PREFERRED FAMILY HEALTHCARE, INC.
TELEHEALTH SERVICE
ACKNOWLEDGEMENT/CONSENT

I, Full Name:______________________________

Social Security #:______________ Date of Birth:____________

Understand that:

- As a consumer of Preferred Family Healthcare there may be healthcare services to treat mental health and/or physical health and wellness available to me through participation in Telehealth services. I understand that participation in Telehealth services is not a requirement of receiving other services through Preferred Family Healthcare and I can refuse to participate in Telehealth services at any time without affecting my right to future care and treatment through Preferred Family Healthcare.

- I will be informed of alternative resources to receiving needed care other than those provided through Telehealth services and understand that all services are voluntary and that Preferred Family Healthcare is not mandated to obtain needed services for me outside of the realm of care provided directly by Preferred Family Healthcare but does so in order to enhance the quality of care provided.

- Any medical information as a product of Telehealth services are subject to the same confidentiality laws as services provided in person and that I have a legal right to that information as provided by law.

- There will be no dissemination, storage or retention of the video interaction produced through the Telehealth service provision.

- I will be informed of all parties who are present at the originating site and the distant site during the Telehealth service provision and I have the right to exclude anyone from either site at my request.

- I will be provided with emergency contact information should a mental health or medical emergency arise.

- My records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.

- I may revoke this consent at any time, except to the extent that services have already been provided in reliance on this or any other consent. Revocation may be accomplished per written request and may be for specific items or the entire release.

This consent will automatically expire1 year from date of signature unless there is a different specification of date, event, or condition noted:______________________

I understand that Preferred Family Healthcare may not generally condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Would you like a copy of this authorization? Please initial: ( ) YES ( ) NO
If yes, copies will be mailed to you if not provided immediately.

Signature of Client:______________________________ Date:__________

Signature of Parent/Guardian/Legal Rep:______________________ Date:__________
(Specify relationship to client:______________________)

PFH-W1064 7/24/14

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.

I would like a copy of this authorization (please initial) Yes ______ No _______

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 and / or Parent/Guardian Signature Date

MONROE CITY SCHOOL DISTRICT
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 / Bi-Weekly / Monthly / 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 Monroe City School District Free or Reduced School Lunch program, there will be no cost to you for services provided at the Monroe City Schools. 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 ______________

MONROE CITY SCHOOL DISTRICT
Consent to Treat and Record Disclosure

Full Name ______________________________ SSN: ________________ DOB: __________

Address: ______________________________ City: ________________ Zip: __________

Phone Number: ____________________ Alternate Phone Number: ____________________

Consent to Treat

___ Yes! I consent for me / my child to receive medical care through Clarity Healthcare/Preferred Family Healthcare at Monroe City School District (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 Clarity Healthcare/Preferred Family Healthcare at Monroe City School District (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 Clarity Healthcare/Preferred Family Healthcare counseling and/ or case management services at Monroe City School District. (Examples: one-on-one counseling, insurance assistance, community resource referrals and outreach, and coordination of outside resources and/or services).

___ Yes! I consent to allowing Monroe City School District 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 child's 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.