MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Telehealth Patient Registration

(Please Print)

PATIENT INFORMATION

Today's date:	Email address:			
Child's last name:	First name:	Middle initial:	Birthdate:	Sex:
Legal name, if different than above:	Primary phone number:	Secondary phone number:	Social Security number:	
Address:				
Parent/Legal guardian name:	Parent/Legal guardian address:		Parent/Legal guardian phone number:	
Parent/Legal guardian date of birth:	School child attends:			

Does child receive free and/or reduced lunches: Yes No

INSURANCE INFORMATION *(please have insurance card available to make a copy)*

Person responsible for bill:	Birthdate:	Phone:
Address of responsible party, if different than above:	Is responsible party a patient at Clarity/Preferred Family? Yes No	
Employer:	Employer address:	
Employer phone number:	Patient's relationship to insurance subscriber: Child Step-child Other_____	

Primary insurance:

Medicare Medicaid Blue Cross/Blue Shield United Healthcare Other:_____

Subscriber's name:	Subscriber's Social Security number:	Subscriber's birthdate:
Policy number:	Group number:	Co-payment amount:

Secondary insurance, if applicable:

Medicare Medicaid Blue Cross/Blue Shield United Healthcare Other:_____

Subscriber's name:	Subscriber's Social Security number:	Subscriber's birthdate:
Policy number:	Group number:	Co-payment amount:

Patient's relationship to insurance subscriber:

Child Step-child Other:_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Primary phone number:	Secondary phone number:

Please continue on next page.

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.

PLEASE CIRCLE RESPONSES TO EACH OF THE FOLLOWING CATEGORIES:

Ethnicity:
Hispanic or Latino
Non-Hispanic or Latino

Race:
Asian
Native Hawaiian
American Indian/Alaska Native
Other Pacific Islander
Black/African American
White (non-Hispanic or Latino)
Hispanic or Latino
Refuse to Report

Primary Language:
English
Other (specify):_____

Housing Status:
Own/Rent
Transitional Housing
Shelter
Homeless
Doubling-up

Marital Status:
Single
Married
Divorced
Widow
Legally Separated

Employment Status:
Patient: Part Full Student
Spouse: Part Full Unemployed

Gender Identity:
Male Female Decline
Neither
Transgender Male (F to M)
Transgender Female (M to F)

Sexual Orientation:
Straight
Bisexual
Lesbian/Gay
Don't know
Decline

How did you hear about Clarity?
Friend/Family Physician Billboard Health Fair
Newspaper/Magazine/Social Media Other:_____

Are you a Veteran?
Yes No

Do you have an Advanced Directive?
No Yes, agent:_____

Income verification Table *(please circle)*

Family Size	Income Range	Income Range	Income Range	Income Range	Income Range	Income Range
1	$0-$12,760	$12,761-$15,950	$15,951-$19,140	$19.141-$22,330	$22,331-$25,520	$25,521+
2	$0-$17,240	$17,241-$21,550	$21,551-$25,860	$25,861-$30,170	$30,171-$34,480	$34,481+
3	$0-$21,720	$21,721-$27,150	$27,151-$32,580	$32,581-$38,010	$38,011-$43,440	$43,441+
4	$0-$26,200	$26,201-$32,750	$32,751-$39,300	$39,301-$45,850	$45,851-$52,400	$52,401+
5	$0-$30,680	$30,681-$38,350	$38,351-$46,020	$46,021-$53,690	$53,691-$61,360	$61,361+
6	$0-$35,160	$35,161-$43,950	$43,951-$52,740	$52,741-$61,530	$61,531-$70,320	$70,321+
7	$0-$39,640	$39,641-$49,550	$49,551-$59,460	$59,461-$69,370	$69,371-$79,280	$79,281+
8	$0-$44,120	$44,121-$55,150	$55,151-$66,180	$66,181-$77,210	$77,211-$88,240	$88,241+

Insurance and Patient Responsibility: Insurance claims are submitted on your behalf by Clarity Healthcare. You are responsible for knowing what your insurance coverage is, and if our providers are in-network or not in-network with your insurance plan. For any questions regarding your coverage, we recommend you contact your carrier or plan provider directly. You will need to update or verify personal information at each visit. Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your benefits, you will be considered a self-pay patient. As a self-pay patient, a minimum $40 fee is expected to be paid in full at the time of service. If you can provide your insurance card and the insurance pays your claim in full, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled.

Photo Consent: I give my consent to have a photo taken for office identification purposes. This photograph will be kept confidential and stored in my electronic medical record at Clarity Healthcare.

Disclaimer: For the protection of your confidentiality, do you have any family members who work at Clarity Healthcare?
If so, who? _____

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 claim.

Patient/Guardian Signature:	Date:

MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Authorization for Disclosure

Patient Name:	
SS#:	DOB:

I hereby authorize Clarity Healthcare and program/person identified below to communicate and disclose to one another written and verbal information regarding my treatment as indicated below:

Provider/Facility Name:
Address:
City/State/Zip:
Phone:
Fax:

I would like the following identifying information released from my records:

	All medical records related to physical/mental health, unless otherwise noted here (STD results require permission below):
	Immunization records
	Mental health evaluation results, psychological evaluation, legal information, intake assessment, psychological/psychiatric information, progress towards goals and discharge summary Dates: _____to_____
	STD results, HIV/AIDS testing whether positive or negative, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone *Sexually transmitted disease (STD) is defined by law, RCW 70.24 et seq, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma vernereuem, HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome) and gonorrhea.
	Release of any records regarding drug and/or alcohol treatment to the person(s) listed above
	Other (please list) *Educational testing, IEP, scales, communication w/teacher and/or counselors

I understand that 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.

The purpose and need for such disclosure is for continuity of care.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made 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 expire 1 year from the date of signature unless there is a different specification of date, event, or condition noted.

I understand that Clarity 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.

Patient Signature	Date
Parent/Guardian Signature	Date

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials: ____

Witness Signature	Date

MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Clarity Healthcare.

Patient Signature:	Date:

If this acknowledgement is being signed by a personal representative on behalf of the patient, complete the following:

Name:	Relationship to patient:

If you would like a copy of this acknowledgement, please initial: _____Yes _____No Witness Initials: ____

This form will be retained as part of your medical record.

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement above, but acknowledgement could not be obtained because:

_____ Individual refused to sign acknowledgement

_____ Communication barriers prohibited the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other, please specify: _____

Employee name:	Date:

MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Patient Portal User Agreement

Clarity Healthcare provides a patient portal 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 refill requests
- The ability to ask questions online between office staff, nurses and physicians
- Review patient's medical summary, medication list, treatment history and visit dates
- The ability to request appointments to see your provider

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 provider.
- This portal is not intended for emergency purposes. If you seek emergency care, call 911.
- No request for narcotic pain medication will be accepted.
- No request for refill medication not currently being prescribed by one of our providers will be accepted.

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 agreements and have been offered 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 this patient portal 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 and avoid unintended access and to notify Clarity Healthcare if I believe that my account has been compromised. I have been given the risks and benefits of patient portal and agree that I understand the risks associated with online communications between my provider and patient and consent to the conditions outlined herein. I acknowledge 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 provider may impose for online communications.

Valid email address		
Patient Signature	Print Name	Date
Parent/Guardian Signature	Print Name	Date

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials: ____

MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Authorization of Communication by

Wireless/Cellular Telephone

Patient Name:	Date of Birth:

_____I authorize Preferred Family Healthcare, dba Clarity Healthcare to send to and receive from me the information identified below by means of wireless or cellular telephone, whether in spoken or written forms of communication, such as text messaging, etc.

The following information may be communicated to me by wireless/cellular telephone:

*Refill reminders *Appointment reminders *Scheduling requests
*General care and treatment *Referrals *Other_____

I understand that use of wireless/cellular telephones may increase the risk of inadvertent or unauthorized disclosure of my protected health information to third parties. I understand that I am responsible for protecting or securing my own wireless/cellular telephone and any information I receive on such device.

Signature:	Date:

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials:_____

MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Telehealth Acknowledgement/Consent

Name:	
SS#:	DOB:
Address:	
Phone #:	Alternate Phone #:
School:	

I understand that:

- As a consumer of Clarity Healthcare/Preferred Family Healthcare, Inc. 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 Clarity Healthcare/Preferred Family Healthcare, Inc. and I can refuse to participate in telehealth services at any time without affecting my right to future care and treatment.
- 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 Clarity Healthcare/Preferred Family Healthcare, Inc. is not mandated to obtain needed services for me outside of the realm of care provided directly by Clarity Healthcare/Preferred Family Healthcare, Inc. 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 C.F.R. part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 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 expire one year from date of signature unless there is a different specification of date, event or condition noted.
- I understand that Clarity Healthcare/Preferred Family Healthcare, Inc. 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.

Signature of client:	Date:

Signature of parent/guardian/legal representative:	Date:	Relationship to client:

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials:_____

MOBERLY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Shared Consent to Treat and Record Disclosure

Patient Name:	
SS#:	DOB:
Address:	
Phone #:	Alternate Phone #:

_____Yes, I consent for the above child to receive health care services through Clarity Healthcare/Preferred Family Healthcare, Inc. via telehealth located at Moberly School District.

_____Yes, I consent to allowing Moberly School District and Clarity Healthcare/Preferred Family Healthcare, Inc. 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 parent or legal guardian may revoke this release of information at any time by submitting the request in writing to Clarity Healthcare.

_____Yes, I understand that information exchange by these persons or agencies may be used only for educational, medical, and mental health decisions for the individual child listed above. The above child 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 and 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 costs not covered under insurance benefits for these services.
- I authorize the release of medical and billing information from Clarity Healthcare/Preferred Family Healthcare, Inc. for the purpose of payment collection; including the release of 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 for 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 consent to allow Clarity Healthcare/Preferred Family Healthcare, Inc. to report communicable diseases as outlined by the Missouri Department 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 parent or legal guardian of the above child, and am authorized to give this consent. I understand I may revoke this consent at any time with a written request.

Signature:	Date:

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials:_____