



Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

First Name	M.I.	Last Name
Date of Birth		Social Security Number
Physical Address		
City	State	Zip
Mailing Address (if different than above)		
City	State	Zip

**CONTACT INFORMATION**

May We Leave Detailed Messages (Appointments, Billing, Results, etc.)?				
Home Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cell Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Work Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Email Address				

**EMERGENCY CONTACT**

Name	Relationship	Phone #
Name	Relationship	Phone #

**HIPAA - DISCLOSURE TO FAMILY AND FRIENDS**

Please list anyone allowed to be given your medical & billing information:

1	
2	
3	
4	
5	

Your information will not be released by telephone or in person to any not on this list.





## BILLING AND INSURANCE INFORMATION

### BILLING INFORMATION

Person Responsible for Bill		Relationship to Patient	
Address		Date of Birth	
City	State	Zip	
Occupation	Employer	Phone #	

### INSURANCE INFORMATION

Type:  Medicaid  Medicare  Commercial  Sliding Fee  Self-Pay

Name of <b>Primary</b> Insurance		Subscriber's Name	
Subscriber's Date of Birth	Subscriber's SSN	Phone #	
Policy #		Group #	
Subscriber's Address			
City	State	Zip	

Name of <b>Secondary</b> Insurance		Subscriber's Name	
Subscriber's Date of Birth	Subscriber's SSN	Phone #	
Policy #		Group #	
Subscriber's Address			
City	State	Zip	

### PREFERRED LABORATORY

Name:
If no laboratory is listed above, all specimens will be sent to the in-house SEMO Health Network Lab. If lab orders cannot be performed at the SEMOHN lab, specimens will be sent to Quest Laboratory.

### PHARMACY INFORMATION

Name	City
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# SOUTHEAST MISSOURI HEALTH NETWORK AUTHORIZATION TO GATHER/RECEIVE MEDICAL RECORDS OR HEALTH INFORMATION

The Execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information, including the Social Security Number (which will be used to locate records for release) is not furnished completely and accurately, Southeast Missouri (SEMO) Health Network will be unable to comply with the request. SEMO Health Network may not condition treatment, payment, enrollment or eligibility on signing the authorization.

Patient's Full Name: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Name and Address of Organization, Individual or Title of Individual from Whom Information Is to Be Gathered:**

**Site to Which Health Information Should Be Sent:**

421 SEMO Drive/P.O. Box 400, New Madrid, MO 63869

105 East 5<sup>th</sup> Street, Caruthersville, MO 63830

200 Southland Drive, Sikeston, MO 63801

500 Russell Street, Kennett, MO 63857

741 S. Walnut Street, Bernie, MO 63822

6724 State Highway 77 E, Benton, MO 63736

**Patient's Request:** I request and authorize SEMO Health Network to gather the information specified below from the organization or individual named on this request. I understand that the information to be released includes information regarding the following conditions:

**PLEASE MARK BELOW IF APPLICABLE**

DRUG ABUSE

ALCOHOLISM OR ALCOHOL ABUSE

SICKLE CELL ANEMIA

TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)

MENTAL HEALTH INFORMATION

IMMUNIZATIONS

MAMMOGRAM

PAP

**INFORMATION REQUESTED** (Check applicable box (es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each).

Copy of Hospital Summary \_\_\_\_\_  Copy of Outpatient Treatment Note(s) \_\_\_\_\_

Other  
(Specify) \_\_\_\_\_

Lab Reports \_\_\_\_\_  X-Ray Reports \_\_\_\_\_  X-ray Films \_\_\_\_\_

Handicap Parking Permit/Application \_\_\_\_\_  Physician Work Statement/Disability Statement \_\_\_\_\_

**PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED**

Personal  Payment  Benefits  State Reporting  Other \_\_\_\_\_

Treatment  Legal  Congressional  Research

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Medical Records Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on date supplied by patient; or (3) under the following condition(s):

**Release will be valid for a period of one (1) year from date signed unless otherwise specified above or revoked.**

\_\_\_\_\_  
Signature of Patient or Person Authorized to Sign for Patient

\_\_\_\_\_  
Date



## No-Show Policy for SEMO Health Network

**Purpose:** To guide the management of Dental/Medical patients who do not keep appointments, cancel without sufficient notice (**defined as less than 24 hours**) or show up more than **15 minutes late** for their scheduled appointments.

### Procedure:

1. All new and existing patients of Dental/Medical at SEMO Health Network will be given a written copy of the No-Show Policy and be required to sign an acknowledgment of the policy that will be scanned in the EMR (electronic medical record).
2. Scheduled appointments will be confirmed the day before. (Patients are still responsible for their scheduled appointment regardless of a successful or unsuccessful reminder).

**Cancelling Appointments:** If you cannot keep your scheduled appointment, you must call **24 hours** in advance to cancel or reschedule. Failure to provide 24 hours' notice is considered a No-Show.

**No-Show Appointments:** No show appointments are taken very seriously and will be documented in the EMR. Following the third (3<sup>rd</sup>) no-show appointment you will not be able to schedule an appointment, you will be placed on a "work-in" only status. (**Medical**): Work-in appointments will be allowed to come in at

