URBANA MEDICAL CENTER
417-993-1002
417-993-1006
ozarkschc.com
PO Box 232 | 406 S. Dallas
Urbana, MO 65767

Dear Parent/Guardian:

Fair Play R-II School District has partnered with OCHC Urbana Medical Center to offer Behavioral Health Services on campus for the 2023-2024 school year. Phoebe Glover, Licensed Clinical social Worker (LCSW), graduated from Missouri Southern State College with a Bachelor's Degree in Sociology. She received her Masters of Social Work (MSW) from Southwest Missouri State University. Phoebe enjoys working with individuals and families to help meet goals and improve quality of life. OCHC is committed to providing qualitative, genuine support to children and families. OCHC is a Federally Qualified Health Center that works to meet the health care needs of our community and surrounding areas.

OCHC offers Medical and Behavioral Health Services in Hermitage and Urbana, as well as, Dental Services in Hermitage, Bolivar, and Greenfield. OCHC also provides Dental Services at schools with the Miles for Smiles Mobile Dental Unit.

This program will provide any pre-registered child an opportunity to receive Behavioral Health Services at school.

We look forward to working with you to provide the best possible Behavioral Health Services for your child. If you have any questions or concerns, please contact OCHC at (417)993-1002.

Sincerely,

Scott Crouch
CEO
Ozarks Community Health Center

URBANA MEDICAL CENTER

REGISTRATION FORM

PATIENT REGISTRATION FORM

Patient Name (please print)____

Parent Name (please print)____

Address____

Male / Female Birth Date____________________ Grade ____________ SS#____________________

Home Phone______________________________ Cell Phone______________________________

Email____

Emergency Contact______________________________ Cell Phone______________________________

Relationship______________________________ Home Phone______________________________

Responsible/Insured Party Information (this section must be completed)

☐ Medicaid#______________________________ ☐ uninsured *Sliding Fee Scale available for those who qualify

☐ Private Insurance____

Policy Number______________________________ Group Number______________________________

Insurance Billing Address (back of card)____

Name of Policy Holder______________________________ Relationship to Patient______________________________

Policy Holder Date of Birth____________________ Phone # on insurance card______________________________

Treatment & Background

Is your child currently in treatment _______Yes _______No If so, Provider Name______________________________

Additional information that you feel is important or would help in the treatment of your child:

____

____

PLEASE INDICATE SCHOOL: ☐ DADEVILLE ☐ FAIRPLAY ☐ HALFWAY ☐ HERMITAGE ☐ HUMANSVILLE ☐ MARION C. EARLY ☐ SKYLINE ☐ WEAUBLEAU ☐ WHEATLAND

URBANA MEDICAL CENTER

CONSENT FOR TREATMENT

Consent for Treatment

I consent to my child receiving Behavioral Health Services at school. This consent allows for treatment today and all future appointments. This consent will expire one year from date consent form is signed. Records may be a part of a centralized electronic medical record that will be available to any OCHC/CMH credentialed physician to whom I present for health care. As appropriate to state and federal law, patient information requested by state and/or federal agencies or a requesting body will be released. The practice of medicine is not an exact science. No guarantees have been made to me about results of tests or treatments. I consent to OCHC and the School to have open and direct communication. Whereas, allowing an outside agency to provide services.

Assignment of Benefits and Authorization to Release Medical Information

I authorize my insurance (including Medicare and Medicaid) to pay OCHC for healthcare services received by me. I also authorize OCHC to file claims with my insurance companies on my behalf. I agree to be responsible for and pay all charges my insurance will not pay. I authorize the release of medical information as required for payment of clinic charges. I understand this release may include my employer, insurance carrier, worker's compensation, or welfare agency.

Verification of Receipts of OCHC HIPAA Privacy Notice

I understand that Ozarks Community Health Center has a HIPAA Privacy Notice. Also, that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for further care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand that the Privacy Notice provides a more complete description of information, uses and disclosures. I understand that I have the right to review the notice prior to signing this consent and that the organization reserves the right to change its notices and practices. Also, that I have the right to object to the use of my health information for directory purposes. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. I understand that I may revoke this consent in writing, except to the extent that the organizations has already taken action to reliance thereon.

I am agreeing to consent of treatment, assignment of benefits and OCHC HIPPA Privacy Notice.

Child's name____

____ _____________________________ ______________

Parent or Legal Guardian Date Time