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

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

PATIENT REGISTRATION

(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	Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ 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)		

Information requested below is for statistical purposes only. Please answer to the best of your ability.

Sex Assigned at Birth:

- □ Male
- □ Female

Race:

(Select ALL that Apply)

- □ American Indian/Alaska Native
- □ Asian
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian
- □ Black/African American
- □ Native Hawaiian
- □ Other Pacific Islander
- □ Guamanian or Chamorro
- □ Samoan
- □ White

Housing Status:

Are you currently:

- □ Homeless Shelter
- □ Transitional Housing
- □ Doubling Up
- □ Street
- □ Permanent Supportive Housing
- □ Other (Own / Rent)
- □ Unknown

Primary Language:

- □ English
- □ Spanish
- □ Russian
- □ Ukrainian
- □ Other: _____

Are you interested in seeing if you qualify for Medicaid?

□ Yes □ No

Gender Identity:

- □ Male
- □ Female
- □ Transgender Man
- □ Transgender Woman
- □ Unknown
- □ Other
- □ Chose Not to Disclose

Ethnicity:

- □ Hispanic or Latino
- □ Mexican/Mexican American/ Chicano
- □ Puerto Rican
- □ Other Hispanic, Latino or Spanish Origin
- □ Non-Hispanic or Latino

Have you ever served in the Military or Armed Forces? (This includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves)

□ Yes □ No

COMC is my Primary Medical Home

□ Yes □ No

COMC Services Utlized:

- □ Behavioral Health
- □ Dental
- □ Medical
- □ I would like more information about COMC

I am using COMC today for an urgent need:

□ Yes □ No

Household Size: _____

Household Income: _____

Sexual Orientation:

- □ Lesbian or Gay
- □ Heterosexual (straight)
- □ Bisexual
- □ Other
- □ Don't Know
- □ Chose Not to Disclose
- □ Unknown

Education:

Current Student: □ Yes □ No

Highest Level of Education:

- □ Not yet in School
- □ Pre-School / Kindergarten
- □ Grade School
- □ Middle School
- □ High School
- □ High School Degree / GED
- □ Didn't complete High School
- □ Technical / Trade School
- □ Some College
- □ College Graduate

Employment Status:

- □ Full-Time □ Part-Time
- □ Migrant Worker
- □ Seasonal Migrant Worker
- □ Currently Unemployed
- □ Disabled

How did you hear about us?

- □ Employee / Friend
- □ Newspaper/TV/Radio
- □ Social Media
- □ Special Event
- □ Website
- □ Other: _____

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

Central Ozarks Medical Centers
Sliding Fee Discount Schedule
Effective February 12, 2025

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 (per procedure)	$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 (2025)					
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 - $ 15,650	$ 15,651 - $ 20,815	$ 20,816 - $ 25,979	$ 25,980 - $ 31,300	$ 31,301 and Above
2	$0 - $ 21,150	$ 21,151 - $ 28,130	$ 28,131 - $ 35,109	$ 35,110 - $ 42,300	$ 42,301 and Above
3	$0 - $ 26,650	$ 26,651 - $ 35,445	$ 35,446 - $ 44,239	$ 44,240 - $ 53,300	$ 53,301 and Above
4	$0 - $ 32,150	$ 32,151 - $ 42,760	$ 42,761 - $ 53,369	$ 53,370 - $ 64,300	$ 64,301 and Above
5	$0 - $ 37,650	$ 37,651 - $ 50,075	$ 50,076 - $ 62,499	$ 62,500 - $ 75,300	$ 75,301 and Above
6	$0 - $ 43,150	$ 43,151 - $ 57,390	$ 57,391 - $ 71,629	$ 71,630 - $ 86,300	$ 86,301 and Above
7	$0 - $ 48,650	$ 48,651 - $ 64,705	$ 64,706 - $ 80,759	$ 80,760 - $ 97,300	$ 97,301 and Above
8	$0 - $ 54,150	$ 54,151 - $ 72,020	$ 72,021 - $ 89,889	$ 89,890 - $ 108,300	$ 108,301 and Above
9 or more	Add $5,500 for each additional member	Add $7,315 for each additional member	Add $9,130 for each additional member	Add $11,000 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 2/12/2025

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

Patient Medical History

Allergies: ☐ **NKDA (No Known Drug Allergies)**

_____

_____

Medications: ☐ **I do not take any medications**

_____

_____

Have you ever had an adverse reaction to Anesthesia? ☐ **Yes** ☐ **No**
If yes, please explain:

_____

_____

Do you, or have you ever taken Bisphosphonate (medication used for bone loss)? ☐ **Yes** ☐ **No**
If yes, which one?

_____

Heart & Circulatory Problems	Yes	No
Heart Inflammation		
Artificial Heart Valve		
Heart Murmur		
Heart Trouble		
Heart Attack		
Stroke		
High Blood Pressure		

Bleeding Disorders	Yes	No
Anemia		
Bleeding Disorder		
Neurological Disorders		
Seizures		
ADHD		
Autism		
Alzheimer's / Dementia		

Infectious Diseases	Yes	No
Hepatitis A, B, C		
AIDS		
HIV Infection		
Tuberculosis / TB		
Muscle & Joint		
Hip / Knee Replacement		
Arthritis		

Other Health Concerns								
Liver Problems			Diabetes			Cancer		
Kidney Problems			Mental Health			Pregnant		
Thyroid Problems			Immune System			Breastfeeding		
						Taking Phentermine		

If you answered yes to any of the above, please explain:

_____

_____

_____

Do you have any pertinent family medical history? (i.e.. Cancer, Autoimmune Disorder, etc.):

_____

_____

_____

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

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information (PHI).

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your PHI is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- PHI may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No

Below, please list the individuals you consent for COMC to share your health record:

Name:	**Relationship:**	**Phone #:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

COMC

MEDICAL · BEHAVIORAL · DENTAL

Your Health.....Our Mission.

Consent for Patient Portal

Be proactive in the management of your healthcare!

COMC's Patient Portal is a secure, web-based, self-service portal that provides on-line interaction between our patients and our practice.
Our Patient Portal allows you to submit requests for refills, referrals, view lab results, send messages to your care team, view current and past statements, and much more!
Fill out this form to gain access to your Portal TODAY!

The portal is not to be used to communicate urgent or emergency issues.

Patient Name: _____ **DOB:** _____

Signature of Patient or Guardian: _____

Relationship to patient: _____

Email address: _____

Cell phone number: _____

Okay to text: □ **Yes** □ **No**

I would like to Opt-Out of Paper Statements, I understand by Opting-Out, I will receive my statements via the Patient Portal and not by US Mail: □ **Yes** □ **No**

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).

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

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

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 or visit www.centralozarks.org We are required by law to obtain your written acknowledgment that you are aware of this notice and have been provided an opportunity to obtain a copy.

Patient Acknowledgment 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:

_____

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

Consent for Treatment

By signing below, **I am giving consent for myself, any minor or adult dependent I am legal custodian of, to receive any treatment or procedure** deemed necessary by the professional staff of COMC which may include Medical, Dental, Behavioral Health Treatment, whether in clinic or via TeleHealth. I freely accept care from this health care team and acknowledge the establishment of the provider-patient relationship. I further understand that this health care team will provide information/or care including but not limited to, medical history, physical exam, assessment of health status, laboratory and diagnostic testing, suturing, prescription medications, and immunizations; however, I maintain the right to make all decisions regarding my care. I understand all services, including Behavioral Health, are documented in my electronic health record and are available for my care providers to view. Additionally, I understand my insurance company may require basic information about me such as diagnosis and how many appointments I have had. By signing below, I hereby state that I am the patient, parent, primary legal custodian, or joint legal custodian of the patient being presented today for treatment. This consent is to remain in effect until I revoke it in writing. I understand that I have the right to revoke this consent at any time.

I acknowledge the above notices, and I permit limited release of my PHI as described.

Print Patient Name	**Date**
Patient / Legal Guardian / Guarantor Signature	**Print Legal Guardian / Guarantor Name (if applicable)**

TeleHealth Informed Consent

I,_____, agree to participate as a patient of Central Ozarks Medical Center's (COMC) TeleHealth delivery system. I will be receiving Healthcare Services through interactive videoconferencing. I understand the use of videoconferencing is an alternative method of health care delivery and that my provider will not be physically in the same room with me.

I understand that although COMC makes 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 TeleHealth Services, I recognize that transmissions over the Internet 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 provider, there are risks and consequences in using TeleHealth 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.

I also understand that TeleHealth Services may not be as complete as services provided via face-to-face, although, several benefits of TeleHealth Services have been identified including increased 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 Healthcare Services (e.g., face-to-face services), 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 Health Service 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 TeleHealth Sessions. I also agree to not record my own TeleHealth Sessions without my provider's knowledge or permission.

I give my consent to receive Healthcare Services through the TeleHealth System. I also understand that the services I receive will become part of my Electronic Health Record and will be kept on file at COMC.

Print Patient Name	**Date**
Patient / Legal Guardian / Guarantor Signature	**Print Legal Guardian / Guarantor Name (if applicable)**