Great Mines
HEALTH CENTER

PATIENT REGISTRATION PAPERWORK

We look forward to assisting you!!

Main Location
#1 Southtowne Drive
Potosi, MO 63664
(573) 438-9355

Farmington Location
508 West Pine Street
Farmington, MO 63640
(573) 664-1100

School-Based Services
Call (573) GET-WELL
438-9355

Revised 10-6-23 VT

Today's Date: _____ **GREAT MINES HEALTH CENTER PATIENT REGISTRATION PAPERWORK**

PATIENT INFORMATION

First Name: **Middle Name**: **Last Name:**

Preferred Pharmacy: **Primary Care Provider:**

Former Name: **Preferred Name:**

Date of Birth (MM/DD/YYYY): **Social Security Number:**

Physical Address:

_____
(Street Address) (City) (State) (Zip)

Mailing Address: ☐ Same as Address Listed Above (if no, please fill in below)

_____
(Street Address) (City) (State) (Zip)

Primary Phone Number: (____) _____
☐ Home ☐ Cell ☐ Work

Alternate Phone Number: (____) _____
☐ Home ☐ Cell ☐ Work

Email Address:

Employment Information: ☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ N/A
Occupation: _____ Employer: _____ Employer Phone: (____) _____

AS AN FQHC WE ARE REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS:

Sex Assigned at Birth: ☐ Female ☐ Male

Gender Identity
☐ Female ☐ Male ☐ Choose Not to Disclose
☐ Transgender Male/Female to Male
☐ Transgender Female/Male to Female
☐ Other: _____

Sexual Orientation
☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual
☐ Bisexual ☐ Choose Not to Disclose
☐ Don't Know
☐ Other: _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your race? (Check all that apply)
☐ More Than One Race ☐ Japanese
☐ American Indian/ Alaska Native ☐ Korean
☐ Asian Indian ☐ Vietnamese
☐ Black/African American ☐ White
☐ Chinese ☐ Unknown
☐ Other: _____ ☐ Choose Not to Disclose

What is your ethnicity?
☐ Chicano ☐ Not Hispanic, Latino/a or Spanish Origin
☐ Cuban ☐ Other Hispanic, Latino/a or Spanish Origin
☐ Mexican ☐ Puerto Rican
☐ Mexican American
☐ Choose Not to Disclose
☐ Other: _____

Primary/Preferred Language:
☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese
☐ Other_____

Do you need an Interpreter? ☐ Yes ☐ No

Are you a migrant /seasonal worker?
Migrant ☐ Seasonal ☐ Neither

Are you experiencing homelessness? ☐ Yes ☐ No (Not Homeless)

If "Yes", please choose one (1) below:
☐ Living in Shelter (Homeless Shelter) ☐ Transitional Housing
☐ Living with Others (Doubling Up) ☐ Street, Camp, Bridge
☐ Permanent Supportive Housing
☐ Other: _____

Are you a Veteran? ☐ Yes ☐ No

Do you have an advance directive? ☐ Yes ☐ No **If yes, is it on file with us?** ☐ Yes ☐ No

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

_____ _____
Printed Name of Patient Relationship to Patient of Individual Signing Form

_____ _____
Patient/Parent/Guardian Signature Date

PARENT/RESPONSIBLE PARTY: Required for patients less than 18 and whenever the guarantor is not the patient

Name (First, M.I., Last): ______________________________ **Date of Birth**: ____________________

Relationship to Patient: ________________ **Phone:** ________________ **Email:** ______________________________

Address: ☐ Same as Patient (if no, fill in below)

____

(Street Address) (City) (State) (Zip)

Occupation: ________________ Employer: ____________________________ Employer Phone: (______) ______________

INSURANCE INFORMATION: ☐ Medical ☐ Dental				
Primary Insurance Company:		Policy #	Group #	Copay:
Policy Holder Name:	Policy Holder DOB:	Relation:	Social Security #:	Employer:
Secondary Insurance Company:		Policy #	Group #	Copay:
Policy Holder Name:	Policy Holder DOB:	Relation:	Social Security #:	Employer:
Tertiary Insurance Company:		Policy #	Group #	Copay:
Policy Holder Name:	Policy Holder DOB:	Relation:	Social Security #:	Employer:

CONTACTS: Must have one person listed as Emergency Contact
Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

Name:	**Relationship:**			**Phone:**
Address:				
Check all that apply:	☐ Emergency Contact	☐ May Share Information	☐ May Leave Voice Message	☐ May Make Appointments
☐ May Bring Minor to Appointments	☐ Authorized to Make Medical Decisions, Including Procedures and Vaccinations **(Notary Form Required)**			☐ Power of Attorney
Name:	**Relationship:**			**Phone:**
Address:				
Check all that apply:	☐ Emergency Contact	☐ May Share Information	☐ May Leave Voice Message	☐ May Make Appointments
☐ May Bring Minor to Appointments	☐ Authorized to Make Medical Decisions, Including Procedures and Vaccinations **(Notary Form Required)**			☐ Power of Attorney
Name:	**Relationship:**			**Phone:**
Address:				
Check all that apply:	☐ Emergency Contact	☐ May Share Information	☐ May Leave Voice Message	☐ May Make Appointments
☐ May Bring Minor to Appointments	☐ Authorized to Make Medical Decisions, Including Procedures and Vaccinations **(Notary Form Required)**			☐ Power of Attorney

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

______________________________ ______________________________

Printed Name of Patient   Relationship to Patient of Individual Signing Form

______________________________ ______________________________

Patient/Parent/Guardian Signature   Date

Today's Date: _____ Patient Name: _____ Patient Date of Birth: _____

PRAPARE Assessment Questions

At Great Mines Health Center, we want to make sure that we provide the best care and services possible to meet your needs. This information will help us determine if we need to add new services or programs to meet the needs of our patients. **This information will be kept private and secure.** Your decision to answer or to refuse to answer will NOT impact your ability to receive care. In many cases, this information will help us determine if you are eligible for any additional benefits, programs, or services. Please let us know if you have any questions, concerns, or suggestions.

Have you been discharged from the armed forces of the United States? ☐ Yes ☐ No ☐ Choose Not to Disclose

How many family members, including yourself, currently live in your home? #_____ ☐ Choose Not to Disclose

Are you worried about losing your housing? ☐ Yes ☐ No ☐ Choose Not to Disclose

What is the highest level of school that you have finished?

☐ Less than high school degree ☐ High school diploma or GED ☐ More than high school ☐ Choose Not to Disclose

What is your current work situation?

☐ Unemployed ☐ Part-time or temporary work ☐ Full-time work

☐ Not seeking work (student, retired, disabled, care giver, homemaker) ☐ Choose Not to Disclose

During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

$_____ ☐ Choose Not to Disclose

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

☐ Food ☐ Clothing ☐ Child Care ☐ Utilities ☐ Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)

☐ Phone ☐ Choose Not to Disclose ☐ Other: _____

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

☐ Yes, it has kept me from medical appointments or from getting my medications.

☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things I need.

☐ No ☐ Choose Not to Disclose

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week ☐ 1-2 times a week ☐ 3-5 times a week ☐ 6 or more times a week ☐ Choose Not to Disclose

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ Choose Not to Disclose

In the past year, have you spent more than two nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No ☐ Choose Not to Disclose

Are you a refugee?

☐ Yes ☐ No ☐ Choose Not to Disclose

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Choose Not to Disclose

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ I have not had a partner in the past year ☐ Choose Not to Disclose

GREAT MINES HEALTH CENTER PATIENT REGISTRATION PAPERWORK

Sliding Fee Discount

Sliding Scale Discount Program fees for clinic services are based on your income and family size and may be reduced if you live on a limited income according to federal guidelines. To qualify for discounts, you must present the following information as applicable:

Acceptable documentation for proof of income (please provide proof for all Family/household income):

- Current paycheck stub.
- A letter on company letterhead. Please include the following information: hourly rate, gross pay and the pay period. If your employer does not have company letterhead, we will accept a notarized letter from your Employer. Please include the following information: hourly rate, gross pay and the pay period.
- Current Unemployment Determination Letter.
- Social Security, pension, trust, SSI Disability award letter, food stamp summary or child support check.
- Current financial aid, Pell Grants, scholarships papers.
- Current tax information.
- W2 Forms (gross income).
- For elderly parents living with adult children or adult grandchildren, include income if adult children or adult grandchildren claim parents as dependents on their tax return. Otherwise, parents should be considered as independent for the purposes of income. (Do not count their adult children's income).
- Noncash items such as food stamps are not included in the income.

Acceptable documentation for proof of family size (please provide proof for all Family/household income):

- Current tax return or tax information
- Driver's license (must include current address)
- Social Security, pension, trust, SSI Disability award letter, food stamp summary or child support check or child support summary, birth certificate or any government issued letter.
- Current piece of mail with family/household members name included
- Letter from Department of Family Services or Court Order

Who does GMHC define as "Family/Household"?

- Husband, wife and dependent children (any age, related biologically or adopted)
- Significant other
- Unmarried partners
- Mother/Father, if included on the tax return
- Grandparents, if included on the tax return
- Grandchildren, if included on the tax return
- All members included on the tax return

PLEASE ENSURE YOU RETURN ALL THE INFORMATION AT THE SAME TIME

I understand if I do not provide the above information within thirty (30) days from today, I will be fully responsible for all services rendered and these services will be billed at the full price until the information is returned. However, I will be awarded the discount on the initial visit based upon Federal Poverty Level guidelines of my self-declared income/family size on the Sliding Fee Discount Application.

You will need to present a copy of the following at the time of each visit:

- Driver's License or Photo ID
- Insurance cards, if applicable

SLIDING SCALE DISCOUNT PROGRAM APPLICATION

It is the policy of Great Mines Health Center to provide primary care services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the Front Desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside entities, including but not limited to: reference laboratory testing, drugs, medical devices and other such services. This form must be completed every 12 months or if your financial situation and/or family size changes.

Please initial what applies to you:

_____ I am a new patient with GMHC. I do not have insurance and I did not bring my proof of income. This form serves as a Self-Statement of income for my first new-patient visit only. **I am aware that I have 30 days to return proof of income.**

_____ I am an established patient at GMHC and recently lost my insurance coverage. This form serves as a Self-Statement of income for today's visit only. **I am aware that I have 30 days to return proof of income.**

_____ I have insurance but would like to submit this application for any services not covered by my insurance company and/or for services that I choose not to submit to my insurance company. **I am aware that I have 30 days to return proof of income.**

Head of Household (circle one): Yes No If no, name of head of household: _____

Address: _____ City/State/Zip: _____

Place of Employment: _____

HOUSEHOLD MEMBERS

Relationship	Name	Birthdate	Phone	Currently GMHC Patient (Yes/No)
Self				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

ANNUAL HOUSEHOLD INCOME - BASED ON ANNUAL COMPENSATION

Source	Self	Spouse	Dependent/Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment				
Unemployment, worker's comp, Social Sec., SSI, public assistance, veteran's pmts, survivor benefits, pension, retirement income				
Interest, dividends, rents, royalties, estates income, trusts, education assistance, alimony, child support, outside household assistance, other misc sources				
TOTAL INCOME	$	$	$	$

I, the person who has signed below, has filled out the application for the Sliding Scale Fee Discount consideration and can prove that this information is true and correct, to the best of my knowledge. I am also aware that if there is any change in the financial status of any of the people in my household, it must be reported immediately to GMHC and a new application must be filled out. I understand that upon request of GMHC and yearly, there will be a review of my application with the chance of discount amount changes. I understand that any untrue information written on these forms or the failure to provide proof of income and/or proof of family size, within 30 days, may result in the disapproval of the discount fee reduced price made available by GMHC. I also understand this discount service is for services provided by GMHC only.

Applicant Signature: _____ **Date:** _____

As a Federally Qualified Healthcare Center, we are required to collect certain information. The information on this form is used to determine the amount of discount that you may receive from GMHC and/or for statistical purposes. I understand that my personal and financial information will not be released.

BELOW TO BE COMPLETED GMHC STAFF ONLY

Patient Name: _____ 30-day expiration date for POI/PFS: _____

Initial Visit: Approved Discount: $_____ or denied due to: _____

GMHC Staff: _____ Date: _____

Notes: _____

VERIFICATION CHECKLIST	Yes	No
Proof of Income (POI): Current year tax return, recent pay stubs or Other: _____		
Proof of Family Size (PFS): Current tax return, government issued letter, mail (includes each family member with same address)		

GREAT MINES HEALTH CENTER CONSENTS

Treatment: I hereby grant permission for Great Mines Health Center (GMHC) to perform those procedures and treatments deemed necessary or advisable for complete care of myself or a dependent for whom I am legally responsible. I authorize any GMHC licensed provider, or auxiliary to perform any treatment, medication administration and therapy that may be indicated in connection with my care or the care of my dependent. I understand that before treatment, a full explanation of the procedure(s) involved will be given by staff. **Initials:** _____

Missed Appointments: New patients are required to check in at least 30 minutes prior to their appointment. All established patients must check in at least 15 minutes prior to their appointment. This will allow time to complete all necessary paperwork and allows the staff to get the patient to the exam room by the actual appointment time. Failure to check in timely will result in the need to be rescheduled. **Initials:** _____

Identification Requirements: All individuals receiving care or accompanying a minor (person under 18years of age) must present a valid government issued photo ID at every visit. If photo ID cannot be provided the visit will be canceled. All minors (children aged 17 and under) must be accompanied by a parent or legal guardian at all appointments. If a parent or legal guardian is unable to accompany minors and is requesting for another individual to accompany the minor then the parent/legal guardian must present a notarized document stating that person can consent to healthcare, treatments, and procedures for the minor. **Initials:** _____

Financial Agreement: I authorize and request my insurance company to pay directly to Great Mines Health Center. I understand that my insurance carrier may pay less than the actual bill for services. I also authorize Great Mines Health Center or insurance company to release any information required to process my claims. 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 am aware that patients will be assessed a $25 fee for checks returned due to Insufficient Funds. A missed appointment fee of $5 for second missed appointment, $10 for third missed appointment, and $20 for each appointment missed thereafter for a three-year time period. Missed appointment fee will be charged if a 24-hour notice of cancellation is not given. No controlled medication will be refilled if the fee is not paid, and patient will be walk-in only until fee is paid.*** **Initials:** _____

Health Information Exchange Opt-In: I hereby authorize Great Mines Health Center to release and obtain all my medical records and medical information, including records which relate to any physical or mental condition, psychological condition, psychiatric evaluation and treatment, psychotherapy, counseling, drug addition, infection status, HIV/AIDs, genetic testing, or treatment for drug or alcohol abuse, even though such information is protected by federal law, to the above HIEs. The purpose of this disclosure is for healthcare treatment purposes, change in providers and continuity of healthcare. I specifically authorize the release of my medical information to and from the HIEs GMHC partner within an electronic format. **Initials:** _____

Opt-Out: _____

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, if requested. A copy of GMHC's HIPAA Notice of Privacy Practices is posted in the main lobby and available for me to read in its entirety. If you choose to receive information from Great Mines Health Center via email or text (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. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI"). **Initials:** _____

Photographs: I agree that photographs of me or my dependent may be taken by a member of Great Mines Health Center staff. The photograph(s) will be used for medical records and to help in avoiding Identity Theft. All photographs are strictly private, and the identity of the patient will not be revealed to anyone outside of Great Mines Health Center unless required by law enforcement. I further authorize, GMHC, to use radiographs, treatment records, and other diagnostic materials for the purpose of teaching, research, and scientific publications with the assurance that my or my dependent's identity will remain confidential. **Initials:** _____

Misc Consents: GMHC representatives may leave a detailed message on my answering machine. **Initials:** _____

I authorize GMHC to release an excuse to this my work/school. **Initials:** _____

I recognize that GMHC is not responsible for any personal property brought onto GMHC's premises. **Initials:** _____

***IF APPLICABLE - School Based Clinic (SBHC) Location – additional consent to treatment, authorization and release:** I, the parent/guardian of said student, give consent for my child to receive services at GMHC SBHC. I, also give consent for GMHC staff to communicate to my child's school district, listed below, to arrange appointments during school hours for my child. I understand that this consent form will be effective until my child leaves or graduates from the District, or until I provide the Center staff with written revocation of this consent. All healthcare information is confidential. By signing the consent form, you are giving the SBHC and your child's regular doctor (if applicable) permission to communicate and share healthcare information regarding your child's medical, dental, or mental health, condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay at the time of service. I agree to all other terms listed above. Confidentiality between the student, parents and the health center is assured. I understand that if guardianship changes a new consent must be signed by the legal guardian. **Initials:** _____

School District: _____

**This signed consent, authorization & acknowledgement is effective until treatment is terminated in writing by you, the patient, or GMHC.*

_____ _____

Printed Name of Patient | Relationship to Patient of Individual Signing Form

_____ _____

Patient/Parent/Guardian Signature | Date

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical, mental, or dental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. I understand the following with respect to telehealth:

1. I understand that telehealth involves the communication of my medical/mental/dental health information in an electronic or technology-assisted format.
2. I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
3. I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s).
4. I understand that there are risks, benefits, and consequences associated with telehealth, despite reasonable efforts on the part of the healthcare provider. These include but are not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. The healthcare provider & GMHC are not responsible for breaches of confidentiality caused by an independent third party or by me or to my personal electronic devices. I agree to not hold GMHC liable for any punitive, exemplary, consequential, incidental, indirect, or special damages arising from or in connection with use of website or external connections not directed by GMHC.
5. I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand I have the right to access my own medical records (and copies of medical records).
6. I understand that GMHC provides a secure HIPAA-Compliant platform for the telehealth appointment. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
7. I understand that there will be no recording of any of the online sessions by either party, unless agreed upon at the time of the appointment. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without patient authorization, except where the disclosure is permitted and/or required by law.
8. I agree to verify to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
9. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
10. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community. I understand that if I am having medical emergency concerns, suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, during the telehealth encounter, it may be determined that telehealth services are not appropriate, and a higher level of care is required.
11. I will be informed if any additional personnel are to be present with me in the room or in the room with the consulting provider. I will give my verbal permission prior to the entry of the additional personnel, and I can exclude anyone from being present at any time during the consultation.

I acknowledge that Great Mines Health Center has explained the telehealth services and consent in a satisfactory manner and that all questions that I have asked about the consultation have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth services offered by GMHC and I acknowledge and agree to the items described above.

_____	_____	_____
Patient Printed Name	Patient (Guardian) Signature	Date