Patient Registration Paperwork

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, 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
- 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

Revised 11-1-21 RJ

Great Mines Health Center

REGISTRATION FORM

Please Print

Today's Date:	Preferred Provider:	Preferred Pharmacy:

PATIENT INFORMATION

Patient's Last Name: First: Middle:			Circle One: Mr. Mrs. Miss. Ms. Marital Status: Circle One Single / Mar / Div / Sep / Wid
Is this your legal name? Yes or No	If No, what is your legal name?		Former Name:
Date of Birth: MM/DD/YYYY	Age:	Sex at birth:M / F	Social Security Number:
Street Address: (PO Box)		City, State & Zip:	
Home Phone: ( )	Cell Phone: ( )	Email:	Contact Preference: Circle One Home / Cell / Email
Appointment reminders: Y / N Text:_____Or email_____	Driver License #		Driver License State:
Occupation:	Employer:		Employer Phone: ( )

Preferred Language: English, Spanish, other_____**Race**: White, Black, Hispanic, other _____

US Military Veteran: Y or N **Do you have an advanced directive:** Y or N

Sexual Orientation: Prefer not to disclose Lesbian/Gay/Homosexual/Straight/Heterosexual/Bisexual/Don't know

Gender Identity: Male/Female/Transgender Male/Female to Male Female/Male to Female

Housing Status: NOT Homeless/ Homeless/Public Housing/Doubling Up/Transitional Housing

Responsible Party Information

Responsible Party, First, M.I. and Last Name:	Date of Birth:	Relationship to Patient:	current patient? Y or N
Street Address, City, State & Zip: (If Different)			
Occupation: Employer:		Employer Phone:	

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ Dental Insurance ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ Dental Insurance ☐ Secondary ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ Dental Insurance ☐ Secondary ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

EMERGENCY CONTACT

Name:	Relationship to Patient:	Home Phone:	Cell Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to GMHC. I understand that I am financially responsible for any co-pays and/or any remaining balance not paid by my insurance company. I also authorize Great Mines Health Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature	*Date:*

Revised 7-26-19

Consent and Authorization Form

Consent to 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, full explanation of the procedure(s) involved will be given by staff.

Authorization and Release

I authorize GMHC to release any information, including the diagnosis and the records of any treatment or examination provided to me or my dependent during the period of such care, to third party payers and /or health practitioners. I understand this may include information regarding HIV, AIDS, Alcohol or drug abuse, mental illness or any mental health condition, sexually transmitted diseases, family planning, pregnancy, genetic tests or genetic diseases.

Persons Authorized to Receive Information:

Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

_____

Name of Person **Relationship** **Phone Number**

_____

Name of Person **Relationship** **Phone Number**

(Please Initial) GMHC representatives may leave a detail message on answering machine: Yes_____ No_____

(Please Initial) I authorize GMHC to release an excuse to my work/school: Yes_____ No_____

Financial Consent

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 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 up to $5 for first missed appointment, up to $10 second missed appointment, up to $15 for third missed appointment, and up to $15 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 fee is not paid and patient will be walk-in only until fee is paid.***

Photographic Consent

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. 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 are 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").

Patient's Name (please print) _____Date Of Birth_____

Signature of patient or patient representative_____

Print name and Relationship to Patient_____ Date_____

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

***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 as 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.

Signature:_____ Date_____ School District SBHC:_____

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				

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)		

Great Mines
HEALTH CENTER

Past Family and Social History
Under 5 years of age

Date:_____ **Patient Name:**_____ **DOB:**_____ **SEX: □M □F**

Patient Up to Date on Immunizations: Yes or No (Please make sure the office has an updated copy)

If not please state why: _____

Child Social History

Parent Information: *(circle all that apply)*

Parents together	Father Involved	Same Sex Partners
Parents separated	Mother Involved	Foster Care
Lives w/Mother	Father not Involved	Guardian Parents (Clarify):_____
Lives w/Father	Mother not Involved	Other (Clarify): _____

Is the patient adopted □ Yes □ No **Is the patient in foster care □ Yes □ No**

Parents Smoke: *(circle all that apply)* Yes No Outside Only

Pets (What Kind, How Many, Inside or Outside): _____

If age appropriate does your child attend: Daycare Preschool Not Applicable

Name of School/Preschool/Daycare: _____

If none, who cares for your child[ren] during the day: _____

Extracurricular activities: (sports, music, etc.) _____

Has the patient ever received anesthesia □ Yes □ No **Any family history of anesthesia reactions □ Yes □ No**

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

Patient Medical History: Please circle Yes or No, if Yes please provide details

If the patient is adopted or in foster care please include any known medical history below

			Past or Current Diagnosis	Physician Name or Name of Facility
Cancer	No	Yes		
Blood Disorder	No	Yes		
Diabetes	No	Yes		
Endocrine/Metabolic Disorder	No	Yes		
Ear, Nose, & Throat Disorder	No	Yes		
Cardiovascular Disorder	No	Yes		
GI/Stomach Disorder	No	Yes		
GU/Kidney Disease	No	Yes		
Musculoskeletal Disorder	No	Yes		
Neurological Disorder	No	Yes		
Psychiatric/Learning Disorder	No	Yes		
Respiratory/Asthma Disorder	No	Yes		
Skin Disease	No	Yes		
Other Chronic Problems	No	Yes		

Past Family and Social History
Under 5 years of age

Pregnancy and Birth History:

If the patient is adopted or in foster care please include any known medical history below

Birth Location/Hospital	
Birth Weight	_____ lbs_____ounces
Discharge Weight	_____ lbs_____ounces
Length	_____ cm/inches
Head Circumference	_____ cm/inches
Gestational Age (Full Term or # of weeks)	
Type of Birth (Vaginal or C-section)	
Apgar Scores	
Did the patient have to stay in the NICU	□ **Yes** □ **No** if yes how long _____
Did the patient receive Oxygen while in the hospital	□ **Yes** □ **No** if yes how long _____
Did the patient have jaundice	□ **Yes** □ **No** if yes did the patient require any phototherapy and how long _____
Was patient provided a Synagis Injection while in the hospital	□ **Yes** □ **No** if yes How many_____Date of last injection_____
Did the patient receive a Hepatitis B Vaccine at Birth	□ **Yes** □ **No** if yes date of administration_____
Newborn Hearing Test	□ **Normal** □ **Abnormal** □ **Test Not Performed**
Newborn State Screening	□ **Normal** □ **Abnormal** □ **Test Not Performed**
Any other Newborn Testing Performed	□ **Yes** □ **No** if yes please describe _____
Did the mother have any medical problems during her pregnancy	□ **Yes** □ **No** if yes please describe _____
After discharge, are you aware of any further follow up diagnostic imaging, bloodwork, referrals, or testing that needs to be ordered	□ **Yes** □ **No** if yes please describe _____

MEDICATIONS: **Does the patient currently take any medications □ Yes □ No**

If you marked Yes, please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc

Medication	Dosage	Directions/ Frequency	Medication	Dosage	Directions/Frequency
1.			**4.**		
2.			**5.**		
3.			**6.**		

HOSPITALIZATONS: **Has the patient ever been hospitalized □ Yes □ No**

If you marked Yes, please list the dates, the name of the hospital, the reason and how long they were there

Date (Month, Day, Year)	**Hospital Name**	**Reason or Diagnosis**	**How long where they there**

Past Family and Social History
Under 5 years of age

Surgical Procedures: Has the patient had any previous surgeries □ Yes □ No
If you marked Yes, please list the date of the surgery, name of the hospital where it was performed and the name of the procedure

Date (Month, Day, Year)	Hospital Name	Surgical Procedure	Date (Month, Day, Year)	Hospital Name	Surgical Procedure
1.			**3.**		
2.			**4.**		

Allergies: Does the patient have any known allergies □ Yes □ No
If you marked Yes, please list the date they were diagnosed, allergy name and the reaction type

Date (Month, Day, Year)	Allergy Name	Reaction (Ex: anaphylactic shock, rash, diarrhea)	Severity (Ex: Mild, Moderate, Severe)

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

FAMILY HISTORY: Please indicate with a check (√) if the patient's family has had any of the following conditions and then specify in the box their diagnosis. In the second column please indicate their living status. L = Living, D = Deceased, U = Unknown. **If the patient is adopted or in foster care please include any known family medical history below**

	Date of Birth	Living Status	Cancer	Diabetes	Heart Disease	Eye Disorder	Ear Disorder	Respiratory	GI Disorder	GU Disorder	Muscle Disorde	Neurological Disorder	Psychiatric Disorder	Skin Disease
Mother			□	□	□	□	□	□	□	□	□	□	□	□
Father			□	□	□	□	□	□	□	□	□	□	□	□
Sibling			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Other			□	□	□	□	□	□	□	□	□	□	□	□

Informed Consent for Telehealth Consultation

To serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management, and treatment of a number of health care problems. This process is referred to as "telemedicine" or "telehealth." This means that you may be evaluated and treated by a health care provider from a distant location. Since this may be different from the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

1. I understand that my health care provider recommends that I engage in telehealth consultation ("consulting provider") with Great Mines Health Center.

2. I understand that the consulting provider will be at a different location from me. A health care provider ("presenting provider") may be present with me in the room to assist in the consultation.

3. I understand that I have the option to refuse telehealth service at anytime without affecting my right to future care or treatment and, if applicable, without risking the loss of or withdrawing from my participation in the MO HealthNet program.

4. I understand that there are alternatives to this telehealth consultation. I may have the option to travel to see the consulting provider, or I may refuse to see the consulting provider. Pathways has fully explained the alternatives to me.

5. I understand that I have the right to access my medical history, examinations, x-rays, tests, photographs or other images ("my medical information") related to this consultation.

6. The presenting provider may transmit or share electronically my medical information with the consulting provider who is at a different location. I consent to this transmission, but I can request that my medical information not be sent to the consulting provider if I make the request before my medical information is transmitted.

7. The consulting provider may store or retain my medical information to comply with any applicable state or federal records retention requirements, but may not store or retain my medical information beyond these limits without my written permission.

8. 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.

9. I understand that I have the right to be informed of and to object to the videotaping or other recording of this consultation. I acknowledge that Great Mines Health Center has explained the telehealth consultation 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 consultation described above.

_____ _____

Name Date

To recipient of information: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by law. A general authorization for release of medical or other information may not be sufficient.

Informed Consent for Telehealth Consultation

INFORMED CONSENT FOR DISCLOSURE OF CLIENT INFORMATION FOR BEHAVIORAL HEALTH SERVICES

I, _____, authorize, Great Mines Health Center (Agency to provide treatment) to make disclosure of the specific information listed below in this document to:

_____

(Agency that provided previous treatment)
to:

_____

(Agency that provided previous treatment)

I authorize these agencies to communicate with and disclose to one another information about my symptoms, diagnosis, medications, chemical dependency information, and treatment plan. (May also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDS testing and treatment, pregnancy testing, prenatal care, birth control, and family planning). This disclosure will be made both verbally and in writing.

I understand that if I do not sign this authorization, I will not be denied treatment; however, I will lose the benefit of my treatment provider knowing about the treatment information from the previous treatment provider.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. pts. 160 &164, and Wis. Adm. Code section HFS 92.05 and 92.06, and cannot be disclosed without my written consent. I may inspect and receive a copy of any material that is disclosed if I request it. I may revoke this consent at any time with WRITTEN NOTIFICATION, except to the extent that action has been taken in reliance on it.

This authorization for disclosure of information is effective until revoked in Writing

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian