OZARKS HEALTHCARE
Clinic Consent

590598054

Patient Name_____

Date of Birth _____/_____/_____ Social Security # _____ Medical Record #_____

The person signing this document certifies that he/she has read the following and is the patient or is duly authorized by the patient as the patient's general agent, legal guardian to execute and accept these terms.

- ☐ All Clinics
- ☐ Alton
- ☐ Behavioral Health Center
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Ear, Nose & Throat
- ☐ Gainesville
- ☐ Heart & Lung Center
- ☐ Internal Medical
- ☐ Infectious Diseases
- ☐ Mammoth Spring
- ☐ Mtn. Grove
- ☐ Mtn. View
- ☐ Orthopaedics & Spine
- ☐ Ozarks Healthcare/Zizzer Clinic
- ☐ Pain Management
- ☐ Pediatrics
- ☐ Podiatry
- ☐ Rheumatology
- ☐ General Surgery
- ☐ Thayer
- ☐ Urology
- ☐ West Plains
- ☐ Winona
- ☐ Women's Health

General Consent: I hereby authorize Ozarks Healthcare to provide health care services as ordered by my physician. I consent to the rendering of such care, which may include routine laboratory, diagnostic and medical treatment, psychological evaluation and/or treatment, counseling and/or coordination of care with other providers and procedures as my physician or other of the clinic/physician office medical staff consider to be necessary. I understand that the practice of medicine and surgery is not a exact Science and may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of the examination or treatment in this clinic/physician office. I recognize that some doctors furnishing services in or for the clinic may be independent contractors and are not employees or agents of Ozarks Healthcare or any of its affiliated facilities. Practitioners who are independent will bill separately for the services that they may provide.

Financial Agreement: In consideration for the services to be rendered, I hereby guarantee payment for the services rendered. It is understood that the undersigned as patient/guarantor is responsible for any health insurance deductible and co-insurance payments. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Any and all suits for any and every breach of this contract shall be instituted and maintained in the County of Howell, State of Missouri.

Communications Regarding Account: I agree that Ozarks Healthcare, or any other collection or servicing agency or agencies retained by Ozarks Healthcare (together referred to hereafter as "collectors") to collect any money that may be owed as a result of services rendered pursuant to this document, may contact me by telephone or text message at any number given by me or otherwise associated with this account, including but not limited to cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages or voice mail message. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with this account.

Assignment of Benefits and Payment Request: I hereby authorize payment directly to Ozarks Healthcare or hospital-based physician, any medical benefits otherwise payable to me under Title XVIII and/or Title XIX of the Social Security Act and/or from any health insurance plan. I certify that the information given by me in applying for payment is correct.

Authorization for Release of Information: I authorize release of information in my medical record to all regulatory and accrediting agencies and to persons or corporations which may be liable under a contract for all or part of the hospital's or hospital-based physician's charges, including but not limited to insurance companies, Worker's Compensation carriers, welfare agencies, Medicare or Medicaid. Medical records may also be released as necessary for the continuity of patient care. I authorize the hospital and its agents to review my medical records for purposes of quality improvement at any meeting of hospital committees for the purpose of evaluating, upgrading and improving patient care in the hospital.

Ozarks Healthcare Foundation: I authorize Ozarks Healthcare to release my name, address and phone number to the Ozarks Healthcare Foundation for the purpose of charitable activities of that organization,_____ Yes _____ No I will receive a copy of Ozarks Healthcare's Patient's Rights and Responsibilities Brochure.

(Patient or guardian should sign and date on line below)

_____ Date_____Time_____

Witness Signature_____ Date_____Time_____

OZARKS HEALTHCARE

Behavioral Health Center
No-Show/Late Cancellation Policy

Definition of No Show: An appointment where the patient does not present on time for the appointment, and does not call to cancel prior to 3:00 pm the preceding business day.

Since appointments with Ozarks Healthcare Behavioral Health Center are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

When an appointment is scheduled, that time has been reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see other patients.

First no-show within a rolling twelve-month period: Patient will be allowed to reschedule.

Second no-show within a rolling twelve-month period: Patient will be allowed to reschedule.

Third no-show within a rolling twelve month period: Patient will be placed on walk-in status.

Patients on walk-in status will not be allowed to schedule appointments but can walk into the clinic and ask to be seen – every effort will be made to accommodate the walk-in patient – but there is no guarantee that the patient will be seen that day.
Reinstatement of scheduling privileges: Provider approval is required to reinstate scheduling privileges. Future no-shows within a year will place patient on walk-in status again.

Additionally, if a patient doesn't arrive by his/her **check-in** time, we reserve the right to cancel the appointment and the no-show policy will apply.

By signing this document, I acknowledge that I understand and am aware of the No Show and Cancellation Policy and will adhere to the terms listed above.

Date: _____ Time: _____

Printed Name of Patient_____Birthdate:_____

Patient/Guardian's Signature: _____

OZARKS HEALTHCARE

Behavorial Health Center

Acknowledgment of Understanding

My signature acknowledges:

- I have read and understand my rights and responsibilities as a client of Ozarks Healthcare Behavioral Health Center.
- I have been informed of the address and telephone number of the civil rights moniter with the Missouri Department of Health.
- I have read and understand the sections on treatment, risks and benefits and confidentiality.
- I have been given the opportunity to ask questions about services and Ozarks Healthcare policies.

Signature:_____ Date:_____ Time:_____

Client Name (please print):_____ Date of birth:_____

1211 Porter Wagoner Blvd, 23 Parkway Center, West Plains, MO 65775 (417) 257- 6762 or (800) 429-9439

Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your record or get more information about it by contacting Ozarks Healthcare's Privacy Officer.

Our **Notice of Privacy Practices**

DESCRIBES IN MORE DETAIL HOW YOUR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Printed name of patient Date of birth

_____ _____

Patient or legally authorized individual signature Date / time

_____ _____

Printed name if signed on behalf of the patient Relationship

Patient or legally authorized individual refused to sign acknowledgment.

_____ _____

Staff signature Date / time

40303035

This form will be retained in you medical record.

OZARKS HEALTHCARE

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Behavorial Health Center
Patient Registration Sheet

Patient information SSN ____/____/_____

Date ____/____/____

Last name _____ First _____ MI ____ Maiden _____

Mailing Address _____ City _____ State _____ Zip _____

Home Address_____City_____ State_____ Zip _____

County _____ Home Phone _____ Cell Phone_____

☐ Male ☐ Female Place of Birth _____ Birthdate____/____/_____

Marital status ☐ M ☐ S ☐ D ☐ W Religion_____ Race _____

Employer _____ Employer phone _____

Family physician _____ Allergies:_____

Do you have a legal guardian? ☐ No ☐ Yes: Name of legal guardian _____

Emergency Contact

Next of Kin

Last name_____First _____MI ____ Relationship _____

Address _____ City _____ State _____ Zip _____

phone _____

Emergency Contact

Last Name _____ First_____ MI _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Do you have a living will? ☐ Yes ☐ No Do you have a durable power of Attorney for Healthcare? ☐ Yes ☐ No

Do you have a Psychiatric Advance Directive? ☐ Yes ☐ No Where can a copy be obtained? _____

Information Brochure ☐ Provided ☐ Refused by client

Medicare - Medicaid - Insurance Signature and Release Form

I authorize payment of all Medicare, Medicaid and/or other health insurance benefits to be reimbursed directly to Ozarks Healthcare for services received by me or the below mentioned patient on this date until this authorization is revoked in writing. I understand this authorization also allows for release of medical records, psychological information and/or drug abuse information required by my designated insurance company or its agent to determine the benefits payable. I acknowledge that I am responsible for payment of all co-pyaments or deductibles as determined by my insurance carrier. I also authorize electronic filing of my claims.

Patient signature _____ Date ___/___/___ Time _____

Legal guardian signature _____Date ___/___/___ Time _____

Witness signature _____ Date ___/___/___ Time_____

OZARKS HEALTHCARE

Behavorial Health Center

410895006

Personal History

Client Name:_____ **Date:**__/_____/_____

Birthdate:_____/_____/_____

Symptom Checklist

Have you had any of the following during the past month?

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Cry Easily	□	□	Loss of Sexual Desire	□	□	Problems Chewing/ Swallowing	□	□
Sweating palms	□	□	Loss of Sexual Functioning	□	□	Nausea/Vomiting	□	□
Fatigue	□	□	Nervous Feeling	□	□	Diarrhea or Constipation	□	□
Bad Dreams	□	□	Excessive Worries/Fears	□	□	Multiple Medical Problems	□	□
Mind Goes Blank	□	□	Excessive Fear of Crowds	□	□	Food Allergies Requiring a Special Diet	□	□
Difficulty Concentrating	□	□	No Interest in Things	□	□	Eating Disorder	□	□
Trouble Making Decisions	□	□	Feeling Inferior	□	□	Weight Gain/Loss	□	□
Trouble Remembering	□	□	Change in Personality	□	□			
Thoughts Hard to Dismiss	□	□	Work Difficulties	□	□			
Trouble Sleeping	□	□	Thoughts of Harming Yourself	□	□			
Easily annoyed/irritable	□	□	Thoughts of Harming Others	□	□			

Personal History

Please state, in your own words, the reason for your visit:

_____

_____

How long has this been a problem for you? _____

What services are you seeking? □Therapy □Medication Services □Case Management □Crisis Services

Have you ever had suicidal thoughts? □Yes □No Do you have them now? □Yes □No _____

Have you ever tried to end your life? □Yes □No Do you have thoughts about harming someone else? □Yes □No

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	Yes	No
1. Have you ever felt that you ought to cut down on you drinking or drug use?	□	□
2. Have people annoyed you by criticizing your drinking or drug use?	□	□
3. Have you ever felt bad or guilty about your drinking or drug use?	□	□
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	□	□

(Permission for use granted by Richard Brown, MD)

OZARKS HEALTHCARE
Behavorial Health Center

410895006

Personal History

Client Name:_____ **Date:**___/___/____

Birthdate:_____/_____/_____

Substance Use History

	Have you ever used?	Age began using?	Are you currently Using?
Alcohol	□Yes □No		□Yes □No
Marijuana	□Yes □No		□Yes □No
Amphetamines	□Yes □No		□Yes □No
Opiates	□Yes □No		□Yes □No
Misuse of Prescription Medication	□Yes □No		□Yes □No
Nicotine	□Yes □No		□Yes □No
Other Drugs:_____	□Yes □No		□Yes □No

Personal Health History

Family Doctor:_____ Other Healthcare Provider(s)_____ Last Physical Exam:_____

Current Medications: _____

_____

_____

Food and Drug Allergies:_____

Current and past medical history including surgical procedures or other hospitalizations_____

_____

_____

_____

Have you ever had inpatient psychiatric treatment? □Yes □No _____

Have you been seen for outpatient mental health services? □Yes □No _____

Have you ever been in a substance abuse program? □Yes □No _____

Family Health History

History of physical illness within family:_____

_____

Is there a history of mental illness within your family? □Yes □No With whom?_____

Is there a history of substance abuse within your family? □Yes □No With whom?_____

Is there a history of suicide within your family? □Yes □No With whom?_____

OZARKS HEALTHCARE
Behavorial Health Center

410895006

Personal History

Client Name:_____ **Date:**___/_____/_____

Birthdate:_____/_____/_____

Education

Are you in school now? □Yes □No In what grade?_____ Highest level of education completed?_____

Did you have any problems in school? □Yes □No If yes, give details:_____

Employment History

Are you currently employed? □Yes □No How long have you been at your current job?_____

Types of jobs held?_____

Legal Status

Are you currently involved in any legal matters? □Yes □No _____

Are you presently on probation/ parole? □Yes □No _____

Please give the name of your probation/parole officer: _____

Social History

How do you usually spend your time?_____

Are religious or spiritual practices an important part of your life? □Yes □No _____

Client Signature: _____ Date: _____/_____/_____ Time: _____

Guardian Signature: _____ Date: _____/_____/_____ Time: _____