



COMC
MEDICAL · BEHAVIORAL · DENTAL
Your Health.....Our Mission.

Child's Name: _____

Dear Parent/Guardian:

Central Ozarks Medical Center (COMC) has partnered with your school district to offer Behavioral Health and Dental Services at your child's school during the 2021-22 school year! This partnership will allow COMC to expand access to convenient care, ensuring your child stays healthy. COMC is a local, non-profit organization that has worked to meet the healthcare needs of your community and surrounding areas since 1979.

Our Mobile Dental Unit is equipped to offer comprehensive dental care, including examinations, cleanings, x-rays, fillings, extractions, and some crowns. Some procedures cannot be completed same day, it may be necessary to refer those children to a COMC Dental Clinic. If this situation should arise, we will gladly provide referral information.

In addition to our Mobile Dental Unit, 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 and 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.

We look forward to providing the best healthcare experience for your child. If you have questions or concerns, please contact our toll-free number: (877) 406-2662. Or send us an email: info@centralozarks.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 which services you would like for us to provide your child.

Dental Behavioral Health

Sincerely,

Kelly Miller, CEO

Your Health... Our Mission



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Central Ozarks Medical Centers
School-Based Healthcare Services - Patient Registration
If you need help filling out these forms, please call: (877)406-2662

(Please Print)

Today's Date: _____ COMC Medical Provider: _____ COMC Dental Provider: _____

PATIENT INFORMATION

Patient's First Name:		Middle Initial:	Last Name:	Social Security Number:	Birth Date:	Age:	Sex:
					/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			City:	State:	Zip Code:		
Mailing Address: <input type="checkbox"/> Same as above				If homeless, please state homeless Status:			
				<input type="checkbox"/> Doubling Up		<input type="checkbox"/> Homeless Shelter	
				<input type="checkbox"/> Homeless		<input type="checkbox"/> Other: _____	
Email Address:			Home Phone Number:	Cell Phone Number:	Work Phone Number:		
			()	()	()		
May we text you for appointment reminders: <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Pharmacy:		Preferred method of contact for reminder calls and messages:			
				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
<input type="checkbox"/> Parent/Guardian OR <input type="checkbox"/> Spouse Information:		Address:		<input type="checkbox"/> Same as above		Primary Phone Number:	
Name:						()	
Does the patient have any problems with: <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Reading <input type="checkbox"/> Speaking Explain: _____							

MEDICAL INSURANCE INFORMATION

Person responsible for bill:		Birth date:	Address (if different):		Primary Phone Number:		
		/ /			()		
Occupation:	Employer:			Employer Phone Number:			
				()			
Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other							
Primary Medical Insurance:		<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid		<input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna		<input type="checkbox"/> Other:	
Subscriber's Name:		Subscriber's SSN:		Birth Date:		Policy #:	
				/ /			
						Group #: _____	
						Co-Payment: \$ _____	
Name of Secondary Medical Insurance (if applicable):		Subscriber's Name:		Subscriber's SSN:		Birth Date:	
						/ /	
						Policy #: _____	
						Group #: _____	

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:		Subscriber's Name:		Subscriber's SSN:			
		Policy #:		Group #:		Subscriber's Birth Date: / /	

Dental Claims Address (on back of card): _____

Home Room Teacher: _____ **Grade student is in:** _____

Emergency Contact Name: _____ **Phone #:** _____

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: _____

Circle of Care: Please list names of ALL providers who are treating you, including -
Behavioral Health, Dentists and Specialists

Name:	Specialty:	Phone:
1.		
2.		
3.		

Ethnicity		Education		Employment Status	
<input type="checkbox"/>	Hispanic or Latino	<input type="checkbox"/>	Current Student?	<input type="checkbox"/>	Full Time/ Part Time
<input type="checkbox"/>	Not Hispanic	<input type="checkbox"/>	Full Time	<input type="checkbox"/>	Migrant Worker
<input type="checkbox"/>	Unreported /Refused to Report Ethnicity	<input type="checkbox"/>	Part Time	<input type="checkbox"/>	Not a Migrant Worker
Race		Highest Level of Education		Housing	
<input type="checkbox"/>	Asian	<input type="checkbox"/>	Not yet in school	<input type="checkbox"/> Homeless	
<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Pre-School Kindergarten	<input type="checkbox"/> Doubling Up <input type="checkbox"/> Shelter	
<input type="checkbox"/>	Other Pacific Islander	<input type="checkbox"/>	Grade School	<input type="checkbox"/> Other <input type="checkbox"/> Street	
<input type="checkbox"/>	Black/African American	<input type="checkbox"/>	Middle School	<input type="checkbox"/> Transitional <input type="checkbox"/> Unknown	
<input type="checkbox"/>	American Indian/ Alaska Native	<input type="checkbox"/>	High School	<input type="checkbox"/> Public Housing-HUD	
<input type="checkbox"/>	White (not Hispanic or Latino)	<input type="checkbox"/>	High School Degree/ GED	<input type="checkbox"/> Permanent Supportive Housing (PSH)	
<input type="checkbox"/>	More than one race	<input type="checkbox"/>	Did not complete High School	Are you a veteran?	
<input type="checkbox"/>	Not Reported / Refuse to Report	<input type="checkbox"/>	Technical Trade School	<input type="checkbox"/>	Yes
Primary Language		<input type="checkbox"/>	College	<input type="checkbox"/>	No
<input type="checkbox"/>	English	<input type="checkbox"/>	College Graduate	I am using COMC today for an urgent care need?	
<input type="checkbox"/>	Spanish			<input type="checkbox"/>	Yes
<input type="checkbox"/>	Russian	COMC is my primary medical home?		<input type="checkbox"/>	No
<input type="checkbox"/>	Ukrainian	<input type="checkbox"/>	Yes	What sex were you assigned at birth on your original birth certificate?	
<input type="checkbox"/>	Other Please Specify:	<input type="checkbox"/>	No	<input type="checkbox"/>	Female
How did you hear about us?				<input type="checkbox"/>	Male
<input type="checkbox"/>	Newspaper/TV/Radio Ad	What is your current gender identity?		<input type="checkbox"/>	Chose not to disclose
<input type="checkbox"/>	Website	<input type="checkbox"/>	Female		
<input type="checkbox"/>	Special Event	<input type="checkbox"/>	Male		
<input type="checkbox"/>	Employee	<input type="checkbox"/>	Transgender Male Female-to-Male		
<input type="checkbox"/>	Other Organization	<input type="checkbox"/>	Transgender Female Male-to-Female		
<input type="checkbox"/>	Friend	<input type="checkbox"/>	Gender queer, neither exclusively male nor female		
<input type="checkbox"/>	Other	<input type="checkbox"/>	Other		
Do you identify yourself as:		<input type="checkbox"/>	Chose not to disclose		
<input type="checkbox"/>	Straight (not lesbian or gay)				
<input type="checkbox"/>	Lesbian or gay				
<input type="checkbox"/>	Bisexual				
<input type="checkbox"/>	Something else				
<input type="checkbox"/>	Don't know				
<input type="checkbox"/>	Chose not to disclose				
<input type="checkbox"/>	Other				

All requested information is for statistical purposes only and is necessary for receipt of federal grants to provide services.



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Central Ozarks Medical Center
 Sliding Fee Discount Schedule
 Effective February 15th, 2021

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	\$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 (2021)

Family Size	Level A (0-100% PFG)	Level B (101-133% PFG)	Level C (134-166% PFG)	Level D (167-200% PFG)	Level E (Above 200% PFG)
1	\$0 - \$ 12,880	\$12,881 - \$ 17,130	\$17,131 - \$ 21,381	\$ 21,382 - \$ 25,760	\$25,761 and Above
2	\$0 - \$ 17,420	\$17,421 - \$ 23,169	\$23,170 - \$ 28,917	\$28,918 - \$ 34,840	\$34,841 and Above
3	\$0 - \$ 21,960	\$21,961 - \$ 29,207	\$29,208 - \$ 36,454	\$36,455 - \$ 43,920	\$43,921 and Above
4	\$0 - \$ 26,500	\$26,501 - \$ 35,245	\$35,246 - \$ 43,990	\$43,991 - \$ 53,000	\$53,001 and Above
5	\$0 - \$ 31,040	\$31,041 - \$ 41,283	\$41,284 - \$ 51,526	\$51,527 - \$ 62,080	\$62,081 and Above
6	\$0 - \$ 35,580	\$35,581 - \$ 47,321	\$47,322 - \$ 59,063	\$59,064 - \$ 71,160	\$71,161 and Above
7	\$0 - \$ 40,120	\$40,121 - \$ 53,360	\$53,361 - \$ 66,599	\$66,600 - \$ 80,240	\$80,241 and Above
8	\$0 - \$ 44,660	\$44,661 - \$ 59,398	\$59,399 - \$ 74,136	\$74,137 - \$ 89,320	\$89,321 and Above
9 or more	Add \$4,540 for each additional member	Add \$6,038 for each additional member	Add \$7,536 for each additional member	Add \$9,080 for each additional member	Add \$9,080 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) *



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Patient Medical History

Name	Date of Birth	Today's Date
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Heart and Circulatory Problems											
	Yes	No	?		Yes	No	?		Yes	No	?
Damaged Heart Valve				Heart Attack				Shortness of Breath with mild exercise or when lying down			
Artificial Heart Valve				Angina(Chest Pain)							
Heart Murmur				High Blood Pressure							
Rheumatic Heart Disease				Low Blood Pressure				Swollen Ankles			
Cardiovascular Disease				Inborn Heart Defects				Other: _____ _____ _____			
Heart Trouble				Stroke							
Cardiac Pacemaker				Chest Pain on Exertion							

Liver Problems				Muscle and Joint Problems				Blood			
	Yes	No	?		Yes	No	?		Yes	No	?
Hepatitis				Hip/Knee Replacement				Anemia			
Jaundice				Painful Swollen Joints				Bleeding / Clotting Disorder			
Liver Disease				Arthritis							

Breathing and Lung Problems				Stomach Problems							
	Yes	No	?		Yes	No	?		Yes	No	?
Asthma				Tuberculosis				Persistent Diarrhea			
Respiratory Problems				Persistent Cough				Recent Weight Loss			
Emphysema (COPD)				Cough Producing Blood				Stomach Ulcer			
Bronchitis								Gastric Reflux			

Other				Neurological							
	Yes	No	?		Yes	No	?		Yes	No	?
Diabetes				Mental Health Problems				Fainting Spells			
AIDS				Kidney Trouble				Seizures			
HIV Infection				Immune System Problems				ADHD			
Thyroid Problems				Cancer				Autism			
Persistent Swollen Neck Glands				Sexually Transmitted Disease				Alcohol / Drug Abuse			
Other conditions not listed: _____								Alzheimer's / Dementia			

Current Allergies											
	Yes	No	?		Yes	No	?		Yes	No	?
Latex				Sulfa Drugs				Aspirin			
Local Anesthetics				Barbiturates				Iodine			
Penicillin				Sedatives				Codeine			
Other Antibiotics				Sleeping Pills				Other:			

No Known Allergies

Current Medications

My child doesn't take any medications



Patient Name: _____ DOB: _____

Central Ozarks Medical Centers Policies and Consents

Permission to Disclose to Family or Other Individuals

Adult Consent (Age 18 and Older)

You may authorize Central Ozarks Medical Centers (COMC) to disclose your protected health information to family members or other individuals in order to assist with the coordination of your care.

- No, I do not give COMC permission to disclose my protected health information to family members or other individuals in order to assist with the coordination of my care.
- Yes, I give COMC permission to disclose my protected health information to the family members or other individuals listed below in order to assist with my coordination of care. This permission is valid for one year from the date of signature unless revoked or changed in writing prior to the expiration.

OR

Pediatric Consent (Age 17 or Younger)

Non-Parental Consent: For pediatric patients, age 17 and under, you may designate another person to attend visits and authorize treatment decisions.

- No, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.
- Yes, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for medical/dental/behavioral healthcare and to make treatment decisions for my child in my absence. I understand that when I designate another person to authorize a treatment decision, COMC may disclose protected health information to the authorized person(s).

Name of Individual(s):	Relationship to Patient:

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

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

Privacy Notice:

- I have been given the opportunity to review or receive a copy of COMC's Notice of Privacy Practices which describes how COMC may use and disclose my protected health information following applicable state and federal law. I understand COMC can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.
- I understand that I have the right to receive a copy of my medical information or to request restrictions on the use of my protected health information.
- I understand that COMC may engage business associates to assist in my coordination of care including after-hours telephone coverage and call reminder service. I understand these calls may be recorded to improve customer service and patient care.
- I understand COMC may use letters, reminder calls, texts, or email correspondences to communicate with me regarding my care. I authorize COMC to communicate with me via these methods.

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.



Patient Name: _____ **DOB:** _____

- 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 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 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.

My Signature Means:

- I have reviewed and completed the *Permission to Disclose to Family or Other Individuals* 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 *Finance Policy/Release of Billing Information/Assignment of Benefits; Consent for Treatment; Privacy Notice; 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.

Printed Name of Patient/Legally Authorized Representative:	Relationship to Patient: <input type="checkbox"/> Patient <input type="checkbox"/> Relationship to Patient: _____
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Signature of Patient or Legally Authorized Representative: _____ Date: _____

Witness to Signature if Legally Authorized Representative: _____ Date: _____



Informed Consent for Extraction (Removal) of Tooth

I understand that there may be alternatives to the extraction of teeth. After reviewing the various options presented to me by the dentist with Central Ozarks Community Center, I have agreed to allow the extraction of tooth/teeth that need to be removed. I understand that there are various normal complications that can occur despite all efforts to the contrary as a result of the extraction(s) which include, but are not limited to: Dry Socket, Infection bleeding and/or bruising which may be prolonged, Swelling, Injury to adjacent teeth or fillings, Unusual reaction to medications given or prescribed, Sinus involvement (which may require surgical repair), Injury to the nerves of the lower lip and tongue causing numbness (which could possibly be permanent), pain or injury of the temporomandibular joint (TMJ), Including broken jaw.

I understand that a perfect result cannot be promised or guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize COMC dentist to do whatever he/she deems advisable to correct the condition.

I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

Informed Consent for Composite (Tooth-Colored) Fillings

I understand that the treatment of dentition (teeth) involving the placement of composite, resin fillings which may be more aesthetic in appearance than some of the conventional materials that have been traditionally used (such as amalgam or gold), may entail certain risks. There is a possibility of failure to achieve the desired or expected results. I agree to assume those risks those that may occur, even if care and diligence is exercised by COMC Mobile Dental Unit dentist, in rendering treatment. These risks include possible unsuccessful results and/or failure of the filling associated with, but not limited to the following: Sensitivity, Risk of Fracture, Necessity for Root Canal Therapy, Possible need to perform direct or indirect Pulp Car, Injury to the Nerves, Tooth coloration that may not exactly match tooth color and color that may change over time, Breakage, Dislodgement, or Bond Failure.

Informed Consent

I understand that it is my responsibility to notify COMC dentist should any undue or unexpected problems occur, or if I experience any problems related or the treatment rendered, or the services performed. I have been given the opportunity to ask any questions regarding the nature and purpose of composite fillings and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, that may be associated with any phase of this treatment in hope of obtaining the desired outcome. By signing this document, I authorize COMC Mobile dentist and/or his associates to render any services deemed necessary or advisable in the treatment of my dental condition, including prescribing and the administration of any medically necessary anesthetic agents and/or medications.

I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

Parent of Guardian Signature

Date

Reviewed by

Date