



821 Westwood
Sedalia, MO 65301
660-826-4774

1620 Hilltop Drive
Warsaw, MO 65355
660-438-2717

Patient Information

Today's Date

First Name, Middle Initial, Last Name, Address, City, State, Zip, Home Phone #, Work Phone #, Cell Phone #, Preferred Phone for Communication, E-Mail Address, Soc Sec#, Birth Date, Marital Status, Gender, Language Spoken, Race/Ethnicity, Veteran, Total Annual Household Income, Family Size, Patient Of: Medical / Dental / Both, Highest Level of Education, Current Student, Full-time, Part-time, Employment Status, Full-time, Part-time, Applying for Sliding Fee Discount?

Preferred Pharmacy

The following persons may accompany minor and make decisions for medical/dental/mental health care and treatment

Emergency Contact

Name, Relationship to Patient, Phone #

Name & Relationship, Phone, Name & Relationship, Phone

Parent/Guardian (If under 18 years old)

The following individuals may obtain my health information from KTCH.

Name, Phone #, Relationship to Patient

Name & Relationship, Phone, Name & Relationship, Phone

How did you hear about us?

Complete this section if you have insurance (Medicaid, Medicare, or Other)

Name of Company, Insured Person's Name, ID Number/SS #, Effective Date, Insured Person's Date of Birth, Group Number

Complete this section to let us know how to contact you in regards to your health care needs. (Check yes or no on each)

Phone Yes No, Mail Yes No, Voice Message Yes No

I understand that if I do not allow KTCH to contact me by the above method(s) checked, I may be jeopardizing my health. Should my provider receive critical test results or deem it necessary to follow-up on my progress, I understand that it is my responsibility to keep my information updated.

Assignment and Release Signature:

I understand that there are certain hazards and risks connected with all forms of treatment and I hereby consent to all treatment deemed necessary by the medical/dental/mental health staff of KTCH for patient/minor. If patient is a minor, I will accompany minor on each visit to the clinic. If I am unable to be present, I authorize and will arrange for the above persons to accompany minor and make decisions. I or the above persons will remain at the clinic while minor is receiving treatment. I have received information prior to scheduling my appointment and understand the financial arrangement and fully agree to abide by it. I authorize the release of any information necessary to process this claim. I request that any money due me for medical benefits be assigned to KTCH. I realize that I am responsible for any and all differences. I have had the opportunity to read the KTCH Privacy Practices and Patient Rights and Responsibilities. I also acknowledge that upon request, I may obtain a copy of the KTCH Privacy Practices and Patient Rights and Responsibilities. I agree to pay fee at the time of service. If payment is not received at the time of service then I understand my appointment will be rescheduled to a future date when I am able to pay.

Patient/Guardian Signature: Date

Witness Signature: Date

All requested information is for statistical purposes only and is necessary for us to continue receiving federal grants.

Katy Trail Community Health

Late Policy

Late Policy

Patients are asked to arrive 15 minutes prior to their scheduled appointment. New patients are required to be here 30 minutes prior to the time they are scheduled. If patients are more than 10 minutes late for a scheduled appointment, the appointment will be rescheduled. This allows our providers to be on time throughout the day.

*Same-Day-Status- *MEDICAL CLINIC**

After missing 2 consecutive medical and/or behavioral health appointments, the patient will be placed on “Same-Day-Status.” This means patients may not book a future appointment. Patients may call each morning, and be seen that day based on appointment availability. Once the patient keeps an appointment, the patient can once again schedule future appointments.

*Same-Day-Status- *DENTAL CLINIC**

After missing 2 dental appointments, the patient will be placed on a pending list. The dental clinic will call when an opening is available for an appointment. After keeping the appointment, the patient can once again schedule appointments.

I have been given a chance to read the above policies and ask questions. I fully understand these policies and their consequences.

Patient/Parent Name (Print)

Signature

Date

Katy Trail Community Health ~ SLIDING FEE DISCOUNT PROGRAM APPLICATION

- Our Sliding Fee Discount Program is designed to help you pay for services provided by Katy Trail Community Health. This includes medical, dental and behavioral health care services.
- Sliding Fee applications are good from May 1st through April 30th of each year, and are based on poverty guidelines provided annually by the U. S. Government. You must complete a new application yearly, even if your income has not changed.
- To qualify, bring in one of the following documents for **each person living in the household and receiving an income**: your previous year income tax return, previous year W2 form, one month recent paycheck stubs, child support (paid or received), social security benefits, Medicaid "denial" letter for children under 19 years old, bank statement and the completed Sliding Fee application. If you have questions on what is needed for *your* application, ask a patient service representative or case manager at Katy Trail Community Health.
- A Medicaid "denial" letter from the Division of Family Services (DFS) office is required for all families with children under the age of 19 years.
- **If your household income or family size changes in any way (goes either up or down) within the year, it is your responsibility to notify us.**
- You **must** pay your minimum amount/co-pay due at the time of check-in or your appointment may be rescheduled.
- If you have insurance, KTCH will file your claim. If you have a co-pay with your insurance, you are responsible to pay that co-pay amount at the time of your service. Once the insurance has responded and insurance payment/adjustments have been posted, the Sliding Fee Discount will be applied to the patient due balance. If the insurance company sends you a payment or a notice that your claim was denied, you need to bring or mail a copy of the Explanation of Benefits to the clinic.
- We can only apply Sliding Fee Discounts to services given by providers of Katy Trail Community Health. We cannot discount charges from hospitals, ambulance services, or physicians outside of Katy Trail Community Health to whom you have been referred. Lab tests ordered by *outside* physicians will not be discounted. Hospital procedures will not be discounted. DOT Physicals are not discounted.
- **Any questions? Just call or come into our office and ask staff about the Sliding Fee Program.**

This Section Completed by Applicant

Household Information

Please list **all** members of your household

- | | | | | |
|-----------------------|---------------------------|---------------------|--------------------|--------------|
| 1. Patient Name _____ | Date of Birth ___/___/___ | Annual Income _____ | SELF | KTCH Patient |
| 2. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |
| 3. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |
| 4. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |
| 5. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |
| 6. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |
| 7. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |
| 8. Name _____ | Date of Birth ___/___/___ | Annual Income _____ | Relationship _____ | Yes/No |

I have read the information and I agree that the above information I have provided is true and correct.

Patient Signature: _____ Date: _____

This Section Completed by KTCH Staff

Annual Household Income: \$ _____ Number of People in Household: _____

Sliding Payment Level: _____ Co-payment Per Visit: _____ OR 100% of Charges

KTCH Employee Signature: _____ Effective Date: _____ Expiration Date: _____

Katy Trail Community Health Patient Rights and Responsibilities

At Katy Trail Community Health, we are committed to providing you quality medical services. As a patient, you have certain rights. Understanding those rights will help you to get the best possible care. You have the right to:

1. Receive compassionate and respectful care regardless of age, sex, race, national origin, religion, disability, or communicable disease.
2. Be well informed from your doctor/designee about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.
3. Know the names and roles of people treating you.
4. Receive sufficient information to help you make decisions involving your health care.
5. Refuse recommended treatment to the extent permitted by law, and to be told what will happen to you medically if that is your choice.
6. Medical privacy and confidentiality of all records pertaining to your treatment, except as required by law or third party payment.
7. Have your medical record read only by individuals directly involved in or supervising your treatment, monitoring the quality of your treatment, or authorized by law or regulation.
8. Have access to information contained in your medical record, within the limit of the law and facility policy.
9. Expect the facility to respond reasonably to your request for medical services. The facility must serve you in a way that reflects the urgency of your case. In extreme cases, you may be transferred to another medical facility. Except in an emergency, you have the right to receive as much information as possible about the need for and alternatives to a transfer. You cannot be relocated until after the other facility has accepted the transfer.
10. Express verbally or by letter, any complaints or recommendations concerning our services. You may communicate a complaint or grievance in writing at our main site at 821 Westwood, Sedalia, MO 65301, or by calling our main site at 660-826-4774.
11. We are concerned and do care about your pain. We do **NOT** however, prescribe narcotics for chronic pain. This has been our long standing policy. We try to use all available methods to treat pain **except** narcotics.

Patient Responsibilities

The care you receive is partially dependent upon your acting in a cooperative manner with your health care providers, including communicating openly and honestly, following treatment plans, and respecting the facility standards of conduct. As a patient at Katy Trail Community Health, you are responsible for:

1. Following all facility rules.
2. Advising us of any changes in the following:

Address	Income	Insurance Information
Phone Number	Family Size	
3. Providing accurate and complete information about current symptoms, past illnesses, hospitalizations, medications, advance directives, and any other matters related to care.
4. Following instructions that you and your health care provider have agreed upon.
5. Asking questions about your care that you may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
6. Knowing what medications or drugs you are taking, why you are taking them, and the proper way to take them according to your provider's instructions.
7. Keeping scheduled appointments, arriving on time for scheduled appointments, and for calling as soon as possible to cancel when you cannot keep a scheduled appointment. If you are more than **10 minutes late**, your appointment will be cancelled. New patients are required to arrive 30 minutes in advance of their appointment. Please notify us at least 24 hours in advance of appointment cancellations. **KTCH reserves the right to terminate service to patients who do not show for appointments more than three times in a 12 month period.**
8. Respecting and considering other people, employees, the property of others, and property of Katy Trail Community Health.
9. Attending and supervising your children while in the facility.
10. Calling your pharmacy to request a refill 1 week before you run out of your prescription. If authorized by a KTCH provider, your request will be filled within 72 business hours.
11. Paying bills and fees promptly. **Patients unwilling to pay at the time of service or unwilling to make payment arrangements will be rescheduled** until willing to pay or make payment arrangements, or may be placed in Same Day Only appointment status.

I have read and understand the Katy Trail Community Health **Patient Rights and Responsibilities** and have been given an opportunity to obtain a copy for my personal records.

Signature

Date