SEMO HEALTH NETWORK

MEDICAL PAPERWORK **Date ____/____/_____**

PATIENT INFORMATION

First Name	M.I.	Last Name
Date of Birth		Social Security Number
Physical Address		
City	State	Zip
Mailing Address (if different than above)		
City	State	Zip

CONTACT INFORMATION

May We Leave Detailed Messages (Appointments, Billing, Results, etc.)?		
Home Phone	☐ Yes	☐ No
Cell Phone	☐ Yes	☐ No
Work Phone	☐ Yes	☐ No
Email Address		

EMERGENCY CONTACT

Name	Relationship	Phone #
Name	Relationship	Phone #

HIPAA - DISCLOSURE TO FAMILY AND FRIENDS

Please list anyone allowed to be given your medical & billing information:	
1	
2	
3	
4	
5	
Your information will not be released by telephone or in person to any not on this list.	

SEMO HEALTH NETWORK

REQUIRED FQHC DEMOGRAPHICS

We are required to ask all patients the following questions.

1. Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other:_____
- ☐ Choose Not to Disclose

2. Race: (Select All That Apply)

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ Choose Not to Disclose

3. Ethnicity:

- ☐ Mexican, Mexican American, Chicano/o
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish Origin
- ☐ Not Hispanic or Latino
- ☐ Choose Not to Disclose

4. Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Choose Not to Disclose

5. Sexual Orientation:

- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay, or Homosexual
- ☐ Bisexual
- ☐ Other
- ☐ Don't Know
- ☐ Choose Not to Disclose

6. Gender Identity:

- ☐ Female
- ☐ Male
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Other
- ☐ Choose Not to Disclose

7. Gender Assigned at Birth:

- ☐ Female
- ☐ Male

8. Family Size and Income:

Family Size (Self + Dependents)	#
Annual Income for Family	$
☐ Choose Not to Disclose	

9. Agriculture Worker:

- ☐ Migrant Agriculture Worker
- ☐ Seasonal Agriculture Worker
- ☐ Not a Farm Worker

10. Housing Status:

- ☐ Not Homeless
- ☐ Doubling Up
- ☐ Homeless Shelter
- ☐ Permanent Supportive Housing
- ☐ Street
- ☐ Transitional
- ☐ Other
- ☐ Unknown

11. Are you a Veteran?

- ☐ Yes
- ☐ No

SEMO HEALTH NETWORK

BILLING INFORMATION

Person Responsible for Bill	Relationship to Patient	
Address	Date of Birth	
City	State	Zip
Occupation	Employer	Phone #

INSURANCE INFORMATION

Type: ☐ Medicaid ☐ Medicare ☐ Commercial ☐ Sliding Fee ☐ Self-Pay

Name of **Primary** Insurance	Subscriber's Name	
Subscriber's Date of Birth	Subscriber's SSN	Phone #
Policy #	Group #	
Subscriber's Address		
City	State	Zip

Name of **Secondary** Insurance	Subscriber's Name	
Subscriber's Date of Birth	Subscriber's SSN	Phone #
Policy #	Group #	
Subscriber's Address		
City	State	Zip

PREFERRED LABORATORY

Name:
If no laboratory is listed above, all specimens will be sent to the in-house SEMO Health Network Lab. If lab orders cannot be performed at the SEMO Health Network, specimens will be sent to Quest Diagnostics.

PHARMACY INFORMATION

Name	City

SEMO HEALTH NETWORK

PATIENT'S ACKNOWLEDGMENT AND CONSENT

BILLING ACKNOWLEDGMENT

Please initial in the box below after reading.

	As a courtesy, SEMO Health Network will file your insurance claim provided that you have given us the current/valid information about your insurance. I hereby authorize my benefits, including Medicare, to be paid directly to SEMO Health Network and also the release of medical information necessary to process claims. This assignment will remain in effect until revoked by me in writing. Applicable co-payments and deductible for those insurance plans will be collected. If insurance does not pay, I will become financially responsible for payment in full.

PRIVACY ACKNOWLEDGMENT

Please initial in the four boxes below after reading.

	We are required to protect your privacy. Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is Available on our website at www.semohealthnetwork.org and/or is furnished.
	We request all patients present photo ID and their insurance card at each visit. Your cooperation with this HIPAA requirement is designed to protect your identity from misuse.
	HIPAA Security Rule establishes national standards to protect your health You will need required personal information when calling our office regarding question's to your account.
	Patients may revoke or change any provided authorizations at any time. Please refer to our NPP at www.semohealthnetwork.org for more details.
	Patients give SEMOHN authority to download Medication History. Your cooperation with this requirement allows SEMOHN to provide quality healthcare by downloading the patient's medication history automatically from pharmacy benefit managers.

CONSENT FOR TREATMENT

Consent for Treatment – ADULT: By signing below I am giving consent to receive treatment or procedure deemed necessary by the professional staff of SEMO Health Network, including any Telehealth visit or other use of electronic means (such as FaceTime), to see my provider. I understand all the preceding statements and will adhere to the stated policies.

Consent for Treatment – CHILD or INCAPACITATED ADULT: By signing below I hereby state that I am the parent, primary legal guardian, or joint legal custodian of the patient being presented today for treatment. I also am giving my consent as guardian for any treatment or procedure deemed necessary by the professional staff of SEMO Health Network, including any Telehealth visit or other use of electronic means (such as FaceTime), to see their provider. I understand all the preceding statements and will adhere to the stated policies.

Print Name of Patient	Date
Patient/Legal Guardian Signature	Date

QA APPROVED APRIL 2023

Parent Permission Form

In the event you are unable to bring your child/children in for an appointment, SEMO Health Network requires your permission for another adult to bring your child into our clinics for Medical/Dental treatment.

Please list below any adult that has permission to bring your child.

Patient Name: _____ _____
Date of Birth

Parent Name: _____ _____
Relationship

Legal Guardian:_____
(if different from Parents)

1. _____ Relationship to Child _____
2. _____ Relationship to Child _____
3. _____ Relationship to Child _____
4. _____ Relationship to Child _____

Please keep in mind that **ONLY** the persons listed above will be allowed to sign for your child.

By signing below, I am acknowledging that I have completed the above information to the best of my knowledge. I have read and understood the above information.

_____

Parents Signature **Date**

_____

SEMO Health Network Staff Signature **Date**

_____

Witness **Date**

SOUTHEAST MISSOURI HEALTH NETWORK AUTHORIZATION TO GATHER/RECEIVE MEDICAL RECORDS OR HEALTH INFORMATION

The Execution of this form does not authorize the release of information other than that specifically described below. the information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information, including the Social Security Number (which will be used to locate records for release) is not furnished completely and accurately, Southeast Missouri (SEMO) Health Network will be unable to comply with the request. SEMO Health Network may not condition treatment, payment, enrollment or eligibility on signing the authorization.

Patient's Full Name: _____

Patient's Social Security Number: _____ Patient Date of Birth: _____

Name and Address of Organization, Individual or Title of Individual from Whom Information Is to Be Gathered:

Site to Which Health Information Should Be Sent:

[ ] 421 SEMO Drive/P.O. Box 400, New Madrid, MO 63869
[ ] 200 Southland Drive, Sikeston, MO 63801
[ ] 741 S. Walnut Street, Bernie, MO 63822
[ ] 105 East 5th Street, Caruthersville, MO 63830
[ ] 500 Russell Street, Kennett, MO 63857
[ ] 6724 State Highway 77 E, Benton, MO 63736

Patient's Request: I request and authorize SEMO Health Network to gather the information specified below from the organization or individual named on this request. I understand that the information to be released includes information regarding the following conditions:

PLEASE MARK BELOW IF APPLICABLE

[ ] DRUG ABUSE [ ] ALCOHOLISM OR ALCOHOL ABUSE [ ] SICKLE CELL ANEMIA

[ ] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)

[ ] MENTAL HEALTH INFORMATION

[ ] IMMUNIZATIONS [ ] MAMMOGRAM [ ] PAP

INFORMATION REQUESTED (Check applicable box (es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each).

[ ] Copy of Hospital Summary _____ [ ] Copy of Outpatient Treatment Note(s) _____

[ ] Other
(Specify)_____

[ ] Lab Reports _____ [ ] X-Ray Reports _____ [ ] X-ray Films _____

[ ] Handicap Parking Permit/Application_____ [ ] Physician Work Statement/Disability Statement _____

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

[ ] Personal [ ] Payment [ ] Benefits [ ] State Reporting [ ] Other _____

[ ] Treatment [ ] Legal [ ] Congressional [ ] Research

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Medical Records Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on date supplied by patient); or (3) under the following condition(s):

Release will be valid for a period of one (1) year from date signed unless otherwise specified above or revoked.

_____ _____

Signature of Patient or Person Authorized to Sign for Patient Date

No-Show Policy for SEMO Health Network

Purpose: To guide the management of Dental/Medical patients who do not keep appointments, cancel without sufficient notice **(defined as less than 24 hours)** or show up more than **15 minutes late** for their scheduled appointments.

Procedure:

1. All new and existing patients of Dental/Medical at SEMO Health Network will be given a written copy of the No-Show Policy and be required to sign an acknowledgment of the policy that will be scanned in the EMR (electronic medical record).
2. Scheduled appointments will be confirmed the day before. (Patients are still responsible for their scheduled appointment regardless of a successful or unsuccessful reminder).

Cancelling Appointments: If you cannot keep your scheduled appointment, you must call **24 hours** in advance to cancel or reschedule. Failure to provide 24 hours' notice is considered a No-Show.

No-Show Appointments: No show appointments are taken very seriously and will be documented in the EMR. Following the third (3rd) no-show appointment you will not be able to schedule an appointment, you will be placed on a "work-in" only status. (**Medical):** Work-in appointments will be allowed to come in at

8:15am-10:00am and will be worked in only if the schedule allows. If you were unable to be seen in the morning then the work-in schedule will open at 12:45pm-3:00pm. (**Dental):** Work-in appointments will be allowed to come in at 7:30am-10:00am and will be worked in only if the schedule allows. If you were unable to be seen in the morning then the work-in schedule will open at 12:30pm-3:00pm. Being placed on the work-in schedule does not guarantee that you will be seen that day or by your Provider. After you have been seen three (3) times on the work-in schedule then you will be allowed to schedule your next appointment.

Please discuss with any Dental/Medical staff if you have any questions regarding the No-Show Policy.

I understand and agree to abide by this No-Show Policy.

_____ _____

Patients Signature Date

_____ _____

Parent/Guardian Signature (for patient under 18) Date

ALL NO SHOW APPOINTMENTS WILL BE TRACKED THROUGH OUR ELECTRONIC MEDICAL RECORDS!

QA Approved June 2018