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_____

COMTREA
HEALTH CENTER

Delegation of Another Person to Consent for Treatment for a Minor

Fill out this form if the patient is a minor and you (the guardian) would like other adults to be able to bring the child to his/her appointments.

Patient / Client Name _____ **Date of birth** _____

Last, First, MI

I, _____
Full name of parent or guardian

legal guardian of the above named child, give the following adults permission to schedule appointments and make decisions regarding the necessary and/or routine treatment of my child, including but not limited to Primary Care services, e.g. examinations, injection, immunization and/or diagnostic procedures including X-ray or laboratory analysis; Dental Services; Mental Health or Substance Abuse Services. I understand that only myself and those listed below will have the authority to authorize treatment. I understand payment is expected for all treatment provided.

I also authorize treatment (except for immunizations) of my teen (16 years and older) without requiring the presence of an adult. However, if my teen needs immunizations and comes alone, a parent/guardian must be available by phone for verbal consent.

Name (authorized person/caregiver)(s)	Phone	Relationship to patient
Name (authorized person/caregiver)(s)	Phone	Relationship to patient
Name (authorized person/caregiver)(s)	Phone	Relationship to patient

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment could be refused or delayed. I understand that in an emergency, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect for one year from date of signature unless so designated in writing that such consent for treatment of minor is cancelled. I will notify COMTREA Comprehensive Health Center, of any changes in the above information.

I have read all the information on this sheet and certify that the information I have provided here is true and correct to the best of my knowledge.

Parent of Minor Child Signature:
Or Legal Guardian Signature _____ Date: _____

Staff Member/Verification: _____ Date: _____

C-STAR OUTPATIENT TRANSPORTATION
BEHAVIORAL EXPECTATIONS

1. Male and female clients will sit in separate areas.

2. Clients will remain seated at all times and will wear seatbelts at all times.

3. Clients will be respectful to each other and staff at all times.
   - Clients will not touch or hug each other.
   - No cursing.
   - No yelling or screaming.
   - No threatening comments.
   - No sexual comments.
   - No gang-related talk or gestures.
   - No gambling or mock gambling.
4. Clients are to keep hands inside the vehicle at all times. Once clients are in the vehicle they will not exit the vehicle until the final destination is reached (except for emergency purposes).

5. Clients will not throw any objects inside or outside of the vehicle.

6. Clients will not touch the radio in the vehicle nor vandalize the vehicle in any way.

7. Clients will not use cell phones while in the vehicle.

8. Clients are to be in staff eyesight at all times.

9. Clients will not bring food or drink on the vehicle and will not eat or drink while riding in the vehicle. Clients will not use cigarettes, cigars or chewing tobacco while riding in the vehicle.

10. Clients will wait for the vehicle at designated areas; clients are to be on time. If a client misses transportation more than three times, transportation will be revoked.

If a client violates any of the above rules, he or she will be suspended for a week from Comtrea transportation. If client continues to violate rules, client will lose all transportation privileges.

I have reviewed and agree to follow the above expectations for my behavior while being transported to Comtrea Outpatient Treatment.

_____ _____
Client Signature Date

_____ _____
Parent Signature Date

_____ _____
Staff Signature Date

COMTREA
HEALTH CENTER

Authorization to pick up client from treatment

I, _____, the parent/guardian of _____
(Parent/Guardian Name) (Client Name)

authorize the following people to pick up my child from treatment:

Name	Phone number	Relationship to client
Name	Phone number	Relationship to client
Name	Phone number	Relationship to client
Name	Phone number	Relationship to client
Name	Phone number	Relationship to client

_____ _____
Parent/Guardian Signature Date

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

STANDARD MEANS TEST FINANCIAL QUESTIONNAIRE

FACILITY	DATE	CLIENT'S DOB	CLIENT'S SOCIAL SECURITY NUMBER
CLIENT'S LAST NAME FIRST MI		CASE NUMBER	DATE ADMITTED / MEDICARE NUMBER
MEDICAID NUMBER	If school aged – Name of Domicile School District	NUMBER IN HOUSEHOLD	IF VETERAN DATES OF SERVICE
BRANCH OF SERVICE	SERVICE NUMBER	PREVIOUS ADDRESS (IF CHANGED IN LAST 6 MONTHS)	
NAME OF PERSON TO BE BILLED	STREET ADDRESS	CITY-STATE-ZIP	PHONE

(A) DOES CLIENT HAVE HEALTH INSURANCE? ☐ YES ☐ NO

POLICYHOLDER	NAME AND ADDRESS OF HEALTH IN SURANCE COMPANY	POLICY / GROUP NUMBER

(B) Is Client And/Or Financially Responsible Person of Client Employed? ☐ Yes ☐ No

NAME OF PERSON EMPLOYED	NAME AND ADDRESS OF EMPLOYER
	NAME: PHONE:
	ADDRESS:
	NAME: PHONE:
	ADDRESS:

(C) Income

LINE NO.	SOURCES OF INCOME	INCOME OF CLIENT				INCOME OF SPOUSE OR PARENT(S)			
		YES	NO	AMOUNT	PAY PERIOD	YES	NO	AMOUNT	PAY PERIOD
1	Armed Forces Allotment								
2	Boarders/Lodgers (Taxable Income)								
3	Bonuses								
4	Child Support								
5	Civil Service Retirement								
6	Dividends and Interest								
7	Maintenance (Alimony)								
8	Military Retirement								
9	Pensions (Company & Union)								
10	Railroad Retirement								
11	Rents (Taxable Income)								
12	Salary or Wages (Gross)								
	Self-Employment (Taxable Income)								
14	Social Security								
15	S.S.I.								
16	Tips and Gratuity								
17	Unemployment Compensation								
18	Veteran's Benefits								
19	Worker's Compensation								
20	Other:								

(D) INCOME CONVERSION (FOR DEPARTMENT OF MENTAL HEALTH USE ONLY)

LINE NO. SECT. C	AMOUNT	PAY PERIOD	MULTIPLIER X	MONTHLY INCOME	LINE NO. SECT. C	AMOUNT	PAY PERIOD	MULTIPLIER X	MONTHLY INCOME

LESS: EXTRAORDINARY MEDICAL EXPENSES		LESS: EXTRAORDINARY MEDICAL EXPENSES	
TOTAL MONTHLY INCOME		TOTAL MONTHLY INCOME	
RATE PER MONTH FROM STANDARD MEANS TEST TABLE $		RATE PER MONTH FROM STANDARD MEANS TEST TABLE $	

(E) IS ANY OTHER MEMBER OF YOUR HOUSEHOLD RECEIVING SERVICES THROUGH (BY) DMH? ☐ YES ☐ NO

If two or more members of a household receive services in the same month, the Provider shall charge no more than the amounts determined for one recipient.

(F) DOES SOMEONE ELSE RECEIVE CLIENT'S GOVERNMENT CHECK? ☐ YES ☐ NO

Name: **Street Address:**

City: State/Zip: Phone:

(G) NAME OF PARENTS OR SPOUSE, IF APPLICABLE

Name FIRST	M.I.	LAST	RELATIONSHIP TO CLIENT	DATE OF BIRTH	DATE OF DEATH	SOCIAL SECURITY NUMBER	VETERAN YES	VETERAN NO

Sections H through J are to be omitted if client is not long term.

(H) Does Client And/Or Client's Spouse Have Personal Property?

DESCRIPTION	YES	NO	IN WHOSE NAME	LOCATION	VALUE
Bonds					
Business equipment					
Cash					
Checking account					
Farm Equipment					
Farm Grain and Produce					
Farm Livestock					
Farm Machinery					
Loans (Not Secured)					
Mobile Home					
Mortgages Owed to You					
Notes Owed to You					
Claims in Probate Court					
Savings Account					
Stock					
Time Certificates					
Trust Funds					
Other:					

(I) Does Client and/or Client's Spouse Own Real Property?

DESCRIPTION AND LOCATION OF REAL PROPERTY	WHOSE NAME IS ON THE DEED?	WHO HOLDS THE MORTGAGE?	CURRENT VALUE	AMOUNT OWED?

(J) DOES CLIENT HAVE LIFE INSURANCE AND/OR A PREPAID BURIAL PLAN? ☐ YES ☐ NO

NAME OF COMPANY	TYPE	POLICY NUMBER	FACE VALUE	PREMIUM	HOW OFTEN PAID?
	Burial				
	Life				

(K) REMARKS

(L) CERTIFICATION

I hereby certify that I have not knowingly withheld any information on income or other financial resources and the amounts I have disclosed are true and correct to the best of my knowledge.

Signature

Relationship to Client	Date
Signature of Interviewer	Date