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Child's Name: _____

Dear Parent/Guardian:

Central Ozarks Medical Center (COMC) is excited to announce, we have partnered with the school district to bring our Mobile Dental Unit to your child's school during the 2021-22 school year! This partnership will allow your child the opportunity to receive dental services during normal school hours. COMC is a local, non-profit organization that has worked to meet the healthcare needs of your community and surrounding areas since 1979.

COMC's Mobile Dental Unit is equipped to offer comprehensive dental care, including examinations, cleanings, x-rays, fillings, extractions, and some crowns. Some procedures cannot be completed same day, and it may be necessary to refer those children to a COMC Dental Clinic. If this situation should arise, we will gladly provide referral information.

COMC's services are available to any child who completes registration information and makes financial arrangements. COMC accepts Medicaid and private medical and dental insurance. We also offer a sliding fee scale based on household size and income. We have dedicated staff to assist in eligibility for our slide scale and to identify if your student is eligible for the Missouri Medicaid program. If your child is insured, please attach a copy of the front and back of their insurance card to the completed packet.

We look forward to providing the best healthcare experience for your child. If you have questions or concerns, please contact our toll-free number: (877) 406-2662. Or send us an email: info@centralozarks.org.

If you would like for your child to be seen by COMC's dental team, please complete the attached registration packet and return it to school at your earliest convenience. For medical and behavioral health services, please reach out to any of our clinics for an appointment.

Sincerely,

Kelly Miller, CEO

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Central Ozarks Medical Centers
School-Based Healthcare Services - Patient Registration
If you need help filling out these forms, please call: (877)406-2662

(Please Print)

Today's Date:	COMC Medical Provider:	COMC Dental Provider:

PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:	Social Security Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	State:	Zip Code:	
Mailing Address: ❑ Same as above	If homeless, please state homeless Status: ❑ Doubling Up ❑ Homeless Shelter ❑ Homeless ❑ 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** ❑ Spouse Information: Name:	Address: ❑ Same as above	Primary Phone Number: ( )		

Does the patient have any problems with: ❑Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:

MEDICAL INSURANCE INFORMATION

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

Primary Dental Insurance:	Subscriber's Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /

Dental Claims Address (on back of card): _____

Home Room Teacher: _____ **Grade student is in:** _____

Emergency Contact Name: _____ **Phone #:** _____

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.		

Ethnicity	
	Hispanic or Latino
	Not Hispanic
	Unreported /Refused to Report Ethnicity

Race	
	Asian
	Native Hawaiian
	Other Pacific Islander
	Black/African American
	American Indian/ Alaska Native
	White (not Hispanic or Latino)
	More than one race
	Not Reported / Refuse to Report

Primary Language	
	English
	Spanish
	Russian
	Ukrainian
	Other Please Specify:

How did you hear about us?	
	Newspaper/TV/Radio Ad
	Website
	Special Event
	Employee
	Other Organization
	Friend
	Other

Do you identify yourself as:	
	Straight (not lesbian or gay)
	Lesbian or gay
	Bisexual
	Something else
	Don't know
	Chose not to disclose
	Other

Education	
	Current Student?
	Full Time
	Part Time

Highest Level of Education	
	Not yet in school
	Pre-School Kindergarten
	Grade School
	Middle School
	High School
	High School Degree/ GED
	Did not complete High School
	Technical Trade School
	College
	College Graduate

COMC is my primary medical home?	
	Yes
	No

What is your current gender identity?	
	Female
	Male
	Transgender Male Female-to-Male
	Transgender Female Male-to-Female
	Gender queer, neither exclusively male nor female
	Other
	Chose not to disclose

Employment Status	
	Full Time/ Part Time
	Migrant Worker
	Not a Migrant Worker
	Seasonal

Housing
☐Homeless
☐Doubling Up ☐Shelter ☐Other ☐Street ☐Transitional ☐Unknown
☐Public Housing-HUD
☐ Permanent Supportive Housing (PSH)

Are you a veteran?	
	Yes
	No

I am using COMC today for an urgent care need?	
	Yes
	No

What sex were you assigned at birth on your original birth certificate?	
	Female
	Male
	Chose not to disclose

All requested information is for statistical purposes only and is necessary for receipt of federal grants to provide services.

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Central Ozarks Medical Center
Sliding Fee Discount Schedule
Effective February 15th, 2021

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	$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 (2021)					
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 - $ 12,880	$12,881 - $ 17,130	$17,131 - $ 21,381	$ 21,382 - $ 25,760	$25,761 and Above
2	$0 - $ 17,420	$17,421 - $ 23,169	$23,170 - $ 28,917	$28,918 - $ 34,840	$34,841 and Above
3	$0 - $ 21,960	$21,961 - $ 29,207	$29,208 - $ 36,454	$36,455 - $ 43,920	$43,921 and Above
4	$0 - $ 26,500	$26,501 - $ 35,245	$35,246 - $ 43,990	$43,991 - $ 53,000	$53,001 and Above
5	$0 - $ 31,040	$31,041 - $ 41,283	$41,284 - $ 51,526	$51,527 - $ 62,080	$62,081 and Above
6	$0 - $ 35,580	$35,581 - $ 47,321	$47,322 - $ 59,063	$59,064 - $ 71,160	$71,161 and Above
7	$0 - $ 40,120	$40,121 - $ 53,360	$53,361 - $ 66,599	$66,600 - $ 80,240	$80,241 and Above
8	$0 - $ 44,660	$44,661 - $ 59,398	$59,399 - $ 74,136	$74,137 - $ 89,320	$89,321 and Above
9 or more	Add $4,540 for each additional member	Add $6,038 for each additional member	Add $7,536 for each additional member	Add $9,080 for each additional member	Add $9,080 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 2/14/2021

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Patient Medical History

Name	Date of Birth	Today's Date

Heart and Circulatory Problems

	Yes	No	?		Yes	No	?		Yes	No	?
Damaged Heart Valve				Heart Attack				Shortness of Breath with mild exercise or when lying down			
Artificial Heart Valve				Angina(Chest Pain)							
Heart Murmur				High Blood Pressure							
Rheumatic Heart Disease				Low Blood Pressure				Swollen Ankles			
Cardiovascular Disease				Inborn Heart Defects				Other: _____			
Heart Trouble				Stroke				_____			
Cardiac Pacemaker				Chest Pain on Exertion				_____			

Liver Problems

	Yes	No	?
Hepatitis			
Jaundice			
Liver Disease			

Muscle and Joint Problems

	Yes	No	?
Hip/Knee Replacement			
Painful Swollen Joints			
Arthritis			

Blood

	Yes	No	?
Anemia			
Bleeding / Clotting Disorder			

Breathing and Lung Problems

	Yes	No	?		Yes	No	?
Asthma				Tuberculosis			
Respiratory Problems				Persistent Cough			
Emphysema (COPD)				Cough Producing Blood			
Bronchitis							

Stomach Problems

	Yes	No	?
Persistent Diarrhea			
Recent Weight Loss			
Stomach Ulcer			
Gastric Reflux			

Other

	Yes	No	?		Yes	No	?
Diabetes				Mental Health Problems			
AIDS				Kidney Trouble			
HIV Infection				Immune System Problems			
Thyroid Problems				Cancer			
Persistent Swollen Neck Glands				Sexually Transmitted Disease			
Other conditions not listed: _____							

Neurological

	Yes	No	?
Fainting Spells			
Seizures			
ADHD			
Autism			
Alcohol / Drug Abuse			
Alzheimer's / Dementia			

Current Allergies

	Yes	No	?		Yes	No	?		Yes	No	?
Latex				Sulfa Drugs				Aspirin			
Local Anesthetics				Barbiturates				Iodine			
Penicillin				Sedatives				Codeine			
Other Antibiotics				Sleeping Pills				Other:			

☐ **No Known Allergies**

Current Medications

_____

_____

_____

☐ **My child doesn't take any medications**

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Patient Name: _____ DOB: _____

Central Ozarks Medical Centers Policies and Consents

Permission to Disclose to Family or Other Individuals

Adult Consent (Age 18 and Older)

You may authorize Central Ozarks Medical Centers (COMC) to disclose your protected health information to family members or other individuals in order to assist with the coordination of your care.

☐ **No**, I do not give COMC permission to disclose my protected health information to family members or other individuals in order to assist with the coordination of my care.

☐ **Yes**, I give COMC permission to disclose my protected health information to the family members or other individuals listed below in order to assist with my coordination of care. This permission is valid for one year from the date of signature unless revoked or changed in writing prior to the expiration.

OR

Pediatric Consent (Age 17 or Younger)

Non-Parental Consent: For pediatric patients, age 17 and under, you may designate another person to attend visits and authorize treatment decisions.

☐ **No**, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.

☐ **Yes**, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for medical/dental/behavioral healthcare and to make treatment decisions for my child in my absence. I understand that when I designate another person to authorize a treatment decision, COMC may disclose protected health information to the authorized person(s).

Name of Individual(s):	Relationship to Patient:

Finance Policy/Release of Billing Information/Assignment of Benefits:

COMC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance: You are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles, or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. If you do not have insurance: We offer a sliding fee scale based on household size and income. You may apply for a discount at the front desk. We can also assist you with obtaining insurance coverage. I authorize COMC and its representatives to release any information they obtain, including medical information to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay COMC for services rendered.

Privacy Notice:

- I have been given the opportunity to review or receive a copy of COMC's Notice of Privacy Practices which describes how COMC may use and disclose my protected health information following applicable state and federal law. I understand COMC can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.
- I understand that I have the right to receive a copy of my medical information or to request restrictions on the use of my protected health information.
- I understand that COMC may engage business associates to assist in my coordination of care including after-hours telephone coverage and call reminder service. I understand these calls may be recorded to improve customer service and patient care.
- I understand COMC may use letters, reminder calls, texts, or email correspondences to communicate with me regarding my care. I authorize COMC to communicate with me via these methods.

Telehealth:

COMC offers its patients Telehealth services as a method to expand access to care. I understand I may be offered a Telehealth appointment at COMC. I consent to receive services via COMC's Telehealth equipment and understand and/or agree to the following:

- I understand I have the right to refuse to participate or revoke consent for services delivered via Telehealth at any time by informing any COMC staff member.
- I understand that my provider will document in my medical chart as if the visit were conducted in person with only the additional information required for Telehealth billing.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my care and treatment require physical examination they may be conducted by other COMC providers and staff under the direction of my Telehealth provider or I may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.

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Patient Name: _____ DOB: _____

- I understand there are potential drawbacks of participating in a Telehealth visit versus a face-to-face visit.
- I understand that no part of the Telehealth visit will be recorded by my provider and agree not to record any part of the visit myself.
- I understand my visit will be conducted via technology and COMC cannot guarantee technology will always work.
- I understand that if there is an equipment failure I may need to be rescheduled for a face-to-face visit.
- I understand COMC utilizes HIPAA compliant, encrypted software to conduct its Telehealth services.
- I understand I have the right to ask any questions regarding the Telehealth equipment, technology, etc. at any time.
- I understand I will be informed and made aware of the role of the Telehealth provider at the distant site, as well as qualified professional staff at the COMC location who are going to be responsible for follow-up or ongoing care, and the location of the distant site as well as be informed of all parties who will be present at each end of the Telehealth transmission; and consent to have COMC staff in the exam room to operate Telehealth equipment, if needed.
- I understand I have the right to have appropriately trained staff immediately available to me while receiving the Telehealth service to attend to emergencies or other needs. I understand this is not possible if conducting a Telehealth visit from my place of residence located within the state of Missouri or other temporary location within or outside the state of Missouri.
- I understand that mandated reporting laws will be followed by my provider during telehealth visits
- I understand that certain situations including emergencies are inappropriate for telehealth services. If I have an emergency, I should immediately call 911 or go to the nearest hospital.
- I understand that I or my insurance will be billed as authorized by my insurance and/or sliding fee plan.

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, healthcare 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, genetic information, STD treatment, 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).

Consent for Treatment:

• I understand that the information in my child's health record is confidential and will not be released to any unauthorized person or agency without my consent.
• I authorize COMC to only disclose any portion of my child's health record to school personnel only as it relates to my child's academic success, including scheduling treatment and confirmation that my child is receiving services.
• I authorize COMC to have access to my child's school records only to assist in providing necessary care to my child.

My Signature Means:

- *I have reviewed and completed the Permission to Disclose to Family or Other Individuals section. I understand that when I designate another person to authorize a treatment decision, Central Ozarks Medical Centers may disclose protected health information to the authorized person(s).*
- *I have reviewed Central Ozarks Medical Center's Finance Policy/Release of Billing Information/Assignment of Benefits; Consent for Treatment; Privacy Notice; and Telehealth Policy*
- *I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.*
- *I understand that my consent will remain in effect for one year unless I notify COMC in writing. I understand that I may revoke my consent at any time.*

Printed Name of Patient/Legally Authorized Representative:	Relationship to Patient: ☐ Patient ☐ Relationship to Patient:_____
Signature of Patient or Legally Authorized Representative:	Date:
Witness to Signature if Legally Authorized Representative:	Date:

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Informed Consent for Extraction (Removal) of Tooth

I understand that there may be alternatives to the extraction of teeth. After reviewing the various options presented to me by the dentist with Central Ozarks Community Center, I have agreed to allow the extraction of tooth/teeth that need to be removed. I understand that there are various normal complications that can occur despite all efforts to the contrary as a result of the extraction(s) which include, but are not limited to: Dry Socket, Infection bleeding and/or bruising which may be prolonged, Swelling, Injury to adjacent teeth or fillings, Unusual reaction to medications given or prescribed, Sinus involvement (which my require surgical repair), Injury to the nerves of the lower lip and tongue causing numbness (which could possibly be permanent), pain or injury of the temporomandibular joint (TMJ), Including broken jaw.

I understand that a perfect result cannot be promises or guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize COMC dentist to do whatever he/she deems advisable to correct the condition.

I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

Informed Consent for Composite (Tooth-Colored) Fillings

I understand that the treatment of dentition (teeth) involving the placement of composite, resin fillings which may be more aesthetic in appearance than some of the conventional materials that have been traditionally used (such as amalgam or gold), may entail certain risks. There is a possibility of failure to achieve the desired or expected results. I agree to assume those risks those that may occur, even if care and diligence is exercised by COMC Mobile Dental Unit dentist, in rendering treatment. These risks include possible unsuccessful results and/or failure of the filling associated with, but not limited to the following: Sensitivity, Risk of Fracture, Necessity for Root Canal Therapy, Possible need to perform direct or indirect Pulp Car, Injury to the Nerves, Tooth coloration that may not exactly match tooth color and color that may change over time, Breakage, Dislodgement, or Bond Failure.
Informed Consent
I understand that it is my responsibility to notify COMC dentist should any undue or unexpected problems occur, or if I experience any problems related or the treatment rendered, or the services performed. I have been given the opportunity to ask any questions regarding the nature and purpose of composite fillings and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, that may be associated with any phase of this treatment in hope of obtaining the desired outcome. By signing this document, I authorize COMC Mobile dentist and/or his associates to render any services deemed necessary or advisable in the treatment of my dental condition, including prescribing and the administration of any medically necessary anesthetic agents and/or medications.
I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

_____ _____

Parent of Guardian Signature Date

_____ _____

Reviewed by Date

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Notice of Privacy Practices

This notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at phone number (573) 836-7112 or amcnulty@centralozarks.org.

Who will follow this notice?

The list below tells you who will follow the outlined practice for keeping your medical record private.
All Central Ozarks Medical Center Medical and Dental Clinics (COMC). Any COMC health care professional that treats you at any of our locations. All COMC employees, temporary or contract staff, students, and volunteers.

What is this Notice?

We are required by law to maintain the privacy of your protected health information. We are also required by law to give you this notice of our legal duties and privacy practices regarding your health information. We are required to notify you if there is a breach of your unsecured protected health information. We are required to follow the terms of the current Notice of Privacy Practices.

We may use and disclose your health information for:

Treatment: We may use and disclose health information for your medical treatment and services. **Payment**: We may use and disclose health information to bill for and receive payment for the services provided to you. **Health Care Operations**: We may use and disclose health information for purposes of health care operations. **Appointment Reminders**: To remind you that you have an appointment scheduled with us. **Treatment Alternatives:** To inform you of treatment options available to you. **As required by Law**: When required to do so by applicable law. **To prevent a Serious Threat to Health or Safety**: To prevent a serious threat to your health and safety or the health and safety of others. **Individuals Involved in your Care:** Unless you object, to friends, family members or others involved in your medical care or who may be helping pay for your care. **Organ and Tissue Donation:** Organ or tissue donation to organizations that handle organ procurement and transplant. **Decedents:** Health records for patients deceased 50 or more years are no longer considered Protected Health Information. **Genetic Information:** Genetic Information is considered Protected Health Information, which may be disclosed with authorization but cannot be used by health plans for underwriting purposes. **Military and Veterans:** If you are a member of the armed forces, as required by military command authority. **Worker's Compensation:** For worker's compensation purposes or similar programs providing benefits for work related injury or illness. **Public Health Activities:** For public health activities such as preventing or control of disease, reporting births and deaths, and reporting child abuse and neglect. **Health Oversight Activities**: To governmental agencies and boards as authorized by law such as licensing and compliance purposes. **Breach Notification:** Uses or disclosures of PHI that are not permissible are now presumed to be a Breach, unless it can be demonstrated a "low probability" exists that your PHI has been compromised or that an exception applies. **Disaster Relief:** Unless you object, to disaster relief organizations to coordinate your care or notify family and friends of your location or condition following a disaster. **Lawsuits and Disputes:** In response to a warrant, court order, or other lawful process. **Law Enforcement:** Pursuant to process and as otherwise required by law. **Coroners, Medical Examiners, Funeral Directors**: As necessary to determine the cause of death or to perform their duties. **National Security and Intelligence Activities**: To authorized federal officials for intelligence and other national security activities as authorized by law. **Protective Services for the President and Others**: To federal officials to provide protection to the President and other authorized persons or conduct special investigations. **Inmates or Individuals in Custody:** If you are an inmate or in the custody of law enforcement, we may disclose to the correctional institution or law enforcement official as necessary to provide you with health care, to protect the health and safety of you and others, or for the safety and security of the correctional institution. **Research Studies and Clinical Trials:** Authorizations may be combined in the research context subject to certain requirements, and authorizations for future research are also permitted. **Business Associates:** Business Associates are directly liable for violations of the HIPAA/HITECH Act. Subcontractors of a business associate that create, receive, maintain or transmit PHI on behalf of the business associate are likewise HIPAA business associates, and subject to the same requirements that the first business associate is subject to. **Fundraising:** For raising funds. You may opt out of receiving fundraising communications at any time. **Other disclosures:** With certain exceptions, we are not allowed to use or disclose psychotherapy notes without your authorization. We are also not

allowed to use or disclose your health information for marketing purposes or sell your health information without your authorization. Other uses and disclosures of your health information not described in this Notice of Privacy Practices or applicable laws will require your written authorization. If you choose to permit us to use or disclose your health information, you can revoke that authorization by informing us of your decision in writing. If you revoke your authorization, we will no longer use or disclose your health information as set forth in the authorization. However, any use or disclosure of your health information made in reliance on your authorization before it was revoked, will not be affected by the revocation.

Your rights regarding your health information: In most cases, **you may make a written request to look at, or get a copy of your health information.** If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you have the right to have that denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review. **If your health information is maintained in electronic format, you have the right to request an electronic copy of your health information.** If your health information is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document. We may charge you a reasonable cost-based fee for the labor associated with transmitting electronic health information. If you feel your health information is incorrect or incomplete, **you have the right to request that we amend your information**. You must submit a written request providing your reason for requesting the amendment to the Privacy Officer. Your request to amend your health information may be denied if it was not created by us; if it is not part of the information maintained by us; or if we determine that the information is correct. You may submit a written appeal if you disagree. Your request for amendment will be included as a part of your health information. **You have the right to receive a list of certain disclosures we made of your health information**, for a period of time up to six years prior to the date of your request. The first list you request in a 12-month period is free. If you make more requests during that time, you may be charged our cost to produce the list. We will tell you about the cost before you are charged. **You have the right to a paper copy of this notice.** You may ask us to give you a copy of this notice at any time. **You have the right to request that your health information be given to you in a confidential manner**. You have the right to request that we communicate with you in a certain way or at a certain location, such as by mail or at your workplace. Any such request must be made in writing to the Privacy Officer. We will accommodate reasonable requests. **You have a right to ask that we not disclose your health information to your health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.** Such restricted disclosure must pertain solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full. **You may request, in writing, that we not use or disclose your health information** for treatment, payment or healthcare operations; or to persons involved in your care; when required by law; or in an emergency. All written requests or appeals should be submitted to our Compliance Office listed at the end of this notice. We are not required to agree with the requested restrictions. **You have the right to be notified if there is an unauthorized use or disclosure of your unsecured protected health information unless we determine that there is a low probability that your information has been compromised.**

Complaints:

If you believe that your privacy rights may have been violated, you may contact our Privacy Officer, Amy McNulty, at 573 836-7112 or by email at amcnulty@centralozarks.org. You may write us at Central Ozarks Medical Center Attn: Amy McNulty PO Box 777, Richland, MO 65556. You may also contact Missouri Department of Health, Bureau of Health Facility Regulation: 1-573-751-6303 and/or the State Attorney General's Office Consumer Hot Line: 1-800-392-8222. You may file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights at:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html The Office of Corporate Compliance can provide the mailing address. We will not retaliate against you for filing a complaint. If we change our policies regarding our use and/or disclosure of your protected health information, we will change our Notice of Privacy Practices and make the revised notice available to you on our website and our practice locations. You may access our website at: https://www.centralozarks.org. You may also request a paper copy of the current Notice of Privacy Practices at any time.