BinaxNOW

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: Male Female Phone: ( )-_____-_____

Race: _____ Ethnicity: _____

Do you currently have symptoms? Yes No

If yes, what are your symptoms? _____

_____

What date did you begin experiencing symptoms? _____

Are you a COMC patient? (circle one) YES NO

BinaxNOW is an antigen test that detects the presence of the SARS-CoV-2, which is the virus that causes a COVID-19 infection, in about fifteen (15) minutes. The specimen for the test is collected via nasal swab. This test is completely voluntary and will not ever be administered unless this form is signed. A positive result of this test will be immediately reported to the Local Public Health Agency (LPHS) so that it can begin contact tracing and instituting appropriate disease control measures. The LPHA solely manages these efforts. Additionally, all test results will be shared with the Department of Health and Senior Services (DHSS) pursuant to state regulation. If symptoms consistent with an infection of COVID-19 develop or persist after a negative test result, consult with a health care provider or the appropriate LPHA to determine the best course of action. Except as required by law, test results and testing information will be kept confidential by COMC, LPHA and DHSS. Completing and signing this form serves as consent for the test to be performed on the named individual and is also an acknowledgment of the above statements.

Signature of person tested or parent/guardian: _____Date:_____

If parent/guardian- print name: _____

Email:_____

Office Use Only

Specimen Collection Date: Received By:

Specimen Source: Accession Number:

Test Results: Patient Contacted:

Notes:

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Central Ozarks Medical Center
If you need help filling out this form, please let us know.

PEDIATRIC MEDICAL REGISTRATION FORM

(Please Print)

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

PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:	Social Security Number: (optional)	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	State:	Zip Code:

Mailing Address: ❑ Same as above	If homeless, please state homeless Status: ❑ Doubling Up ❑ Homeless Shelter ❑ Homeless ❑ Other: _____

Email Address:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )

May we text you for appointment reminders: ❑Yes ❑ No	Preferred Pharmacy:	Preferred method of contact for reminder calls and messages: □ Cell □ Home □ Work

❑ Parent/Guardian **OR** ❑ Emergency Contact Name: _____ Number: _____	Address: ❑ Same as above	Primary Phone Number: ( )

Does the patient have any problems with: ❑ Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Primary Phone Number: ( )

Occupation:	Employer:	Employer Phone Number: ( )

Patients relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other

Primary Medical Insurance:	❑ Medicare	❑ Medicaid	❑ Blue Cross Blue Shield	❑ Cigna	❑ 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

(Please give your insurance card to the receptionist)

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

If you are enrolled in Medicare, please provide HIC number and sign below

I request payment of authorized medical benefits be made to Central Ozarks Medical Center, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.
HIC Number: _____
Signature: _____ Date: _____

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	
	Hispanic or Latino
	Not Hispanic
	Unreported /Refused to Report Ethnicity

Race	
	Asian
	Native Hawaiian
	Other Pacific Islander
	Black/African American
	American Indian/ Alaska Native
	White (not Hispanic or Latino)
	Not Reported / Refuse to Report

Primary Language	
	English
	Spanish
	Russian
	Ukrainian
	Other Please Specify:

How did you hear about us?	
	Newspaper/TV/Radio Ad
	Website
	Special Event
	Employee
	Other Organization
	Friend
	Other

Do you identify yourself as:	
	Straight (not lesbian or gay)
	Lesbian or gay
	Bisexual
	Something else
	Don't know
	Chose not to disclose
	Other

Education	
	Current Student?
	Full Time
	Part Time

Highest Level of Education	
	Not yet in school
	Pre-School Kindergarten
	Grade School
	Middle School
	High School
	High School Degree/ GED
	Did not complete High School
	Technical Trade School
	College
	College Graduate

COMC is my primary medical home?	
	Yes
	No

What is your current gender identity?	
	Female
	Male
	Transgender Male Female-to-Male
	Transgender Female Male-to-Female
	Gender queer, neither exclusively male nor female
	Other
	Chose not to disclose

Employment Status	
	Full Time/ Part Time
	Migrant Worker
	Not a Migrant Worker
	Seasonal

Housing
☐Homeless
☐Doubling Up ☐Shelter ☐Other ☐Street ☐Transitional ☐Unknown
☐Public Housing-HUD
☐ Permanent Supportive Housing (PSH)

Are you a veteran?	
	Yes
	No

I am using COMC today for an urgent care need?	
	Yes
	No

What sex were you assigned at birth on your original birth certificate?	
	Female
	Male
	Chose not to disclose

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% FPG)	Level D (167-200% FPG)	Level E (Above 200% FPG)
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)

Revised 2/14/2021

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Pediatric Medical History

Child's Name: _____ Date: _____
Date of Birth: _____ City and County of Birth:_____
Parent / Guardian 1: _____
Parent/ Guardian 2: _____
Email address: _____
Preferred method of communication: □ Phone □ Text □ Email

Main reason for today's visit:

_____

Where was your child receiving care before?

_____

PREGNANCY & BIRTH: Please fill in the following information about your pregnancy and birth history with this child, as you remember.

PREGNANCY HISTORY:
Prenatal Care: □ Yes □ No Provider: _____
Blood Type: _____ Hepatitis B: □ + or □ –
How many times pregnant? _____
How many children? _____
Miscarriage/Abortion? _____

MATERNAL HEALTH PROBLEMS:
□ Pre-eclampsia □ Bleeding
□ Pre-Term Labor □ High Blood Pressure
□ Infections □ Diabetes
□ Abnormal U/S □ Rh Incompatibility
□ Alcohol/Drugs □ Tobacco/Smoking
□ Shoulder Dystocia □ Bleeding/Bruising
□ Infection □ Urine/Stool Problems
□ Birth defects □ Feeding Problems

BIRTH HISTORY:
Birth Location: □ Hospital □ Home □ Other
Hospital Name: _____
Due date: _____ Birth was □ Vaginal □ C-Section
Gestation: □ Term (37+ wks) □ Pre-Term (36 wks or less)
Birth Weight: _____ Birth Length: _____
Birth Head Circumference: _____
Circumcision? □ yes □ no
Hepatitis B vaccine? □ yes □ no

BIRTH PROBLEMS:
□ Breach □ Forceps
□ Nuchal Cord □ Low APGARs
□ Jaundice □ Breathing Problems

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know that you wrote there.

□ **MY CHILD TAKES NO MEDICATIONS** Please list your pharmacy of choice:_____

MEDICATION	DOSE (MG/PILL)	HOW MANY TIMES PER DAY

ALLERGIES:

□ **NO KNOWN DRUG ALLERGIES**

ALLERGIES	TYPE OF REACTION

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PERSONAL MEDICAL HISTORY

Please provide child's past medical conditions:

_____

_____

_____

_____

_____

Please indicate which of the following diseases parents and siblings have had:

√	DISEASE	RELATIONSHIP (Parents and siblings)	COMMENTS
	No significant history known		
	Alcoholism/Drug abuse		
	Alzheimer's Dementia		
	Asthma		
	Autoimmune Disease		
	Bleeding or Clotting Disorder		
	Cancer _____		
	Coronary Artery Disease (Heart attack, Angina)		Age of Onset:_____
	Depression/Suicide/Anxiety		
	Diabetes – Type 1 (childhood onset)		
	Diabetes – Type 2 (adult onset)		
	Emphysema (COPD)		
	Genetic Disorder (explain)		
	Heart Failure (CHF)		
	Hepatitis (A, B, or C)		
	High Blood Pressure (Hypertension)		
	High Cholesterol		
	Hypothyroidism/Thyroid Disease		
	Kidney Disease		
	Migraine Headaches		
	Osteoporosis		
	Stroke		
	Other (please list)		

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Growth/Development:
Do you think your child is growing and developing normally? □ yes □ no

Do you have any concerns about your child's growth?
_____
_____

Do you any concerns about your child's development?
_____
_____

Education:
Grade in school: ___ School Name: _____
Teacher's name: _____
Does your child do well in school? □ Yes □ No
Does your child enjoy school? □ Yes □ No
Is your child concerned about bullying? □ Yes □ No
Is your child concerned about safety? □ Yes □ No

Health Maintenance Screening Tests:
□ Newborn Screening
□ Lead Screening
□ Anemia (Hgb/Hct) Screening
□ Cholesterol Screening
□ Autism Screening (18 months of age)
□ Dentist - Last visit: _____
□ Eye doctor - Last visit: _____

Activity:
Estimated hours of physical activity or active playtime your child engages in each week: _____

Estimated hours of TV, video games, or computer time your child engages in each week: _____

Sport or school activities: _____

Family activities: _____

Diet:
For infants: □ Breastfeeding □ Formula
Balanced Diet? □ yes □ no
Food allergies? □ yes □ no
Special diet? □ yes □ no
Do you have any concerns about your child's nutrition?
_____
_____

Safety:
Type of car seat: □ Rear-facing □ Forward facing

Do you use your car seats or seatbelts consistently?
□ Yes □ No

Do you have your child use a bike helmet?
□ Yes □ No

Home has a working smoke detector?
□ Yes □ No

Is violence in your home a concern for you?
□ Yes □ No

Tobacco / Alcohol / Drug Exposure:
Is your child exposed to any of the following at home, school or other location?
Tobacco □ Yes □ No
Alcohol □ Yes □ No
Drugs □ Yes □ No
Are prescription medications kept locked away from your child at home? □ Yes □ No

Home Environment:
Who lives at home with your child?
_____
_____
_____
Please list siblings names and ages:
_____
_____
_____
Problems or stress at home?
_____
_____
_____

Thank you for taking the time to fill out this important health information.

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Consent for Treatment of a Minor

I, _____, consent for treatment of _____.
Printed Name of Parent/Guardian Printed Name of Minor

I attest that I have legal responsibility for this patient and the legal right to direct the medical treatment of this patient. I understand that for any treatment to occur, this minor must be accompanied by the adult(s) (over the age of 18) named below.

This consent allows for treatment today and all future appointments. This record may be given to other providers within Central Ozarks Medical Center to treat this minor as needed.

_____ _____
Signature of Parent/Guardian Date

Please list the names of all adults and their relationship to the minor patient who may bring this minor to appointments **and** consent for any and all recommended dental/medical services. *This authorization will remain in effect until changes are made by the parent/guardian signing this form.*

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

Minor Children (Ages 16 and older)

My child, _____ may be seen for medical / dental attention at Central Ozarks Medical Centers – WITHOUT a parent or legal guardian present. I understand that I will be contacted for treatment plans or any changes in treatment.

Parent/Legal Guardian: _____ Date: _____

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Date: _____

I hereby authorize the below listed individuals access to my health information (if this section is not completed, we will only use your medical record for treatment, payment and healthcare purposes. We will not be able to release your medical information to family members or friends unless they are listed by name below):

Individual	**Relationship**	**Phone Number**

_____
Patient, Guardian, or Power of Attorney Signature

_____
If not the patient; please note if you are the Guardian or Power of Attorney

_____
Witness Signature

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Consent for Patient Portal

The patient portal allows for electronic access to view personal medical history, update personal information and ensure patient information is correct and complete. **The portal is not to be used to communicate urgent or emergency issues.**

Patient Name: Date:

_____ _____

Signature of Patient or Guardian:

_____

Relationship to patient:

_____

Date of Birth:

_____

Email address:

_____

Cell phone number:

Ok to text? □ yes □ no

_____

Witness: Date:

_____ _____

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Consent to Obtain External Prescription History

By authorizing Central Ozarks Medical Centers (COMC), and its affiliated providers, you allow us to view your external prescription history via our electronic medical records system (eClinical Works). This will allow your provider to have information regarding medications you're taking in order to minimize adverse drug reactions.

By accepting this consent you understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacies may be viewed by my provider and authorized staff, and it may include prescriptions back in time for several years.

This consent will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on your treatment.

By signing this consent form you are agreeing that COMC, and its affiliated providers can request and use your prescription medication history from other healthcare providers, insurance companies, and pharmacies.

My signature certifies that I read and understand the scope of my consent and that I authorize access.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Patient's Date of Birth

_____

Print Legal Guardian's Name, if applicable

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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, health care 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 and test results; genetic information and test results; STD treatment and 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).

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Notice of Privacy Practices

Please tear this page off and retain for your records

This notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at phone number (573) 836-7112 or amcnulty@centralozarks.org.

Who will follow this notice?

The list below tells you who will follow the outlined practice for keeping your medical record private.
All Central Ozarks Medical Center Medical and Dental Clinics (COMC). Any COMC health care professional that treats you at any of our locations. All COMC employees, temporary or contract staff, students and volunteers.

What is this Notice?

We are required by law to maintain the privacy of your protected health information. We are also required by law to give you this notice of our legal duties and privacy practices regarding your health information. We are required to notify you if there is a breach of your unsecured protected health information. We are required to follow the terms of the current Notice of Privacy Practices.

We may use and disclose your health information for:

Treatment: We may use and disclose health information for your medical treatment and services. **Payment**: We may use and disclose health information to bill for and receive payment for the services provided to you. **Health Care Operations**: We may use and disclose health information for purposes of health care operations. **Appointment Reminders**: To remind you that you have an appointment scheduled with us. **Treatment Alternatives:** To inform you of treatment options available to you. **As required by Law**: When required to do so by applicable law. **To prevent a Serious Threat to Health or Safety**: To prevent a serious threat to your health and safety or the health and safety of others. **Individuals Involved in your Care:** Unless you object, to friends, family members or others involved in your medical care or who may be helping pay for your care. **Organ and Tissue Donation:** Organ or tissue donation to organizations that handle organ procurement and transplant. **Decedents:** Health records for patients deceased 50 or more years are no longer considered Protected Health Information. **Genetic Information:** Genetic Information is considered Protected Health Information, which may be disclosed with authorization but cannot be used by health plans for underwriting purposes. **Military and Veterans:** If you are a member of the armed forces, as required by military command authority. **Worker's Compensation:** For worker's compensation purposes or similar programs providing benefits for work related injury or illness. **Public Health Activities:** For public health activities such as preventing or control of disease, reporting births and deaths, and reporting child abuse and neglect. **Health Oversight Activities**: To governmental agencies and boards as authorized by law such as licensing and compliance purposes. **Breach Notification:** Uses or disclosures of PHI that are not permissible are now presumed to be a Breach, unless it can be demonstrated a "low probability" exists that your PHI has been compromised or that an exception applies. **Disaster Relief:** Unless you object, to disaster relief organizations to coordinate your care or notify family and friends of your location or condition following a disaster. **Lawsuits and Disputes:** In response to a warrant, court order, or other lawful process. **Law Enforcement:** Pursuant to process and as otherwise required by law. **Coroners, Medical Examiners, Funeral Directors**: As necessary to determine the cause of death or to perform their duties. **National Security and Intelligence Activities**: To authorized federal officials for intelligence and other national security activities as authorized by law. **Protective Services for the President and Others**: To federal officials to provide protection to the President and other authorized persons, or conduct special investigations. **Inmates or Individuals in Custody:** If you are an inmate or in the custody of law enforcement, we may disclose to the correctional institution or law enforcement official as necessary to provide you with health care, to protect the health and safety of you and others, or for the safety and security of the correctional institution. **Research Studies and Clinical Trials:** Authorizations may be combined in the research context subject to certain requirements, and authorizations for future research are also permitted. **Business Associates:** Business Associates are directly liable for violations of the HIPAA/HITECH Act. Subcontractors of a business associate that create, receive, maintain or transmit PHI on behalf of the business associate are likewise HIPAA business associates, and subject to the same requirements that the first business associate is subject to. **Fundraising:** For raising funds. You may opt out of receiving fundraising communications at any time. **Other disclosures:** With certain exceptions, we are not allowed to use or disclose psychotherapy notes without your authorization. We are also not

allowed to use or disclose your health information for marketing purposes or sell your health information without your authorization. Other uses and disclosures of your health information not described in this Notice of Privacy Practices or applicable laws will require your written authorization. If you choose to permit us to use or disclose your health information, you can revoke that authorization by informing us of your decision in writing. If you revoke your authorization, we will no longer use or disclose your health information as set forth in the authorization. However, any use or disclosure of your health information made in reliance on your authorization before it was revoked, will not be affected by the revocation.

Your rights regarding your health information: In most cases, **you may make a written request to look at, or get a copy of your health information.** If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you have the right to have that denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review. **If your health information is maintained in electronic format, you have the right to request an electronic copy of your health information.** If your health information is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document. We may charge you a reasonable cost based fee for the labor associated with transmitting electronic health information. If you feel your health information is incorrect or incomplete, **you have the right to request that we amend your information**. You must submit a written request providing your reason for requesting the amendment to the Privacy Officer. Your request to amend your health information may be denied if it was not created by us; if it is not part of the information maintained by us; or if we determine that the information is correct. You may submit a written appeal if you disagree. Your request for amendment will be included as a part of your health information. **You have the right to receive a list of certain disclosures we made of your health information**, for a period of time up to six years prior to the date of your request. The first list you request in a 12-month period is free. If you make more requests during that time, you may be charged our cost to produce the list. We will tell you about the cost before you are charged. **You have the right to a paper copy of this notice.** You may ask us to give you a copy of this notice at any time. **You have the right to request that your health information be given to you in a confidential manner**. You have the right to request that we communicate with you in a certain way or at a certain location, such as by mail or at your workplace. Any such request must be made in writing to the Privacy Officer. We will accommodate reasonable requests. **You have a right to ask that we not disclose your health information to your health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.** Such restricted disclosure must pertain solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full. **You may request, in writing, that we not use or disclose your health information** for treatment, payment or healthcare operations; or to persons involved in your care; when required by law; or in an emergency. All written requests or appeals should be submitted to our Compliance Office listed at the end of this notice. We are not required to agree with the requested restrictions. **You have the right to be notified if there is an unauthorized use or disclosure of your unsecured protected health information unless we determine that there is a low probability that your information has been compromised.**

Complaints:

If you believe that your privacy rights may have been violated, you may contact our Privacy Officer, Amy McNulty, at 573 836-7112 or by email at amcnulty@centralozarks.org. You may write us at Central Ozarks Medical Center Attn: Amy McNulty PO Box 777, Richland, MO 65556. You may also contact Missouri Department of Health, Bureau of Health Facility Regulation: 1-573-751-6303 and/or the State Attorney General's Office Consumer Hot Line: 1-800-392-8222. You may file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights at:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html The Office of Corporate Compliance can provide the mailing address. We will not retaliate against you for filing a complaint. If we change our policies regarding our use and/or disclosure of your protected health information, we will change our Notice of Privacy Practices and make the revised notice available to you on our website and our practice locations. You may access our website at: https://www.centralozarks.org. You may also request a paper copy of the current Notice of Privacy Practices at any time.

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About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices detail the following:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this notice.

To receive a copy of the Notice of Privacy Practices, please ask registration. We are required by law to obtain your written acknowledgement that you are aware of this notice and have been provided an opportunity to obtain a copy.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have been provided an opportunity to obtain a copy of the Notice of Privacy Practices and Notice of Health Information Exchange Participation.

Signature of Patient, Guardian, or Power of Attorney:

_____

Date:

_____