MUSTANGS

Welcome to registration 2025-26!

We are excited for another great year at Upper!

Please take the time to let us know if your enrollment form includes changes and/or updates, or if your information from last year is exactly the same and DOES NOT require any changes. All enrollment forms must be filled out but knowing if there are changes, updates, etc. will allow us to work more efficiently on those that need updated for the 2025-26 school year.

- **YES**,
  I have made changes and/or updates to my student's information. _______

- **NO**,
  I have not made changes and/or updates to my student's information. _______

*Note that all address changes will require proof of residency.

Thank you! ☺

TOGETHER WE RISE
FAMILY SCHOOL COMMUNITY

Title One Home-School Compact

Upper Elementary School is a school-wide Title 1 building; therefore, all students have the opportunity for additional assistance in learning.

Students of Upper Elementary School are encouraged to be responsible for their own success. To aid in this success they can make the following commitments:

1. Attending school on time every day.
2. Doing their best in class and completing homework on time.
3. Respecting others and themselves, making good choices and being a cooperative learner.
4. Keeping parents informed about progress in school and asking for help when needed.
5. Using time wisely at home and at school.

Parents are encouraged to be involved in their child's education in an effort to help with his/her achievement, attitude and behavior. To aid in this effort parents can make the following commitments:

1. Sending child to school every day, well rested and ready for the day.
2. Providing appropriate learning supplies and a place and time for learning.
3. Letting child know how much they care about their learning.
4. Checking child's homework and their graded schoolwork.
5. Making sure communication flows two ways, both from school to home and from home to school.

As educators at Upper Elementary School, we understand the importance of the educational experience for every student and our role as the teacher and role model. Therefore, in order to insure learning that takes place for every student we are committed to the following:

1. Maintain high expectations for every child to learn and achieve.
2. Provide a safe, positive and respectful learning environment.
3. Recognize and adapt for each students' needs and encourage individual talents.
4. Communicate with parents and students on a regular basis concerning student progress.
5. Help parents to support learning and positive behavior and encourage interaction at school.

By signing this compact, I acknowledge that I have access to a printed and online version of the Student/Parent Handbook and understand the terms and conditions. Together, students, parents, and educators become partners to enable the child to know success and a lifelong love of learning.

____

Parent Signature

____

Student Signature

MUSTANGS

Social Media Permission

2025 - 2026

Dear Parents/Guardians,

We believe sharing pictures of our students on social media and in the newspaper is a great way for the community to see what great students and staff we have. We enjoy providing a way for the community to see and hear about the achievements of our students and they fun they have learning here at Upper. This may include special events on or off campus. **Please let us know if we may publish pictures of our student on social media and/or the local newspaper.** You may update your preference at any time.

Student Name ______________________ Teacher 25-26 ______________________

☐ **YES**, I give permission for my student's picture to be published.

☐ **No**, I prefer my student's picture NOT be published.

Parent/Guardian ______________________________ Date ______________

Thanks for all you do.

When families and schools work together, GREAT things can happen!

Access to Devices/Internet

Please provide as much information as possible

Student Name: ______________________________ Grade: ____________

Teacher Name: ______________________________________

Please check all that apply:

- Does your student have internet access? Yes ____ No____
- Does your student have access to a computer during school hours? Yes____ No____

Please check all that apply:

- My student has access to the following devices during school hours:
- Computer/Chromebook _____
- Tablet/I-Pad _____
- Phone _____
- My student does not have access to any of the devices listed above. _____

What internet provider do you have access to? ____________________

Email address to best reach you: ____________________________

Thank you ☺

Eldon R-1 School District – Health Services
Student Health Information 2025-2026

Student Name ____**Grade** ________________

Regular or Emergency Medications Your Child Is Taking:

(at home) ____

(at school) ____

I request that you give over the counter medication to my child during the school year in accordance with the Board Policy. I authorize the school nurse or designee to give my child medication. I will not hold the school staff responsible for any undesired reaction that may occur from the medication. (Examples of non-prescription medication to be given with parent permission are: non-aspirin pain relievers including Acetaminophen, Ibuprofen, Tylenol, sore throat spray, antacid, antibiotic ointment, hydrocortisone cream, calamine lotion, throat lozenges, topical anti-sting treatments and generic substitutes.

Please initial below for over the counter medications:

_______ Yes, I give permission

_______ No, I do not give permission

I hereby give my permission for the Eldon School District to obtain and release my student's immunization records by phone, mail or fax to and from the physician's office.

Please initial below:

_______ Yes

_______ No

Please mark below if your child has any of the following:

___ **Asthma**	___ **ADHD**	___ **Other Medical Condition EXPLAIN**
___ **Diabetes**	___ **ADD**	______________________
___ **Seizures**	___ **Hearing problem**	______________________
___ **Severe Allergies**	___ **Vision problem**	______________________
___ **Heart Condition**	___ **Seasonal Allergies**	______________________

List **All** Child's **Medication Allergies** ____

List **All** Child's **Food Allergies and provide Doctors note:**

____

Students Physician ____

1. Any medication that is sent to school with a student must be in the original container with the student's name on it.
2. Medication sent to school with a student must be accompanied by a signed and dated note from the parent/guardian requesting the medication to be given.
3. It is recommended that a small container of medication be sent to school.
4. All medications must be given to the school nurse as soon as the student arrives at school.
5. Please make sure the medication is age appropriate.

It is my understanding that my signature allows all of the above information and treatment to be administered to my student.

Parent Cell Phone ______________________________

Parent Signature ____ **Date** ____________________

BUS TRANSPORTATION

Dear Parents/Guardians:

1. All requests must be completed and given to the student's Building Official for review prior to their approval. *THREE SCHOOL DAYS NOTICE IS REQUIRED BEFORE A REQUEST MAY BE GRANTED.*
2. Final approval of request must be made by the Transportation Department prior to the student being placed on a transfer bus to ensure that all parties involved (parent/guardian, teacher, building official, Transportation Department and bus driver) are informed and the student's safe transportation is assured.
3. Transfer students must present a bus pass to the driver, given to them by the Principal's Office, to ride their new bus to their new location. The transfer stop should be written on the bus pass given to the new driver.

Please complete this form and return to the Building Office.

Grade: __________ **Current Teacher:** ______________________________

Student's name ____

Address: ____

My student will load the bus in the *morning* at the following *designated* bus stop:

____ **AM Bus#:** ______________

My student will ride the bus in the *afternoon* to the following *designated* bus stop:

____ **PM Bus#:** ______________

My child does *NOT* require bus transportation: __________

My child is enrolled in the afternoon LEAP program: YES ____ NO____

No Bus Discipline Warnings: If a student does not follow the bus driver's rules, they will lose their bus privilege immediately. The bus driver will document discipline issues and submit them to the transportation director promptly. Immediate action will take place. The six bus rules must be followed at all times in order to keep not only all students safe, but also the other motorists on the road.

Discipline Guidelines for Buses

1. Obey the driver promptly
2. Stay seated until the bus comes to a complete stop
3. Keep hands, feet and items to yourself at all times and no throwing objects
4. No offensive language or disruptive behavior
5. No food, candy, gum, or beverages on the bus
6. No large equipment, animals, skateboards or other equipment on the bus

____

Parent/Guardian Signature Phone Number Date

****

(OFFICE USE ONLY)

Bldg Approval: ____________________ Date: __________________ (Must be approved prior to request from transportation)

****

(TRANSPORTATION DEPARTMENT)

AM Bus # ________________ AM Bus Stop ______________________________ AM P/U Time: ______________

PM Bus # ________________ PM Bus Stop ______________________ PM D/O Time: ______________

Effective Date: : ______________________ Date (Parent/Guardian/Teacher) notified: ______________________

School Safety Alert: District's Bus Transfer Requests Policies and Procedures

BUS TRANSFER REQUESTS

The Eldon School District continuously strives to maintain and improve its operation as a Safe School District for all students and staff. One area that the District needs continued parent cooperation is in following the District's procedures and policies for requesting bus transfers for students because of childcare and related reasons.

Please note that all bus transportation requests are to be in writing on the correct form and they are to be made in advance, at least three (3) school days prior to the requested transfer start date. The time is necessary to ensure that the transfer is consistent with Board policy and that all parties (Building Official, Homeroom Teacher, Bus Driver, and Transportation Office) are informed in a timely manner. Please provide an updated copy of your new address any time that you move and need to make a change to your child's transportation.

BUS STOP POLICIES AND PROCEDURES

The District needs continued parent cooperation in drop-off procedures. It has been the District's practice to drop-off students at their regular bus stop with a parent or guardian present. If a responsible adult is not present at the bus stop for an individual student, the student will be taken back to their school and the parent(s) or guardian will be called using the emergency phone numbers listed in the student's file. Parent(s) or guardians will be expected to pick-up their child at the school within 30 to 60 minutes for being notified before local police or Children and Youth Services is called. Persistent lack of parental or guardian presence at the student's assigned stop for the student's return home trip may result in a suspension of bus riding privileges.

The above procedures are being restated with the intent of requesting the assistance of all District parents to help the District maintain a safe student transportation system for ALL of our children.

Contact the Eldon R-1 transportation dept if you have any questions or need assistance with the above bus procedures and policies.

If you marked that your student **<u>DOES NOT</u> need bus transportation**, please fill out an orange Pick Up/Walker form. This form will authorize your student to be picked up or walk. This will also authorize certain individuals to pick up your student. You may update your list at any time.

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 2025-26 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

FOR A FULL LIST OF COMC LOCATIONS & SERVICES, OR TO FIND OUT WHERE YOU CAN GET CARE

Please scan the QR Code below:

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: ______________

CENTRAL OZARKS MEDICAL CENTER
COMC
ELDON SCHOOL CLINIC

Date: ____________
Phone #: ____________

COMC
Sliding Fee Discount Program
Interest Form

At COMC, we offer a Sliding Fee Discount Program to help reduce the cost of care for our patients. Eligibility is based on household size and income—and you may qualify even if you have insurance. Please complete the following information to the best of your ability so we can determine your eligibility:

If you DO NOT wish to apply for the Sliding Fee Discount Program:

Name: ______________________ Date of Birth: ____________

☐ I have been given the opportunity to apply for the COMC Sliding Fee Discount program, and I DO NOT WISH TO APPLY FOR THE COMC SLIDING FEE DISCOUNT PROGRAM AT THIS TIME

Patient/Guardian Signature: ______________________ Date: ____________

If you DO wish to apply for the Sliding Fee Discount Program:
The data gathered on this form will only be used to get information about you and your family so that we can better meet your Medical, Behavioral Health and Dental needs. **This form will not be used to withhold or deny services to you.**

1. Is any other family member applying for a discount? ☐ Yes ☐ No
   If yes, please indicate in final column below
2. Are you covered under Medicaid, Medicare or any other insurance? ☐ Yes ☐ No
3. Would you like assistance applying or re-applying for Medicaid? ☐ Yes ☐ No
4. Are you unemployed? ☐ Yes ☐ No
5. Are you too sick to work or are you disabled? ☐ Yes ☐ No

TO BE COMPLETED BY PATIENT/GUARDIAN: Please list all members of our household whom you are financially responsible for, including yourself. See attached list for acceptable forms for proof of income and household members.

Name	Relation in Family	Date of Birth	Income	Frequency	Proof of Income	Health Insurance plan(s)	Annual Deductible	Applying for Assistance?
Ex: John Doe	self	5/16/46	$346	weekly	Tax Form	Medicare	none	yes

I have attached proof of income for the amounts listed above. ☐ Yes ☐ No
I have provided identification for household members listed above. ☐ Yes ☐ No

---

I understand that the information I provide on this form is subject to COMC staff verification. I certify that the above information is true and correct to the best of my knowledge and that I understand & agree that providing false information can result in me being denied ability to apply for the program; furthermore, I agree to adhere to all terms and conditions of the Sliding Fee Discount Program. I will report any changes of the above information to COMC. **I also understand that I must supply proof of income before my next visit, or I will have to pay the full price with no discount.**

______________________ ______________________ ____________
Patient/Guardian Signature Printed Name Date

Central Ozarks Medical Centers
Sliding Fee Discount Schedule
Effective February 12, 2025

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 (per procedure)	$30	*Tier 1 - $40 **Tier 2 - 30% of Charges	*Tier 1 - $60 **Tier 2 - 40% of Charges	*Tier 1 - $80 **Tier 2 - 50% of Charges	Full Fee
Hospital (per day)	$30	$40	$60	$80	Full Fee
Surgery	Tier 1 - $100.00 Tier 2 - $300.00 Tier 3 - $500.00	40% of Charges	60% of Charges	80% of Charges	Full Fee
Federal Poverty Guidelines (2025)					
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 - $ 15,650	$ 15,651 - $ 20,815	$ 20,816 - $ 25,979	$ 25,980 - $ 31,300	$ 31,301 and Above
2	$0 - $ 21,150	$ 21,151 - $ 28,130	$ 28,131 - $ 35,109	$ 35,110 - $ 42,300	$ 42,301 and Above
3	$0 - $ 26,650	$ 26,651 - $ 35,445	$ 35,446 - $ 44,239	$ 44,240 - $ 53,300	$ 53,301 and Above
4	$0 - $ 32,150	$ 32,151 - $ 42,760	$ 42,761 - $ 53,369	$ 53,370 - $ 64,300	$ 64,301 and Above
5	$0 - $ 37,650	$ 37,651 - $ 50,075	$ 50,076 - $ 62,499	$ 62,500 - $ 75,300	$ 75,301 and Above
6	$0 - $ 43,150	$ 43,151 - $ 57,390	$ 57,391 - $ 71,629	$ 71,630 - $ 86,300	$ 86,301 and Above
7	$0 - $ 48,650	$ 48,651 - $ 64,705	$ 64,706 - $ 80,759	$ 80,760 - $ 97,300	$ 97,301 and Above
8	$0 - $ 54,150	$ 54,151 - $ 72,020	$ 72,021 - $ 89,889	$ 89,890 - $ 108,300	$ 108,301 and Above
9 or more	Add $5,500 for each additional member	Add $7,315 for each additional member	Add $9,130 for each additional member	Add $11,000 for each additional member	

Tier 1 Services - Includes preventative care services such as new patient/recall exams, x-rays, polishing and fluoride

Tier 2 Services - Includes (but not limited to) restorative care services such as fillings, extractions, deep cleanings, or prosthetic devices (such as crowns, partials and dentures)

Revised 2/12/2025

**MEDICIAL INSURANCE INFORMATION

surance Carrier: ______

ll billing address on back of card: ______

oup Number: ______ Plan Number: ______

rticipant's ID Number: ______

ıbscriber Name (if different than patient): ______

elationship to Patient: ☐ Spouse ☐ Parent ☐ Step-Parent

ıbscriber's Birthdate: ______ Subscriber's Phone#: ______

ıbscriber's Social Security Number: ______

ıbscriber's Address: ______

FAILURE TO PROVIDE INSURANCE/SLIDING FEE INFORMATION WILL RESULT IN BEING BILLED FULL PRICE FOR SERVICES RENDERED

**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 Phone#: ______

Subscriber's Social Security Number: ______

Subscriber's Address: ______

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

Due to our participation in Federal Programs, we are required to request the following information. Your responses are optional

ousehold Size: ______

ousehold Income: ______

Sex Assigned at Birth:
- ☐ Male
- ☐ Female

Race:
(Select ALL that Apply)
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ White

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Ukrainian
- ☐ Other: ______

Sexual Orientation: (Optional)
- ☐ Lesbian or Gay
- ☐ Heterosexual (straight)
- ☐ Bisexual
- ☐ Other
- ☐ Don't Know
- ☐ Chose Not to Disclose
- ☐ Unknown

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Mexican/Mexican American/ Chicano
- ☐ Puerto Rican
- ☐ Other Hispanic, Latino or Spanish Origin
- ☐ Non-Hispanic or Latino

Gender Identity: (Optional)
- ☐ Male
- ☐ Female
- ☐ Transgender Man
- ☐ Transgender Woman
- ☐ Unknown
- ☐ Other
- ☐ Chose Not to Disclose

Have you ever served in the Military or Armed Forces? (This includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves)

☐ Yes ☐ No

Employment Status:
- ☐ Full-Time ☐ Part-Time
- ☐ Migrant Worker
- ☐ Seasonal Migrant Worker
- ☐ Currently Unemployed

Are you interested in seeing if you qualify for Medicaid or our Sliding Fee Discount Program?
- ☐ Medicaid
- ☐ Sliding Fee Discount Program
- ☐ None of these

Education:

Current Student: ☐ Yes ☐ No

Highest Level of Education:
- ☐ Not yet in School
- ☐ Pre-School / Kindergarten
- ☐ Grade School
- ☐ Middle School
- ☐ High School
- ☐ High School Degree / GED
- ☐ Didn't complete High School
- ☐ Technical / Trade School
- ☐ Some College
- ☐ College Graduate

Housing Status:

Are you currently:
- ☐ Homeless Shelter
- ☐ Transitional Housing
- ☐ Doubling Up
- ☐ Street
- ☐ Permanent Supportive Housing
- ☐ Other (Own / Rent)
- ☐ Unknown

CENTRAL OZARKS MEDICAL CENTER

COMC

ELDON SCHOOL CLINIC

Patient Medical History

Allergies: ☐ NKDA (No Known Drug Allergies)

____

Medications: ☐ I do not take any medications

____

Have you ever had an adverse reaction to Anesthesia? ☐ Yes ☐ No

If yes, please explain:

____

Do you, or have you ever taken Bisphosphonate (medication used for bone loss)? ☐ Yes ☐ No

If yes, which one?

____

Heart & Circulatory Problems	Yes	No	Bleeding Disorders	Yes	No	Infectious Diseases	Yes	No
Heart Inflammation			Anemia			Hepatitis A, B, C		
Artificial Heart Valve			Bleeding Disorder			AIDS		
Heart Murmur			**Neurological Disorders**			HIV Infection		
Heart Trouble			Seizures			Tuberculosis / TB		
Heart Attack			ADHD			**Muscle & Joint**		
Stroke			Autism			Hip / Knee Replacement		
High Blood Pressure			Alzheimer's / Dementia			Arthritis		
Other Health Concerns								
Liver Problems			Diabetes			Cancer		
Kidney Problems			Mental Health			Pregnant		
Thyroid Problems			Immune System			Breastfeeding		
						Taking Phentermine		

If you answered yes to any of the above, please explain:

____

Do you have any pertinent family medical history? (i.e.. Cancer, Autoimmune Disorder, etc.):

____

CENTRAL OZARKS MEDICAL CENTER
COMC

(Printed Name of Minor)

Patient Name:_________________________________ **DOB:** ____________

Central Ozarks Medical Centers Policies and Consents

Consent to Treat:

I,_________________________________, consent for the 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. 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 my child.

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)

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

CENTRAL OZARKS MEDICAL CENTER
COMC
ELDON SCHOOL CLINIC

Patient Name:______________________ DOB:__________

Central Ozarks Medical Centers Policies and Consents

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 c overage. 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

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:______________________

CENTRAL OZARKS MEDICAL CENTER
COMC
ELDON SCHOOL CLINIC

Introducing COMC's Healthy Tooth Club

Each child with a perfect exam (no cavities) will be added to the Healthy Tooth Club

- Entry in our monthly giveaway
- COMC "Healthy Tooth Club" T-Shirt
- Certificate of Achievement for Healthy Teeth

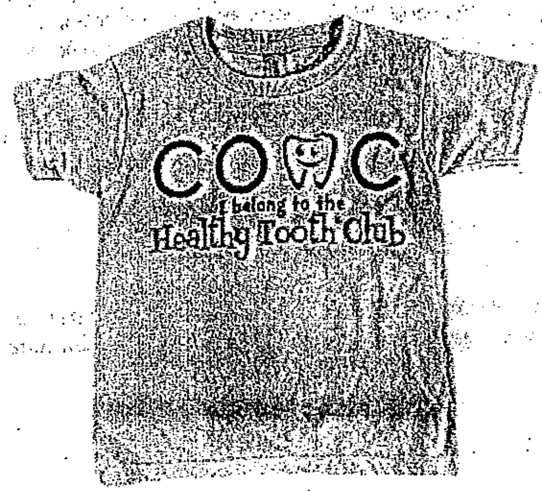

Photo Release Form

Student's Name:______________________________ School:____________________

Parent(s) Name:______________________________ Phone#:____________________

Address:___________________________________ Email: ____________________

________ I DO give permission for my child's picture to be used by COMC on their Facebook account or any other publication in conjunction with Central Ozarks Medical Centers, with the understanding that his/her name will not be used with the photo nor will he/she be identified in any other way.
(Initial)

________ I DO NOT give permission for my child's picture to be used by COMC
(Initial)

______________________________ ______________________________
Parent/Legal Guardian Name (print) Parent/Legal Guardian Signature

____
Date