Medicare Recipients Only*** 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.

_____ (Initial) 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:** _____

PLEASE EMAIL A COPY OF FRONT AND BACK OF INSURANCE CARD TO: INFO@CENTRALOZARKS.ORG

MEDICIAL INSURANCE INFORMATION

Insurance Carrier: _____

Full billing address on back of card: _____

Group Number: _____ Plan Number: _____

Participant's ID Number: _____

Subscriber Name (if different than patient): _____

Relationship to Patient: □ Spouse □ Parent □ Step-Parent

Subscriber's Birthdate: _____ Subscriber's Social Security Number: _____

Subscriber's Phone #: _____ Subscriber's Address: _____

DENTAL INSURANCE INFORMATION

Insurance Carrier: _____

Full billing address on back of card: _____

Group Number: _____ Plan Number: _____

Participant's ID Number: _____

Subscriber Name (if different than patient): _____

Relationship to Patient: □ Spouse □ Parent □ Step-Parent

Subscriber's Birthdate: _____ Subscriber's Social Security Number: _____

Subscriber's Phone #: _____ Subscriber's Address: _____

By participating in certain federal programs, we are required to request the following information

Race

Please check all that apply

- ❑ American Indian/Alaskan Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ White

Primary Language:

- ❑ English
- ❑ Spanish
- ❑ Russian
- ❑ Ukrainian
- ❑ Other: _____

Gender Identify (18+ years)

❑ Male ❑ Female ❑ Decline to Specify
❑ Transgender Male ❑Transgender Female
❑Gender Neutral

Highest Level of Education

- ❑ 1-Not yet in school
- ❑ 2-Pre-School/Kindergarten
- ❑ 3-Grade School
- ❑ 4-Middle School
- ❑ 5-High School (Currently)
- ❑ 6-High School Grad/GED
- ❑ 7-Did Not Complete High School
- ❑ 8-Technical/Trade School
- ❑ 9-Some College
- ❑ 99-College Graduate

Ethnicity

- ❑ Latino or Hispanic
- ❑ Not Hispanic

Sexual Orientation (18+ years)

- ❑ Straight or heterosexual
- ❑ Lesbian, gay or homosexual
- ❑ Bi Sexual
- ❑ Something else
- ❑ Don't know
- ❑ Decline to Specify

Public Housing:

Do you currently live in public (income-based) housing?:
❑ YES ❑ NO

Patient Self Determination Act:

Please check **ALL** that apply

- ❑ None
- ❑ DNR
- ❑ Living Will
- ❑ Durable Power of Attorney
- ❑ HC Proxy

Estimated Annual Household Income

- ❑ $10,000 or below
- ❑ $10,001 - $20,000
- ❑ $20,001 - $30,000
- ❑ $30,001 - $40,000
- ❑ $40,001 - $50,000
- ❑ $50,001 - $60,000
- ❑ $60,001 - $70,000
- ❑ $70,001 - $80,000
- ❑ $80,001 - $90,000
- ❑ $90,001 - $100,000

Number of Persons in Household:

_____

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Patient Health History

Patient Name: _____ DOB: _____ Today's Date: _____

Medical Primary Care Provider: _____ Last Visit:_____

Tobacco Usage: (smoke or smokeless): ❒ Never used tobacco ❒ Daily tobacco user ❒ Ex-tobacco user ❒ Vape ❒Marijuana

Have you ever been diagnosed with, or treated for any of the following? **(Check all that apply):**

❒ Abnormal bleeding	❒ Diabetes Type I	❒ Hyper-tension (high blood pressure)
❒ Acid Reflux	❒ Diabetes Type II	❒ Hypo-tension (low blood pressure)
❒ ADHD	❒ Drug Abuse	❒ Joint Replacement; Type_____
❒ Alcohol Abuse	❒ Emphysema	❒ Kidney Disease
❒ Anemia	❒ Epilepsy	❒ Lupus
❒ Anxiety	❒ Fainting Spells	❒ Mitral Valve Prolapse
❒ Artificial Bones/ Joints	❒ Gestational Diabetes	❒ Non- Epileptic Seizures
❒ Artificial Heart Valves	❒ Glaucoma	❒ Obesity
❒ Asthma	❒ Heart Attack	❒ Osteoporosis
❒ Autism- mild	❒ Heart Disease	❒ Psychiatric Problems
❒ Autism-severe	❒ Heart Murmur	❒ PTSD
❒ Behavioral Issues	❒ Hemophilia	❒ Rheumatic Fever
❒ Bipolar	❒ Hepatitis A	❒ Rheumatoid Arthritis
❒ Cancer	❒ Hepatitis B	❒ Scarlet Fever
❒ Congenital Heart Defects	❒ Hepatitis C	❒ Shortness of Breath
❒ Congestive Heart Failure	❒ HIV/AIDS	❒ Thyroid Disease
❒ COPD	❒ Hyperlipidemia (high cholesterol)	❒ Tuberculosis
❒ Coronary Artery Disease (CAD)		❒ Other

Are you currently taking medications? (List any medications that you are currently taking, dose and how often you take it)

_____

_____

_____

❒ *Not currently taking any medications*

Medication/Food/Environmental Allergies	**Reaction**
❒ *No known Drug/Food allergies*	

Have you had any recent surgery and/or hospitalizations? ❒ No ❒ Yes

Date of hospitalization: _____

If yes, please explain **: _____**

_____

Please list any significant family history: _____

_____

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Patient Name:_____ **DOB:** _____

Central Ozarks Medical Centers Policies and Consents

Consent to Treat:

I,_____, consent for the treatment of_____.
(Printed Nameof 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. I give permission for Central Ozarks Medical Centers (COMC) to provide healthcare services to my child - WITHOUT a parent or legal guardian present. However, Medical Services will be PROVIDED ONLY AFTER attempting to reach a parent/guardian. COMC's Behavioral Health Services WILL NOT begin until an intake is completed with a parent/guardian. This consent allows for treatment today and all future appointments. I understand this record may be given to other providers within COMC to treat this minor as needed. I understand that I will be contacted for treatment plans or any changes in treatment. 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 mychild.

Consent for Services:

I agree to my child receiving the below School Based Services while at school. Initial all that apply:

_____**Medical Services**
(Initial)

_____**Dental Services**
(Initial)

_____**Behavioral Health Services**
(Initial)

Finance Policy/Release of Billing Information/Assignment of Benefits:

COMC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance: You are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles, or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. If you do not have insurance: We offer a Sliding Fee Scale based on household size and income. You may apply for a discount at the front desk. We can also assist you with obtaining insurance coverage. I authorize COMC and its representatives to release any information they obtain, including medical information to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay COMC for services rendered.

Notice of Health Information Exchange Participation:

COMC may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, healthcare operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your health care providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information, genetic information, STD treatment, test results, and family planning information. The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be found at: www.mhc-hie.org or you may call us at (877) 406-2662. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

Consent for Patient Portal

Be proactive in the management of your healthcare!
COMC's Patient Portal is a secure, web-based, self-service portal that provides on-line interaction between our patients and our practice. Our Patient Portal allows you to submit requests for refills, referrals, view lab results, send messages to your care team, view current and past statements, and much more!

Email address:_____ **Phone:**_____ **Text:** □ **Yes** □ **No**

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Patient Name:_____ **DOB:** _____

Central Ozarks Medical Centers Policies and Consents

Telehealth:

COMC offers its patients Telehealth services as a method to expand access to care. I understand I may be offered a Telehealth appointment at COMC. I consent to receive services via COMC's Telehealth equipment and understand and/or agree to the following:

- I understand I have the right to refuse to participate or revoke consent for services delivered via Telehealth at any time by informing any COMC staff member.
- I understand that my provider will document in my medical chart as if the visit were conducted in person with only the additional information required for Telehealth billing.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my care and treatment require physical examination they may be conducted by other COMC providers and staff under the direction of my Telehealth provider or I may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.
- I understand there are potential drawbacks of participating in a Telehealth visit versus a face-to-face visit.
- I understand that no part of the Telehealth visit will be recorded by my provider and agree not to record any part of the visit myself.
- I understand my visit will be conducted via technology and COMC cannot guarantee technology will always work.
- I understand that if there is an equipment failure I may need to be rescheduled for a face-to-face visit.
- I understand COMC utilizes HIPAA compliant, encrypted software to conduct its Telehealth services.
- I understand I have the right to ask any questions regarding the Telehealth equipment, technology, etc. at any time.
- I understand I will be informed and made aware of the role of the Telehealth provider at the distant site, as well as qualified professional staff at the COMC location who are going to be responsible for follow-up or ongoing care, and the location of the distant site as well as be informed of all parties who will be present at each end of the Telehealth transmission; and consent to have COMC staff in the exam room to operate Telehealth equipment, if needed.
- I understand I have the right to have appropriately trained staff immediately available to me while receiving the Telehealth service to attend to emergencies or other needs. I understand this is not possible if conducting a Telehealth visit from my place of residence located within the state of Missouri or other temporary location within or outside the state of Missouri.
- I understand that mandated reporting laws will be followed by my provider during telehealth visits
- I understand that certain situations including emergencies are inappropriate for telehealth services. If I have an emergency, I should immediately call 911 or go to the nearest hospital.
- I understand that I or my insurance will be billed as authorized by my insurance and/or sliding fee plan.

Notice of Privacy Practices:

We are committed to protecting your personal health information in compliance with the law.
Our Notice of Privacy Practices detail the following:

- Our obligation under the law with respect to your personal health information
- How we may use and disclose the health information we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this notice

To receive a copy of our Notice of Privacy Practices, please visit: www.centralozarks.org or send an email to: info@centralozarks.org

My Signature Means:

- I have reviewed and completed the Protected Health Information section. I understand that when I designate another person to authorize a treatment decision, Central Ozarks Medical Centers may disclose Protected Health Information to the authorized person(s).
- I have reviewed Central Ozarks Medical Center's Consent for Treatment; Finance Policy/Release of Billing Information/Assignment of Benefits; Notice of Health Information Exchange; Notice of Privacy Practices and Telehealth Policy.
- I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.
- I understand that my consent will remain in effect for one year unless I notify COMC in writing. I understand that I may revoke my consent at any time.

By signing below, I am acknowledging that I have completed the information in this packet to the best of my knowledge.
By signing below and initialing on the above lines, I am acknowledging that I have read and understand the above information.

SIGNATURE:_____ **DATE:** _____

Printed Name of Person Signing: _____

Relationship to Patient: _____