THE P.A.T.C.H. CENTER
PATIENT REGISTRATION FORM
(Please Print)

Today's Date:				Primary Care Provider:	
PATIENT INFORMATION					
Patient's Last Name: First: Middle:			Mr. Ms. Mrs. Miss	Primary Phone Number:	Email Address:
Is this your legal name? Yes No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: M F
Street Address:		Social Security Number:		Secondary Phone Number:	
P.O. Box:	City:	State:		ZIP Code:	
Patient Occupation:	Patient Employer:			Employer Phone Number:	
Spouse Information: Name:	Address:			Phone Number:	
Guardian Information: Name:	Address:			Phone Number:	
INSURANCE INFORMATION (Please give your insurance card to the receptionist)					
Person responsible for bill:	Birth date:	Address (if different):		Primary Phone Number:	
Is this person a patient here? Yes No					
Occupation:	Employer:	Employer address:		Employer Phone Number:	
Patients relationship to subscriber: Self Spouse Child Step Child Other					
Please indicate **Primary Insurance**	Medicare	Medicaid	Blue Cross Blue Shield	United Healthcare	Other
Subscriber's Name:	Subscriber's SSN	Birth Date:	Policy #	Group #	Co-payment: $
Name of **Dental and/or Secondary Insurance** (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: Self Spouse Child Step Child Other					
IN CASE OF EMERGENCY					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Primary Phone #	Secondary Phone #		

The following information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of Preferred Family Healthcare dba Clarity Healthcare. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in aggregate form.

(continued on back)

Please circle one answer in each of the following categories.

Ethnicity: Hispanic or Latino Not Hispanic or Latino	**Race:** Asian Native Hawaiian	Other Pacific Islander Black/African American American Indian/Alaska Native	White (not Hispanic or Latino) Hispanic or Latino (all races) Refuse to Report	**Primary Language:** English Other (Specify)_____
Are you a veteran?: YES NO	**Housing Status:** Homeless Own/Rent	Transitional Housing Doubling Up Shelter	**Marital Status:** Single Married	Divorced Widow Legally Separated	**Employment Status:** ***Patient*:** Part Full Unemployed ***Spouse*:** Part Full Unemployed
Number Living in Household:	**Income:** _____ Annual Monthly Bi-Weekly Weekly		**Does your child qualify for the school lunch program?** Yes No	

Insurance and Patient Responsibility

Insurance claims are submitted on your behalf by Clarity Healthcare. If your child is on the HPS Free or Reduced School Lunch program, there will be no cost to you for services provided at the P.A.T.C.H. Center. For children or faculty with insurance, we will file a claim with your insurance and you will be billed for any applicable coinsurance or deductible.

Agreement to Pay for Services

I authorize Preferred Healthcare dba Clarity Healthcare to release my medical information necessary to Medicaid or my insurance plan to process claims and further authorize payment of medical benefits payable directly to Preferred Family Healthcare dba Clarity Healthcare.

Privacy Practice Acknowledgment

- I am aware that the Clarity Healthcare has a HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices.
- I may request a copy at any time by contacting Clarity Healthcare at 573-603-1460 or download a copy at www.clarity-healthcare.org.

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Preferred Family Healthcare dba Clarity Healthcare. I understand that I am financially responsible for any balance. I also authorize Preferred Family Healthcare dba Clarity Healthcare or my insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

THE P.A.T.C.H. CENTER
CLARITY HEALTHCARE /PREFERRED FAMILY HEALTHCARE AND HANNIBAL SCHOOL DISTRICT #60
Shared Consent to Treat and Record Disclosure

Full Name _____ SSN: _____ DOB: _____

Home Address: _____City: _____ Zip: _____

Phone #: _____ Alternate Phone #: _____ School: _____

___ Yes! I consent for me / my child to receive medical care through the P.A.T.C.H. Center (examples: physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, and referrals) Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian

___ Yes! I consent for me / my child to receive dental care through the P.A.T.C.H. Center (Examples: cleanings, x-rays, sealants, fluoride application). Some treatment may be delivered by a hygienist or assistant.

___ Yes! I consent for me / my child to receive counseling and/ or case management services. (Examples: one-on-one counseling, insurance assistance, community resource referrals and outreach, and coordination of outside resources and/or services).

___ Yes! I consent for me / my child to be transported to appointments by HPS. This permission can be revoked at any time.

___ Yes! I consent to allowing Hannibal School District #60 and Clarity Healthcare/Preferred Family Healthcare to share and receive medical and mental health information for the purpose of continuity of care and treatment. I understand that all information exchanged by these persons within these two agencies is confidential and will not be disclosed to any other party without the prior written consent of the parent or legal guardian except as permitted by law. The individual or the parent/guardian (if individual listed above is a minor) may revoke this release if information at any time by submitting the request in writing to the Superintendent of School.

Information exchange by these persons or agencies may be used only for educational, medical, and mental health decisions for the individual listed above. The individual may not have access to certain services if this release of information is not authorized.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I consent to allow Clarity Healthcare/Preferred Family Healthcare, Inc. to obtain emergency medical or psychiatric treatment and/or medical services deemed necessary for my physical and mental health unless otherwise specified through written consent. I understand that I will be responsible for payments not covered under insurance benefits for these services. I also give permission to Clarity Healthcare/Preferred Family Healthcare and other healthcare and payment purposes.

I authorize the release of medical and billing information from Clarity Healthcare/Preferred Family Healthcare, Inc. records for the purpose of payment collection; including the release of alcohol or drug abuse (if applicable) information that may be contained in the records/ Authorization includes the release of preadmission, recertification, and appeal information to insurance companies or their agents which may include diagnosis, symptoms, treatment plans, test results, or consultations. I further authorize the release of DMH69 Standard Means and DMH 8004 Notice of Cost information for the purpose of collection (if applicable).

I also consent to allow Clarity Healthcare/Preferred Family Healthcare to report communicable diseases as outlined by the Missouri Dept. of Health and Senior Services to that agency and to cooperate with investigations, providing client information as requested.

By signing this consent, I confirm I am the ___ patient / ___ parent/legal guardian of the above listed individual and am authorized to give this consent. I understand I may revoke this consent at any time with a written request.

_____

Patient or Parent/Legal Guardian Signature Date

If you would like a copy of this authorization, please initial: _____ Yes _____ No Witness Init_____

CLARITY HEALTHCARE

Medical History Form

Name: _____

Date: _____ DOB: _____

Please provide the following current information as to why you are being seen today:

Over the last two weeks, how often have you been bothered by any of the following problems

Please use X to indicate your answer.

1. Little interest or pleasure doing things: 0 ☐ 1 ☐ 2 ☐ 3 ☐
   (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)

2. Feeling down, depressed, or hopeless: 0 ☐ 1 ☐ 2 ☐ 3 ☐
   (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)

Physical Issues: _____

Mental Health Issues: _____

Current Medications: _____

Allergies: _____

Medical/Psychiatric Hospitalizations: _____

ER Visits in the last 3 mo:_____

Past Procedures/Biopsies:_____

Highest level of education completed?:_____

Exercise Program? ☐**Yes** ☐**No** **Satisfied with Amount?** ☐**Yes** ☐**No** **If not, why?**

Do you have an Advanced Directive? ☐**Yes** ☐**No**

If not, would you like more information? ☐**Yes** ☐**No**

Do you have any of the following? Check all that apply					
Ear/Eyes/Nose/Throat		**Skin/Dermatological**		**Dental**	
Glasses/Contacts	☐	Changing Moles	☐	Condition of Teeth: ☐ Good ☐ Bad	
Hearing Aid	☐	Rash/Sores	☐	Name of Current Dentist:	
Dentures	☐	Tattoos/Piercings	☐		
Sore Throat	☐	**Stomach/Gastrointestinal**		**Substance Abuse**	
Earaches	☐	Acid Reflux/Heartburn	☐	History of Alcohol Abuse	☐
Infections	☐	Abdominal Pain/Cramping	☐	Current Alcohol Use	☐
Heart/Lungs		Diarrhea	☐	If Yes, How often?	
Shortness of Breath	☐	Constipation	☐		
Chest Pain	☐	Special Diet:		History of Drug Use	☐
Night Sweats	☐			Current Drug Use	☐
Leg Cramps	☐	Weight Change	☐		☐
Swelling of Hands/Feet	☐	**Musculoskeletal/Neurological**		**Women Only**	
History of Tobacco Use	☐	Headaches	☐	Are you pregnant?	☐
Current Tobacco Use	☐	Fainting	☐	Date of last period:	
If Yes, Type:		Blurred Vision	☐		
		Numbness	☐	Form of birth control?	
If Yes, How Often:		Backache	☐		
		Joint Pain	☐	Other:	
Other Respiratory Conditions:		Stiffness	☐		

Please list all physicians/specialists involved in the treatment of above conditions:	

(continued on back)

General (Please Check if you have any of the following)					
Usually Feel Lonely	☐	Strong Dislike of Criticism	☐	Suicide Thoughts	☐
Loss of Temper	☐	Often Annoyed By Little Things	☐	Suicide Plans	☐
Difficulty Remembering	☐	Trouble by Work	☐	Suicide Attempts	☐
Difficulty Making Decisions	☐	Disturbed by Family	☐	Domestic Violence	☐
Difficulty Relaxing	☐	Tendency to Worry	☐		

Have you had any of the following immunizations? Check all that apply.			
Influenza/Pneumovax Shots?	☐	Influenza Type B (HiB)	☐
Diptheria, Tetanus & Pertussis (DTP/Dtap)	☐	Chicken Pox (Varicella)	☐
Polio (IPV)	☐	Shingles	☐
Measles, Mumps & Rubella (MMR)	☐		

Personal Medical History

Conditions/Illnesses (Check all that apply)					
Arthritis	☐	Date:	Seizures	☐	Date:
High Blood Pressures	☐	Date:	Ulcer/Stomach Dis.	☐	Date:
Heart Disease	☐	Date:	Anemic	☐	Date:
Cancer	☐	Date:	Gout	☐	Date:
Diabetes	☐	Date:	Stroke	☐	Date:
Thyroid Disorder	☐	Date:	Bronchitis	☐	Date:
Asthma	☐	Date:	Other:		

Family Medical History

Family History: (specify relationship i.e. grandma, mother, brother, etc)					
Cancer	☐	Specify:	Anemia/Blood Disorder	☐	Specify:
Heart Attack	☐	Specify:	Gout	☐	Specify:
Diabetes	☐	Specify:	Glaucoma/Eye Disorder	☐	Specify:
Asthma	☐	Specify:	Arthritis	☐	Specify:
High Blood Pressure	☐	Specify:	Stroke	☐	Specify:
Stomach Issues/Ulcers	☐	Specify:	Sexual Disease/HIV	☐	Specify:
Mental Illness	☐	Specify:	Seizures	☐	Specify:
Drug Abuse/Alcoholism	☐	Specify:	Sinus/Hay Fever	☐	Specify:
Depression/Anxiety	☐	Specify:	Thyroid Disease	☐	Specify:

Completed By: **Date:**

Patient Portal User Agreement

Clarity Healthcare provides this site for the exclusive use of its established patients. The patient portal is designed to enhance patient – physician communications and provides access to helpful resources made available to you.

At Clarity Healthcare, we strive to keep your information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, any information that you provide to us, you agree that it is factual and correct information.

The patient portal provides the following services to you:

- Medication re-fill requests
- The ability to ask questions online between office staff, nurses and physicians.
- Review Patient's medical summary, medication list, treatment history and visitation dates.
- The ability to request appointments to see your doctor

The patient portal is not intended to provide internet based diagnostic medical services. Additionally, the following limitations apply:

- No internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and sees the doctor.
- This portal is not intended for emergency purposes. If you seek emergency care, please call 911.
- No request for narcotic pain medication will be accepted.
- Request for re-fill medication not currently being treated by one of our physicians.

The patient portal is provided in partnership with NextGen, our Electronic Health Record software and provider. Please read our HIPAA policy for information on how protected health information (PHI) is used at Clarity Healthcare. All new and established patients have signed HIPAA agreement and have been given a copy of our HIPAA policy. If you do not recall signing a HIPAA agreement, please ask our receptionist for a copy for you to review. The patient portal is provided by Clarity Healthcare as a courtesy to our patients. However, if abuse of the patient portal occurs, Clarity Healthcare reserves the right to terminate or suspend user access as directed by administrative personnel.

Once you have signed the Patient Portal User Agreement and provided a valid email address, you will be given a copy of our Patient Portal Registration Guide that will assist you in signing up for your account. While our patient portal is user friendly, if you have technical questions, please feel free to call our office during normal business hours at (573) 603-1460.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand that it is my responsibility to keep my password secure to avoid unintended access and to notify Clarity Healthcare if I believe that my account has been compromised. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communications between my physician and patient and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Clarity Healthcare should I decide against using the patient portal. I understand that Clarity Healthcare reserves the right at their discretion to terminate the use of the patient portal or to suspend user access as directed by the administrative personnel. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications.

Valid Email Address

Patient Signature | Print Name | Date

Parent/Guardian Signature | Print Name | Date