COMTREA
HEALTH CENTER

Welcome to COMTREA and thank you for choosing us for your services.

The following pages will provide you with information about our services and help us obtain required information. Please ask if you need assistance in filling out the information and please return your completed forms. Again, thank you for choosing COMTREA. We promise to provide you excellent care at the most reasonable cost possible.

Susan M. Curfman, CEO

ORIENTATION TO SERVICES

We want to ensure that you know about all of the services we provide and the policies under which we operate. While some of that information is listed in this packet, additional information is located in the Client Orientation binder located in the lobby including the following:

- Orientation to the service location
- COMTREA rules and guidelines
- Service Provider
- Information on all agency services
- Grievance Policy
- Appointment Policy

PATIENTS RIGHTS AND RESPONSIBILITES

It is our goal to help you enjoy the best possible health. Below are our responsibilities to you and your responsibilities as a patient:

- You have the right to refuse treatment.
- You have the right to be informed of all available routine and emergency services.
- You have the right to an explanation about charges for services including third-party payment.
- You are entitled to receive information about your health and about the plan for your treatment.
- You may refuse to participate in any experimental research.
- You have the right to submit complaints and recommend policy changes to COMTREA staff and our governing body.
- Your records are confidential. You have the right to refuse the release of your information except as required by third-party payment contracts or court order.
- At all times you are to be treated with respect, consideration and dignity, including privacy in treatment.
- Persons served have a right to freedom from abuse, financial or other exploitation, retaliation, humiliation and neglect.
- Persons served have a right to access or referral to legal entities for appropriate representation, self-help support services and advocacy support services.
- You are expected to abide by all rules and regulations with regard to patient conduct. COMTREA reserves the right to discharge any patient from care at our discretion. Rude or abusive behavior towards staff or other patients by you or your parent or guardian may result in immediate discharge.
- You are responsible for following treatment recommendations and discussing any concerns with your provider.
- You are responsible for following all patient financial responsibilities.
- You are responsible for helping keep COMTREA facilities and grounds drug free, weapons free, and tobacco free.

INFORMED CONSENT

Confidentiality and respect are critical in the services we provide. Anything said in an appointment and any treatment documentation in your record is privileged communication and is explained in COMTREA's Notice of Privacy Practice. Privileged communication is your legal right. This means that information about the patient cannot be given to anyone without written permission. In the following situations, you do not have privileged communication and your provider may be required by law to provide confidential information without written permission

A. If you tell your provider you plan to harm yourself or someone else, the provider has a duty to report this information to the proper authorities and to warn those you plan to harm.
B. If you report the abuse or neglect of a child, an elderly person, or an adult with a disability, the provider is required by law to report this information to the proper authorities.

Your treatment sessions cannot be recorded without your written consent. Your case may be discussed with other professional staff or treatment team members when appropriate. Efforts will be made to protect your identity in these consultations.

Your participation in treatment is voluntary and can be stopped at any time. If you are required by the courts or your legal guardian to participate in services, you may refuse, but your provider will be required to report this information to the appropriate person/authorities.

CONFIDENTIALITY OF SUBSTANCE USE TREATMENT INFORMATION

COMTREA is an integrated, comprehensive treatment center, offering Behavioral Health, Primary Care, and Dental services. To help us provide you with comprehensive care, information regarding any substance use disorder treatment may be shared with our Primary Care and/or Dental treatment providers. Information will include all substance use disorder treatment information, which may include diagnosis, medications, treatment planning information, counseling notes, and discharge planning, to assist with coordination of care. This includes all past, present, and future treatment information. You have the right to request and be provided a list of entities to which your information has been disclosed. This authorization will remain in effect from the date of your signature on this form until the time of your death or if authorization has been revoked. Any disclosures outside of COMTREA will require you to sign a separate authorization and will not be done so without authorization.

FINANCIAL POLICY AND AGREEMENT

Patient financial responsibilities include the following:

- The patient or patient's guardian/conservator is responsible for the payment of treatment and care.
- We will bill your insurance. You are required to provide updated insurance information.
- You are responsible for full payment of copays, coinsurance, deductibles, and for all other procedures/treatments not covered by your insurance plan.
- Copays are due at time of service.
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing invoice.
- Patients may incur and are responsible for payment of any additional charges. Charges may include a $30 fee for all returned checks.

MEDICATION REFILL POLICY

After seeing a COMTREA doctor or nurse practitioner for an evaluation and attending a follow-up appointment, you can contact your pharmacy to request a refill. Please allow 3 business days for your request to be addressed. Refills will not be provided for patients who have not been seen on a routine basis or do not have a follow-up appointment scheduled.

CONSENT FOR TELEHEALTH SERVICES _____(Initial to Acknowledge)

Services at COMTREA may be provided through telehealth. Participation in telehealth services is voluntary, but refusal to utilize telehealth may limit available services. COMTREA's telehealth policy has been provided to me. It is also available online at: https://www.comtrea.org/familytrea/privacy-practices

LATE ARRIVAL AND CANCELLATION POLICY _____(Initial to Acknowledge)

COMTREA's Appointment Policy has been provided to me. It is also available online at: https://www.comtrea.org/familytrea/privacy-practices

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT _____(Initial to Acknowledge) COMTREA's Notice of Privacy Practices (NPP) has been provided to me in addition to the agency HIPAA NPP trifold. It is also available online at: https://www.comtrea.org/familytrea/privacy-practices

AGREEMENT FOR SERVICES

I hereby request COMTREA services. By my signature on this form, I agree that I have read and do understand the policies listed here, and have been provided a copy of the Notice of Privacy Practices and Brochure. I authorize assignment of financial benefits directly to COMTREA and its associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient/Guardian Signature:_____**Date**: _____

Staff Member/Verification:_____ **Date**:_____

COMTREA Health Center

PATIENT INFORMATION SHEET Date_____

As a Federally Qualified Health Center, we are required by the Bureau of Primary Health Care to collect data on all our patients annually. COMTREA does not discriminate based on age, sex, race, creed, marital status, religion, national origin, disability, sexual preference, public assistance status or criminal record.

Please check all the services you have received as a patient of COMTREA:

☐ Medical Services ☐ Dental Services ☐ Behavioral Health Services

PATIENT NAME:_____

Last First Middle Suffix

Date of Birth:_____ **Social Security No**:_____ **Sex at birth:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Mailing Address: _____Apt_____

City_____ State_____ Zip_____

Physical Address: (if different)_____ Apt_____

City_____ State_____ Zip_____

County of Residence:_____

Primary Phone:_____ **Cell/Alternate Phone:**_____

E-mail Address:_____ Do you use the **Patient Portal:** ☐ Yes ☐ No

Preferred method of communication: ☐ Phone/Cell ☐ Email ☐ Text

(check all that apply) ☐ Patient Portal ☐ Letter

Legal Guardian: _____ **Relationship:** _____

Name of Secondary/Emergency Contact:_____ **Phone:**_____

(family, friend or neighbor, not living with you, who can get a message to you)

Relationship to Secondary/Emergency Contact_____

Preferred Pharmacy:_____ **Location:**_____

Preferred Lab:_____

Primary Care Physician:_____ **Phone #:** _____

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COMTREA Health Center

PATIENT INFORMATION SHEET

Employed? ☐ Full-time ☐ Part-time ☐ No **Employer:** _____

Agricultural Worker: ☐ No ☐ Migrant **Do you have a family member attending Pre K- 12? Identify which district or N/A:**

Student? ☐ Full-time ☐ Part-time ☐ No ☐ Dunklin ☐ Fox ☐ Northwest ☐ Other ☐ N/A
(If Other, list below)

Highest Level of Education: _____ SchoolDistrict: _____

Veteran? ☐ Yes ☐ No School Name: _____

Sexual Orientation: ☐ Lesbian or gay ☐ Straight (not lesbian or gay) ☐ Bisexual
☐ Something else ☐ Don't know ☐ Decline

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female ☐ Gender queer ☐ Other ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Language assistance. If you need such assistance, please check what kind of assistance you require. ☐ Sign Language ☐ Visual Aides ☐ Interpreter _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Race: Please check ALL that apply: ☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline

Housing Status: ☐ Not Homeless ☐ Homeless (without permanent housing)

HOUSEHOLD INFORMATION: The following questions are about everyone living in your household.

Number of Adults living at home: _____ **Number of Children living at home:** _____

Total annual household income: _____
(estimate gross income from wages, child support, alimony, disability, SSI, unemployment)

COMTREA Health Center

PATIENT INFORMATION SHEET

Name of primary medical insurance? _____ Insurance ID: _____

Do you have: ☐ Medicare ☐ Medicaid (please check one or both

Name of dental insurance? _____ Insurance ID: _____

PLEASE PRESENT YOUR PHOTO IDENTIFICATION

ACCOUNT TO BE PAID BY (Subscriber Information) - ***If someone other than the patient***

Name_____ Social Security No._____

Date of Birth_____ Sex: ☐ Male ☐ Female

Relationship to Patient_____

Home Address (if different than the patient's) _____

City_____ State_____ Zip_____

Home Phone_____ Cell/Alternate Phone_____

COMMUNITY TREATMENT, INC.

277 E MAIN STREET FESTUS, MO. 63028
Phone: (636) 931-2700 FAX: (636) 931-5304

Community Treatment, Inc. (COMTREA) receives a grant from the federal government; this grant enables patients without medical insurance to apply for a discount. Patients who qualify for this grant are eligible for a discount on their medical cost, with the balance being paid by the federal government. Please complete the attached form and return to the address listed above. Please contact the office for approval determination.

We require the application for sliding fee to be completed, signed, and dated with accurate proof of total household income as required by federal regulations. A "household" is defined as father, mother, guardian and children under 18yrs of age or dependents under guardianship.

Acceptable income documents

Provide all of the following that applies to your household.

- ☐ Previous year federal tax returns or W9 forms
- ☐ Last **2 paycheck stubs** for **each** adult working **in the household**
- ☐ A statement from your employer (signed, dated on company letterhead) stating rate of pay, average number of hours worked weekly, and including your hire date
- ☐ Quarterly tax statement if member of your household are self employed
- ☐ Unemployment benefit letter
- ☐ Benefit letter from Social Security showing your monthly payment (a letter for each person who receives these benefits in your household)
- ☐ Documentation of alimony (letter from divorce paperwork, ect.)
- ☐ Copy of pension/retirement benefits
- ☐ **Full time unemployed students**: Provide us with your payment history for the current semester (this can be obtained from the cashier's office)
- ☐ State support: Food stamps, we require the packet you received with your approval, this includes start and stop dates, and **Food Stamp Budget Summary page**

If you receive none of the above we require you to apply for assistance from the State of Missouri first. Contact the **Division of Family Support** at **(855) 373-4636** or visit **mydss.mo.gov**. You must apply for medical assistance and food stamp assistance. **If you are denied bring us the denial packet, including the food stamp budget summary page, for possible Federal assistance.**

Community Treatment, Inc.

Application for Sliding Fee Program

_____ DOB: _____SSN_____
Applicant Name (please print)

_____
Address (please print) City State Zip

Phone Number_____ Additional Phone Number_____

Under 18 years, parent/guardian name _____ Phone_____

Reason for Applying

- ☐ I have no medical/mental health insurance
- ☐ I have no dental insurance
- ☐ I have medical/mental health insurance with a deductible over $1000/per year
- ☐ I have dental insurance with a deductible over $1500/per year
- ☐ I have medical/mental health insurance that only has limited coverage (i.e. covers contraception only).
- ☐ I have dental insurance that only has limited coverage

Total number in household _____

Adults _____ Children(under 18) _____Dependents under guardianship_____

Names of household members:

Name	Date of Birth	Relationship	Current COMTREA Patient (Yes/No)

Have you applied for Medicaid? ☐ **YES** ☐ **NO** Reason for Denial _____

Does the Patient currently reside in a COMTREA facility? _____

Is the Patient participating with the Supportive Community Living Program through COMTREA?____

Sources of Income for HOUSEHOLD (Check YES or NO)

Employed? ☐**YES** ☐ **NO** *Please provide 2 current pay-stubs for **EACH** person in household and **EACH** Job.*

Hire Date_____

How often are you paid? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Twice per Month

Self Employed? ☐ **YES** ☐ **NO** *Please provide net receipts or tax return.*

Social Security? ☐ **YES** ☐ **NO** *Please provide Social Security Award letter.*

Alimony ☐ **YES** ☐ **NO** *Please provide court order print-out.*

Retirement/Pension? ☐ **YES** ☐ **NO** *Please provide documentation.*

Unemployment Income? ☐ **YES** ☐ **NO** *Please provide print out of Unemployment Benefit letter.*

If you have none of the sources of income listed above, please provide your Food Stamp Budget Summary Letter to verify income for our grant.

By signing this form:

- I verify that the above information is true to the best of my knowledge.
- I agree to pay my Sliding Fee discount fee at the time of each visit.
- I also understand that referral services outside of Community Treatment, Inc. are not covered by my Sliding Fee Discount, and if lab services are used during my visit that the lab will bill me separately from Community Treatment, Inc. for those services.
- If my income changes in anyway, I will notify Community Treatment, Inc. of these changes and provide updated income documentation.

_____ _____

Signature of Applicant Date

Reserved for Community Treatment, Inc. Staff

Acct/Chart#_____ ☐ **BH** ☐ **PC** ☐ **OH** **Qualify:** ☐ **Yes** ☐ **No**

Annual Household Income:_____ **Sliding Fee Level:**_____

Comments:_____

Expiration Date: _____**Processing Employee:** _____ **Processing Office:**_____

COMTREA
HEALTH CENTER

Sliding Fee – Proof of Income Deadline

I, _____, understand that I
(Please print name)
have 30 days from the date of signing this form to provide Comtrea with proof of income in order for my sliding fee application to be active. If I neglect to provide proof of income before the 30 day deadline, I acknowledge I will be responsible for paying the full standard rate of any and all services I have received.

Patient Signature: _____ Date: _____

Staff Member/Verification: _____ Date: _____