MISSOURI Highlands SBHC
SCHOOL-BASED HEALTH CLINIC

Medical Health History

Please be aware that not providing an accurate health history may result in a negative health outcome. Complete historical information is necessary for providers to appropriately treat your medical condition. Thank you

Name: _____ DOB: _____

Health Information *(Additional health, family & developmental history may be collected by your site)*

1. Doctor's name / phone number: _____

2. Please initial here if you would like your child to have a physical exam completed at the SBHC: _____
My child has not had a physical exam within the last year. If time allows, I would like my child to have a comprehensive wellness physical exam during the school year.

3. How often does your child go to the dentist? At least once a year___ Only with toothaches___ Never___

4. When was your child's last dental exam? _____Name of Dentist: _____

5. If we need to send a prescription, which pharmacy would you like to use? _____

6. **ALLERGIES**:

_____

7. Immunizations ○ Immunization Record Is Attached ○ I give my permission for you to obtain my child's immunization record from the school

Signature: _____Date:_____

Check any of these health problems that affect <u>your family</u> (brothers, sisters, parents, grandparents, aunts, uncles)

☐Alcohol/drug problems ☐Allergies ☐Anemia ☐Anxiety ☐Arthritis ☐Asthma
☐Blood clots ☐Cancer ☐Depression ☐Diabetes ☐Eating disorder ☐Epilepsy ☐Glaucoma
☐Heart problems ☐Hepatitis ☐High blood pressure ☐High cholesterol ☐Kidney problems
☐Liver disease ☐Mental Health problems ☐Migraine headaches ☐Seizures/epilepsy
☐Sickle Cell disease/trait ☐Stroke ☐Thyroid Disease ☐Other serious illness

_____

What else should we know about your health or your family's health?

_____

_____

Hospital Admissions: Year, Illness or Operation

_____

_____

_____

List all Medications you are currently taking: (please use reverse side if needed)

_____

Please list any assistive devices you use:

_____

Medical History- Please circle if <u>you</u> have or have had any of the following:

Heart Murmur	German measles	Thyroid Disease	Rheumatic Fever
Pneumonia	Stroke	Crohn's Disease	Polio
Polio	HIV/AIDS	Anemia	Depression
Osteoporosis	Chickenpox	Measles	Glaucoma
Colitis	Arthritis	Herpes	Gout
Ulcer	Blood Disease	Alzheimer's disease	Rheumatism
Eczema	Artificial Heart Valve	Artificial Joint	Mumps
Heart Pacemaker	Heart Attack/Failure	Blood Transfusions	Scarlet Fever
Alcoholism	Hepatitis A, B, C	Chronic Fatigue	Diverticulosis
Diabetic	Sexually Transmitted Disease	High Blood Pressure	Seizures
Psoriasis	Tuberculosis	Anaphylaxis	Hernia

Cancer: _____ Other: _____

Social History:

Do you drink alcohol? Yes or No if yes, how much do you consume in one week? _____

Do you smoke? Yes or No if yes, how many cigarettes per day? _____

Do you vape? Yes or No if yes, how many times per day? _____

I HAVE READ AND UNDERSTAND THE ABOVE AND HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE:

Name of Parent/Guardian:_____**(please print clearly)**

Signature of Parent/Guardian: _____ **Date:** _____

Name of Student: _____

Relationship to Student: _____

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

As a Federally Qualified Health Care Center, we are required by the Bureau of Primary Health Care to collect data on all our patients annually. Missouri Highlands Health Care does not discriminate based on age, sex, race, creed, marital status, religion, national origin, disability, sexual preference, public assistance status, or criminal record.

PATIENT IDENTIFICATION AND CONTACT (Please Print)

Patient Full Name:					
Legal Sex: ☐ Male ☐ Female		**Date of Birth:**		**Social Security #:**	
Residential Address:			**Mailing Address:** ☐ Same		
City:	**State:**	**Zip**	**City**	**State**	**Zip**

Place a check in the box next to the number you prefer to be called first and consent to text

Home Phone: ☐	**Cell Phone:** ☐ **Text OK** ☐ Y ☐ N	**Work / Alternative Phone:**
Patient Email Address		
Preferred Methods of Communication: ☐ Phone Call ☐ Text Message ☐ Email ☐ Letter ☐ Patient Portal		
Missouri Highlands Health Care has resources available to assist patients who may need hearing, vision, or language assistance. If you need such assistance, please check what kind of assistance you require. ☐ Sign Language ☐ Visual Aides ☐ Interpreter for (indicate which language):		

CONTACT and GUARDIAN INFORMATION (If patient is under the age of 17)

Contact below is: ☐ Custodial Parent ☐Legal Guardian ☐ Caretaker ☐ NA	Contact below is: ☐ Custodial Parent ☐Legal Guardian ☐ Caretaker ☐ NA
Guardian Name:	**Guardian Name:**
Guardian Email:	**Guardian Email:**
Home Phone: ☐ Same as Patient **Cell Phone**	**Home Phone:** ☐ Same as Patient **Cell Phone**
Relationship: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (Please Specify)	**Relationship:** ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (Please Specify)

EMERGENCY CONTACT

Name:	**Home Phone:**	**Cell Phone:**
Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Cousin ☐ Guardian ☐ Other		

NEXT OF KIN

Name:	**Phone:**	**Relationship:** ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Cousin ☐ Other

DEMOGRAPHICS

Primary Language: ☐English ☐ Spanish ☐ Other (Specify)	**Race (check all that apply):** ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to Answer
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Partner
Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐Bisexual ☐ Don't Know ☐ Choose not to Disclose ☐ Something else please describe:	
Gender Identity: ☐ Male ☐ Female ☐ Transgender (FTM) ☐ Transgender (MTF) ☐ Gender non-confirming (not exclusively M or F) ☐ Choose not to disclose ☐ Other (Please specify)	
Gender at Birth: ☐ Male ☐ Female	**Pronouns:** ☐ he/him ☐ she/her ☐ they/them

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

Household Size & Annual Income Range: Check the household size **THEN** circle the annual income range on the line beside the household size you have selected.

Household Size		Annual Income Range			
☐	1	$0 – 15,060	$15,061-20,030	$20,031-25,000	$25,001-30,120
☐	2	$0-20,440	$20,441-27,185	$27,186-33,930	$33,931-40,880
☐	3	$0-25,820	$25,821-34,341	$34,342-42,861	$42,862-51,640
☐	4	$0-31,200	$31,201-41,496	$41,497-51,792	$51,793-62,400
☐	5	$0-36,580	$36,581-48,651	$48,652-60,723	$60,724-73,160
☐	6	$0-41,960	$41,961-55,807	$55,808-69,654	$69,655-83,920
☐	7	$0-47,340	$47,341-62,962	$62,963-78,584	$78,585-94,680
☐	8	$0-52,720	$52,721-70,118	$70,119-87,515	$87,516-105,440

Housing Status: ☐ Not Homeless ☐ Doubling Up (Staying with others temporarily) ☐ Homeless Shelter ☐ Public Housing (Senior Living / HUD) ☐ Street (Living outdoors, in a car, makeshift shelter) ☐ Transitional (No permanent housing / one place to another) ☐ Other (Hotels/Motels)

Agricultural Worker: ☐ Migrant ☐ Seasonal ☐ Decline to Answer | **Veteran?** ☐ Yes ☐ No ☐ Decline to Answer

GUARANTOR INFORMATION (To whom statements will be sent)

Guarantor Relation to the patient: ☐ Patient / Self ☐ Child ☐ Spouse ☐ Other (Specify)			
Guarantor Full Name:			**Guarantor DOB:**
Guarantor Mailing Address: ☐ Same as patient			
City:		**State:**	**Zip:**
Guarantor SSN:	**Guarantor Phone:**	**Guarantor Email:**	

Preferred Pharmacy:_____ **Location:**_____

PATIENT INSURANCE ☐ Check if uninsured (You will be contacted by a MHHC representative prior to your visit, if checked)

Relation to the Insured: ☐ Patient / Self ☐ Child ☐ Spouse ☐ Other (Specify)	
Member ID / Policy #:	**Group #:**
Name of Insured:	

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family members or friends may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for any member of my medical care team to discuss my medical information in any way with anyone without expressed written consent. By signing this form, I give Missouri Highlands Health Care permission to discuss my medical information with the people listed below. I recognize that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I may limit the amount of information that I authorize to be disclosed. It is my expressed wish that ALL medical information may be released. If I have any information that I do not want to give I will list below. I also understand that I may revoke this authorization at any time by reaching out to Missouri Highlands Health Care in writing. Unless sooner revoked by me, this authorization will expire on: _____. Types of Information that may NOT be disclosed:_____

_____

Individual(s) I authorize to receive my medical information:

Name:	**Phone:**	**Relation:**	**DOB:**
Name:	**Phone:**	**Relation:**	**DOB:**

_____ / _____

Signature of Patient/Patient Representative **Date**

_____ / _____

Signature of MHHC Witness **Date**

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

MISSOURI HIGHLANDS HEALTH CARE PATIENT CONSENT, AUTHORIZATION, AND ACKNOWLEDGEMENT

Consent to Treatment: I hereby grant permission for Missouri Highlands Health Care to perform those procedures and treatments necessary for complete care of myself or a dependent for whom I am legally responsible.

Authorization and Release: I authorize Missouri Highlands Health Care 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 medical care, to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Missouri Highlands Health Care for any insurance benefits otherwise payable to me. 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 authorize my medical care team to perform any treatment, medication administration, and/or 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.

SureScripts: I, or my authorized representative, request the health information regarding my care and treatment be released as set forth on this form. In accordance with Missouri State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 *HIPAA), I understand that:

1. BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE uses Surescripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my medical care team and the pharmacy. The information sent between these systems may include details of all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV-related information by SureScripts, Inc. to BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE.
3. I have the right to revoke this authorization at any time by writing to BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment, in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Patient's Rights and Responsibilities: I acknowledge that Missouri Highlands Health Care has shared a copy of their Patient's Rights and Responsibilities, to ensure you are aware of your rights and responsibilities.

Photographic Consent: I agree that photographs of me or my dependent may be taken by a member of the Missouri Highlands Health Care 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 Missouri Highlands Health Care unless required by law enforcement.

About our 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 the Notice of Privacy Practices (which is a separate document provided to you along with this form) and to obtain your written acknowledgment that you have received a copy of that notice. If you choose to receive information from Missouri Highlands Health Care via email (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.

- **Fundraising** – Unless you request us not to, we will use your name and address to support our fundraising efforts. If you do not want to participate in fundraising efforts, please mark the following box:

  ☐ Please do not use my information for fundraising purposes.

- **Marketing** – We will not share your information for marketing purposes unless you give us your written permission. Please mark the following box to give us permission to use your name and address for marketing activities and to provide you with information about services available at our practice. You may revoke your permission at any time, but it will not affect information that we already used and disclosed.

  ☐ I hereby allow MHHC to use my information for marketing purposes.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS DOCUMENT READ OR EXPLAINED TO ME. I UNDERSTAND AND AGREE TO TERMS AND CONDITIONS CONTAINED IN THIS FORM. I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED SATISFACTORILY. I VOLUNTARILY CONSENT TO MISSOURI HIGHLANDS HEALTH CARE OR ANY PHYSICIAN, APRN, RN, LPN, OR OTHER PROVIDER DESIGNATED OR SELECTED BY IT OR UNDER THE DIRECT SUPERVISION AND CONTROL OF IT TO PERFORM THE SERVICES REQUESTED BY ME.

Patient Name (please print): _____

Name of Representative/Guardian (If applicable): _____

_____ _____

Signature of Patient/Patient Representative **Date**

_____ _____

Signature of MHHC Witness **Date**

Delegation of Another Person to Consent for Treatment of a Minor

I, (parent/legal guardian), _____, cannot accompany my child, (child's name) _____, to Missouri Highlands Health Care. Therefore, I give permission to the following adult(s) (must be 18 years of age or older):

1. _____
2. _____
3. _____

_____ (initial here)

I give permission for this person to seek treatment for my child including any type of medical care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a Physician, Nurse Practitioner, or Dentist, to be necessary for the welfare of my child, and provide consent for such treatment **if attempts to contact me are unsuccessful.**

_____ (initial here)

I give permission for this person to seek treatment for my child including any type of medical care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a Physician, Nurse Practitioner, or Dentist, to be necessary for the welfare of my child, and provide consent for such treatment **without having to contact me.**

This form will remain in effect until revoked by filling out the form on Page 2

This form is VALID ONLY during the following timeframe:

Effective Date:_____/Expiration Date: :_____

X_____ _____

(Signature of parent or legal guardian) (Date and time signed – REQUIRED)

X_____ _____

(Signature of MHHC employee witness) (Date and time signed – REQUIRED)

Address_____

Home Phone_____ Work Phone_____

Cell Phone_____

MISSOURI Highlands HEALTH CARE

Virtual Visit Informed Consent

I, _____, agree to participate as a patient of Missouri Highlands Virtual Delivery System of providers. I will be receiving medical health and/or mental health services through interactive virtual visits. I understand the use of a virtual visit is an alternative method of medical and/or mental health care delivery and that my provider will not be physically in the same room with me.

I understand that although Missouri Highlands Healthcare providers make every effort to protect my privacy by using a secure server, they cannot guarantee the security of any information I transmit to them over the internet. By using virtual services, I recognize that transmissions over the internet or phone service are at my own risk and that third parties may unlawfully intercept or access the transmissions. I also understand that despite reasonable efforts on the part of my virtual provider, there are risks and consequences in using virtual services. The risks include, but are not limited to, the possibility that the transmission of sessions could be disrupted or distorted by technical failures. In case of technical failures, my provider will make every effort to re-connect with me through my clinic site.

I also understand that virtual services may not be as complete as services provided via face-to-face, although, several benefits of virtual services have been identified including access to specialized services in remote areas, lower healthcare costs, reduced travel, minimizing time off work, and decreased waiting time for services. I have also been notified that if my provider believes I would be better served by another form of service, I will be referred to a provider who can provide such services. Finally, I understand that there are potential risks and benefits associated with any form of medical and/or mental health services and that, despite my efforts and the efforts of my provider, my condition may not improve and in some cases may even get worse. I understand that my participation in this is voluntary and I may decide to terminate my treatment at any time. My privacy and confidentiality will be protected.

I understand that there will be no recordings of my virtual sessions on any platform. I also agree to not record my own virtual sessions without my provider's knowledge or permission.

I understand that I must confirm my appointment by 4pm on the business day prior to my scheduled appointment. If I do not confirm my appointment, I know my time slot may be forfeited and given to someone else in need.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Witness Date

MISSOURI HIGHLANDS HEALTH CARE
BEHAVIORAL HEALTH CONSENT FOR TREATMENT

Patient's Name: _____ DOB_____ Soc Sec #_____

Missouri Highlands Health Care provides behavioral health services to residents of Iron, Shannon, Carter, Reynolds, and Butler counties. All persons are eligible regardless of age, race, income, or gender status.

Services: Your first appointment with your behavioral health professional is for screening and assessment and usually lasts 45 min - one hour. The goal of the screening and assessment is to determine the best course of treatment for you. You will also discuss options at that time to determine the type and extent of services that are best for you. The follow-up visits usually last between 15--50 minutes. Counseling is a confidential process designed to help address your concerns, better understand yourself, and learn effective personal and interpersonal coping strategies. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however the level of satisfaction for any individual is not predictable. Your counselor is available to support you throughout the counseling process.

Scheduling: If you are unable to make the appointment, please call the receptionist at the clinic to cancel at least 24 hours before the appointment time. If you miss a scheduled appointment and have not cancelled it in advance, you are responsible for re-scheduling another appointment. If you experience a crisis between appointments you can call the clinic (or the MOCARS crisis line after hours: 800-811-8760 (Iron County) or 800-356-5395 for all other areas).

Confidentiality: Information shared in a session is strictly confidential. While the behavioral health professional may at times need to consult with your doctor (or other members of your health team) at the clinic in order to insure you get the best treatment, information about you will never be shared with outside agencies or people without your written permission.
The only time staff can disclose information without your consent are the following:

1. If a staff member has reason to believe that a child under the age of 18 or an elderly or dependent adult is being abused or neglected s/he is required by law to report this to the appropriate state agency.
2. If a staff member has reason to believe that you are in danger of harming yourself s/he may have to make an involuntary referral to a hospital and/or contact a family member or a friend to help protect you.
3. If a staff member has reason to believe that you are seriously intending to harm another person s/he will have to notify the police and the intended victim as well as seek hospitalization for you to insure the safety of all involved.
4. If records are subpoenaed for a court case you are involved in we may need to release some or all of your record. If this happens, you will be notified before records are released.

By signing this Consent for Treatment, I certify that (1) I have read and understand the information above; (2) I have the legal authority to consent to treatment as the Patient or as the Patient's Legal Guardian; and (3) I understand that this consent is continuing in nature and that it will remain fully effective until it is revoked in writing.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient

_____ _____
Witness Signature Date

_____ _____
Printed Name of Witness Witness Job Title