Patient Registration Paperwork

Great Mines
HEALTH CENTER

We look forward to assisting you!!

Main Location:	Farmington Location:	School-Based Services
#1 Southtowne Dr	508 West Pine St	Call (573) GET-WELL
Potosi, MO 63664	Farmington, MO 63640	438-9355
(573) 438- 9355	(573) 664-1100	

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, 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
- Grand Parents if included on the tax return
- Grand Children 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 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

Great Mines HEALTH CENTER

Med History

Patient Name:_____ **Birth Date:**_____ **Date Created:**_____

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	OYes ONo	If yes
Have you ever been hospitalized or had a major operation?	OYes ONo	If yes
Have you ever had a serious head or neck injury?	OYes ONo	If yes
Do you take, or have you taken, Phen-Fen or Redux?	OYes ONo	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	OYes ONo	If yes
Are you taking any medications, pills, or drugs?	OYes ONo	If yes
Are you on a special diet?	OYes ONo	If yes
Do you use tobacco?	OYes ONo	
Do you drink alcohol?	OYes ONo	

Women: Are you....

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	OYes ONo	If yes
Do you use controlled substances?	OYes ONo	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	OYes ONo	Cortisone Medicine	OYes ONo	Hemophilia	OYes ONo	Radiation Treatments	OYes ONo
Alzheimer's Disease	OYes ONo	Diabetes	OYes ONo	Hepatitis A	OYes ONo	Recent Weight Loss	OYes ONo
Anaphylaxis	OYes ONo	Drug Addiction	OYes ONo	Hepatitis B or C	OYes ONo	Renal Dialysis	OYes ONo
Anemia	OYes ONo	Easily Winded	OYes ONo	Herpes	OYes ONo	Rheumatic Fever	OYes ONo
Angina	OYes ONo	Emphysema	OYes ONo	High Blood Pressure	OYes ONo	Rheumatism	OYes ONo
Arthritis/Gout	OYes ONo	Epilepsy or Seizures	OYes ONo	High Cholesterol	OYes ONo	Scarlet Fever	OYes ONo
Artificial Heart Valve	OYes ONo	Excessive Bleeding	OYes ONo	Hives or Rash	OYes ONo	Shingles	OYes ONo
Artificial Joint	OYes ONo	Excessive Thirst	OYes ONo	Hypoglycemia	OYes ONo	Sickle Cell Disease	OYes ONo
Asthma	OYes ONo	Fainting Spells/Dizziness	OYes ONo	Irregular Heartbeat	OYes ONo	Sinus Trouble	OYes ONo
Blood Disease	OYes ONo	Frequent Cough	OYes ONo	Kidney Problems	OYes ONo	Spina Bifida	OYes ONo
Blood Transfusion	OYes ONo	Frequent Diarrhea	OYes ONo	Leukemia	OYes ONo	Stomach/Intestinal Disease	OYes ONo
Breathing Problems	OYes ONo	Frequent Headaches	OYes ONo	Liver Disease	OYes ONo	Stroke	OYes ONo
Bruise Easily	OYes ONo	Genital Herpes	OYes ONo	Low Blood Pressure	OYes ONo	Swelling of Limbs	OYes ONo
Cancer	OYes ONo	Glaucoma	OYes ONo	Lung Disease	OYes ONo	Thyroid Disease	OYes ONo
Chemotherapy	OYes ONo	Hay Fever	OYes ONo	Mitral Valve Prolapse	OYes ONo	Tonsillitis	OYes ONo
Chest Pains	OYes ONo	Heart Attack/Failure	OYes ONo	Osteoporosis	OYes ONo	Tuberculosis	OYes ONo
Cold Sores/ Fever Blisters	OYes ONo	Heart Murmur	OYes ONo	Pain in Jaw Joints	OYes ONo	Tumors or Growths	OYes ONo
Congenital Heart Disorder	OYes ONo	Heart Pacemaker	OYes ONo	Parathyroid Disease	OYes ONo	Ulcers	OYes ONo
Convulsions	OYes ONo	Heart Trouble/Disease	OYes ONo	Psychiatric Care	OYes ONo	Venereal Disease	OYes ONo
Yellow Jaundice	OYes ONo						

Have you ever had any serious illness not listed above? OYes ONo if yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

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

(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 ☐ Other: _____
☐ Don't Know ☐ Choose Not to Disclose

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

What is your race? (Check all that apply)
☐ More Than One Race ☐ Korean
☐ American Indian/ Alaska Native ☐ Vietnamese
☐ Asian Indian ☐ White
☐ Black/African American ☐ Unknown
☐ Chinese ☐ Other: _____
☐ Japanese ☐ 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.

_____ _____
Print 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
____
(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 Number:**
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 Number:**
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 Number:**
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.

______________________________ ______________________________

Print Name of Patient **Relationship to patient of Individual Signing Form**

______________________________ ______________________________

Patient/Parent/Guardian Signature **Date**

Dental Consent and Authorization Form

Great Mines
HEALTH CENTER

Dental Consent to Treatment

I hereby grant permission for Great Mines Health Center (GMHC) and/or other affiliated dentists or dental auxiliaries of GMHC to perform those procedures and treatments deemed necessary or advisable for complete care of a dependent for whom I am legally responsible. Unforeseen circumstances or conditions may require a departure from the original proposed treatment plan. I authorize any Great Mines Health Center licensed provider, and/or dental auxiliary, to perform comprehensive dental care to include but not limited to the following:

Procedures: dental Radiographs (x-rays), examinations and diagnosis, dental prophylaxis (cleaning), and topical fluoride, application of sealants to the grooves of the teeth, Use of local anesthesia to numb the teeth and tissues, treatment of diseased or injured teeth with dental restorations (fillings): Composite Resin (white fillings), Amalgam (silver fillings), Stainless Steel Crowns, Pulpal Treatment (nerve involvement), treatment of injured or infected pulps (nerve) of teeth, removal (Extraction of teeth), Primary (Baby), Permanent (Adult), replacement of missing teeth with dental prosthesis, treatment of diseased or injured oral tissues (hard and soft), treatment of malposed (crooked) teeth and/or oral developmental and growth abnormalities.). Nitrous Oxide/Oxygen (commonly called laughing gas) to alleviate anxiety during dental treatment.

Safety - Physical restraint or restraining devices will be used only when necessary to safely accomplish the dental procedure(s). Physical restraint will consist of: Holding hands and head still, and/or Blanket Wrap and/or Pillowcase (arms).

List any exception:_____

Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated; therefore, there can be no guarantee expressed or implied either as to the result of the treatment or as to the cure.

Risk - Although occurrences are not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complication associated with pediatric dental treatment is nausea following anesthesia. Less common complications to local anesthetics are: prolonged of permanent numbness of the cheeks, lips, tongue, or gums, allergic reaction, rapid heart rate, or a reaction with other drugs they are taking. There is a possibility that the patient might bite the inside of the mouth or tongue before the local anesthetic wears off. The child must be instructed not to do so. Less common treatment complications are: numbness, infection, swelling, prolonged bleeding, tooth discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form or extracted tooth or gauze packing, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root, which may require additional surgery for its removal. I further understand and accept that complications may occur and may require additional medical, dental or surgical treatment, and hospitalization. After treatment, your child may experience pain and swelling. Although child is usually alert and awake upon leaving the office, if Nitrous oxide (laughing gas) is administered, there are rare instances of lingering sedation.

If I do not remain in the dental office while my child is receiving treatment, I am leaving the treatment up to the doctor's judgment and experience, understanding that other treatment may be necessary. If contact with me is not successful, the doctor and GMHC staff have my permission to perform procedures and treatment deemed necessary or advisable.

I have read and understand this informed consent form. I have had an opportunity to ask any questions I might have, and all of my questions, about the procedures, have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I understand that during the course of the planned procedure(s), unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those contemplated. I understand that I am free to withdraw my consent to treatment, with written notice, at any time and that this consent will remain in effect until I choose to terminate it.

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

Signature of Parent or Guardian: _____

Name and Relationship to Patient: _____ **Date**_____

Office Staff Only_____

Witness:_____ Date_____

I certify that I explained the above procedures to the parent or legal guardian before requesting his or her signature.

Revised 3/21/24

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.

Opt Out:_____ **Initials:** _____

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 the 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. **School District:** _____ **Initials**_____

***This signed consent, authorization and acknowledgment is effective until treatment is terminated in writing by you, the patient, or* GMHC**

_____ _____

Print Name of Patient **Relationship to patient of Individual Signing Form**

_____ _____

Patient/Guardian Signature **Date**

Revised 10-05-23 - VT

Great Mines
HEALTH CENTER

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 including but 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 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 resent 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

Guardian Printed Name (If Applicable) _____

Great Mines Health Center

Patient Recommendations and Grievance Policy

We at Great Mines Health Center are delighted that you have entrusted our organization with your medical, behavioral health and/or dental needs. We want you to have the best possible encounter every time you visit. We encourage you to bring to our attention any recommendations or complaints by contacting our Patient Advocate at:

Telephone:	(573) 438-9355 ext. 355
Email:	customerservice@gmhcenter.org
Mail:	Great Mines Health Center Attn: Patient Advocate #1 Southtowne Drive Potosi MO 63664

_____

Print Name of Patient

_____

Patient/Parent/Guardian Signature Date

_____

Relationship to patient of Individual Signing Form

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:

1. ____ 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 I have 30 days to return proof of income*
2. ____ 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 I have 30 days to return proof of income*
3. _____ 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 to not submit to my insurance company. *I am aware I have 30 days to return proof of income*

Head of Household: Yes or No Name of Head of Household _____

Address:_____

Street City, State, Zip

Place of Employment:_____

RELATIONSHIP	NAME	DATE OF BIRTH	PHONE	Currently a GMHC Patient Y/N
SELF				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

Great Mines
HEALTH CENTER

Sliding Fee Discount Application

Annual Household Income – Based on ***Annual*** compensation

SOURCE	SELF	SPOUSE	DEPENDENT/OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business/self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

I, the person who has signed below, have filled out this application for the Sliding 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 financial status of any of the people in my household it must be report immediately to Great Mines Health Center, (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 form or the failure to provide proof of income and proof of family size, within 30 days, may result in the disapproval for the Discount Fee reduced priced made available by GMHC. I also understand this discount service is for services provided within GMHC only.

Applicants Signature:_____ **Date:**_____

As a Federally Qualified Health Care 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 or financial information will not be released.

BELOW TO BE COMPLETED BY 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)		