Sports Physical

The Mercy School-Based Clinic will perform MSHSAA Sports Physicals in April and May 2022. For your child to participate please read and complete all items below.

- ☐ Sign and date this form.
- ☐ Complete and sign MSHSAA form.
- ☐ Attach copy of insurance card. (Front and Back)
- ☐ Complete and sign Mercy forms. (Physician and Hospital Services Agreement and PHI Communication Form)

Sports physical will not be performed unless all items are completed.

I consent for my child, _____, to have a physical exam/sports physical at the Mercy School-Based Clinic. By signing this consent, I acknowledge I will not be contacted the day of the visit unless there are any medical concerns that need to be discussed.

_____

Parent/Guardian Signature Date

_____

Phone Number

Your insurance will be billed for the sports physical. If this is your child's only preventive visit in the calendar year it is typically covered at no cost. If this is not their only preventive visit, then a co-pay charge may apply. If you have questions regarding cost, please contact your insurance carrier. NO money will be collected on the day of the visit.

After the permission slip is signed, completed, and returned to your child's homeroom teacher, the physical will be completed. No appointment is needed. Mercy staff will contact your child's teacher and they will be excused from class to visit the school-based clinic for the exam.

You may contact the Mercy School-Based Clinic, at 417-847-6088, M-F 7am-1030am with any questions.

ALL ITEMS MUST BE COMPLETED AND RETURNED TO THEIR HOMEROOM TEACHER BY APRIL 1.

PRE-PARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM – VALID FOR 2 YEARS

Name:	Date of Birth:

Physician Reminders:

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff or dip?
   - During the past 30 days, did you use chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Questions 4-13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Yes ☐ No
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP) and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal • Hearing		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, auscultation supine and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA) or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test and box drop or step drop test		

* Consider electrocardiography (ECG), echocardiogram, referral to cardiology for abnormal cardiac history or examination findings, or a combination of those.

☐ **Cleared for all sports without restriction for two (2) years.**

☐ Cleared for all sports without restriction for two (2) years with recommendation for further evaluation or treatment for:

☐ Cleared for all sports without restriction for less than two (2) years. Specify reasons and duration of approval below:

☐ Not Cleared
☐ Pending further evaluation ☐ For any sports ☐ For certain sports (please list):

Reason:

Recommendations/Comments:

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of healthcare professional (type/print):	Date of Issue:
	Phone:
Address:	
Signature of healthcare professional (MD/DO/ARNP/PA/Chiropractor):	

This physical is valid for a 2-year period unless otherwise noted by the physician in the "Recommendations" field listed above.

MEDICAL HISTORY

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. The physician should keep a copy of this form in the chart for their records.

Note: An injury or medical condition results in a separate medical release.

Name:	Date of Birth:
Date of examination:	
Sex assigned at birth (F, M or intersex):	How do you identify your gender? (F, M or other):

List past and current medical conditions:

Have you ever had surgery? If yes, list all past surgical procedures:

Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, stinging insects):

PATIENT HEALTH QUESTIONNAIRE VERSION 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems (circle response).

	Not at All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge:	0	1	2	3
Not being able to stop or control worrying:	0	1	2	3
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed or hopeless:	0	1	2	3

A sum of ≥3 is considered positive on either subscale (questions 1 and 2, or questions 3 and 4) for screening purposes.

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever ordered a test for your heart? (For example, electrocardiography (ECG) or echocardiography?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you, or does someone in your family, have sickle cell trait or disease?		
24. Have you ever had, or do you have, any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to, or has anyone recommended, that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

IF "YES," EXPLAIN ANSWERS HERE

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of Athlete:
Signature of Parent(s) or Guardian:
Date:

MSHSAA PRE-PARTICIPATION DOCUMENTATION – ANNUAL REQUIREMENTS

INTERIM MEDICAL HISTORY	
Note: Complete and sign this form (with your parents if younger than 18). **Note: An injury or medical condition results in a separate medical release.**	
Name:	Date of Birth:
Date:	
Sex assigned at birth (F, M or intersex):	How do you identify your gender? (F, M or other):
List past and current medical conditions:	
Have you had surgery since your last Pre-Participation Physical Examination (physical)? If yes, list those surgical procedures:	
Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional):	
Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, stinging insects):	
Have you been diagnosed with any medical or health condition since your last PPE (physical)? If yes, please describe:	

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of Athlete:
Signature of Parent(s) or Guardian:
Date:

PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)

Informed Consent: By its nature, participation in interscholastic athletics includes risk of serious bodily injury and transmission of infectious disease such as HIV, Hepatitis B, severe acute respiratory syndrome (COVID-19) and/or any mutation or variation thereof. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA- SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident, injury or illness whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

In the event of an emergency or when the Parent(s) or Guardian is unable to directly supervise health care services needed by the student for injuries or illnesses sustained at any athletic practice, conditioning exercise or contest, I also give my consent to the rendering of necessary health care services for the student by a qualified provider (QP) covering the athletic practice, conditioning exercise or contest, including an athletic trainer, physician, physician assistant, nurse practitioner or other medically-trained professional licensed by the State of Missouri (or the state in which the student injury or illness occurs) and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by state law. In emergency situations, the QP may also be a certified paramedic or emergency medical technician for the purpose of providing emergency health care and transport. Health care services are defined as services including, but not limited to, evaluation, diagnosis, first aid, emergency care, stabilization, treatment and referral. I further authorize the QP who provides such health care services to disclose such information about the student's injury or illness, diagnosis, care and treatment in the professional judgment of the QP to the student's athletic director, coaches, school nurse and any classroom teacher required to provide academic accommodation to assure the student's recovery and safe return to activity. If the Parent(s) or Guardian believes that the student is in need of further evaluation, treatment, rehabilitation or health care services for the injury or illness, the student may be treated by the physician or provider of his or her choice.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year as indicated below:

Name of Insurance Company:	**Policy Number:**
Signature of Parent(s) or Guardian:	**Date:**

Has this student incurred a medical condition since their last physical examination?	☐ Yes ☐ No

STUDENT AGREEMENT (Regarding Conditions for Participation)

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at www.mshsaa.org).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Signature of Athlete:	Date:
Have you experienced a medical condition since your last physical examination?	☐ Yes ☐ No

PARENT AND STUDENT SIGNATURE (Concussion Materials)

I accept responsibility for reporting all injuries and illnesses to my school and medical staff (athletic trainer/team physician) including any signs and symptoms of a CONCUSSION. I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

Signature of Athlete:	Date:
Signature of Parent(s) or Guardian:	Date:

EMERGENCY CONTACT INFORMATION

Parent(s) or Guardian	Address	Phone Number
Name of Contact	Relationship to Athlete	Phone Number

PHI Communication Form

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ Last 4 digits of SSN: _____

_____ Telephone: _____

I, _____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

Printed Name	Relationship to Patient	Telephone
Printed Name	Relationship to Patient	Telephone
Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Mercy will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information or Patient's Request to Access Protected Health Information*** form is completed or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: _____ Date: _____
Signature

Patient or Legal Personal Representative: _____
Printed Name

Authority of Personal Representative: _____

Patient Name:
MRN#:
Date of Birth:

Mercy

Mercy

Name:_____

DOB:_____ MR#:_____ CSN#:_____

Physician and Hospital Services Agreement

1. **Annual Agreement for Services:** I agree to the services that may be performed by a Mercy physician or non-physician provider ("provider") or facility. I understand I can withdraw this agreement at any time. This agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician's office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits, and alternatives.
2. **Telehealth Services:** I give my permission for consult-based services that may be provided to me from another location by live video technology ("telehealth"). I understand that I can withdraw this permission at any time by telling my provider when telehealth services are recommended to me and that if I choose to withdraw this permission, there may be certain services that I am not able to receive at a Mercy facility. I also understand and agree that: (i) I may refuse telehealth services at any time without affecting my right to future care or treatment and without risking any third party payor benefits to which I am entitled; (ii) I will be informed of the alternatives, if any, to the telehealth services that are available to me; (iii) I will have the right to access the medical record of the telehealth services as provided by law; (iv) I give my permission for the sharing, storage, and retention of identifiable images or other information from the telehealth service, with the understanding that like in-person care, any identifiable images or other information will not be shared except as required or permitted by law; (v) I have the right to know who will be present during the telehealth services and may exclude anyone from either location; and (vi) there will be no videotaping or recording of telehealth services.
3. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Mercy's Charge Description Master as of the date of treatment, or a different amount as may be determined under my (or the patient's) insurance plan(s) or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.
4. **Assignment of Insurance Benefits:** I assign to Mercy, my physician or other non-Mercy healthcare professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Mercy

Name:_____

DOB:_____ MR#:_____ CSN#:_____

6. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Mercy's website.
7. **Images and Monitoring:** I understand that Mercy may make and use recordings, films, or other images for identification, diagnosis, treatment, performance improvement, or educational purposes. I understand that Mercy may provide or make available monitoring services through mobile application, medical device, or other technology. I understand that Mercy facilities may use video monitoring in patient care areas when there is clinical need and in common areas for security purposes. I consent to such images, technology and video monitoring, with the understanding that any images, audio, or data are not readily available to visitors or the public and will not be disclosed except as required or permitted by law.
8. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.
9. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Mercy may pursue corrective action.
10. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of usual value, Mercy is not responsible for the loss or damage to these items.
11. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.
12. **Independent Contractor/Provider:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.
13. **Phone Calls, Text Messages:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account or my experience, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone, voice message, and text message and authorize the use of automated dialing and texting technology and artificial or pre-recorded voice, even if I am charged for the call or text under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Mercy and its collection agencies may monitor and/or record any communication. If I wish to opt out of this Section 13, I understand that I may contact the registration department of the Mercy facility where I received services.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Nondiscrimination Notice

Mercy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Mercy does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Mercy provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. Mercy also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, you or your representative can contact your local Mercy facility. If you believe that Mercy has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Mercy by mail or phone at: 14528 S. Outer 40, Suite 100, Chesterfield, MO 63017, Attention: Chief Compliance Officer, 1-844-764-0100. If you need help filing a grievance, the Chief Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Available

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-364-0425.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-802-3924.

繁體中文 (Chinese)
注意：如果您講中文，可免費為您提供語言援助服務。普通話服務請致電 1-844-802-3927；粵語服務請致電1-844-372-8337。

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-802-3930.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-802-3925번으로 전화해 주십시오.

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-802-3928.

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-820-7170.

Français (French)
ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-802-3931.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, вы можете воспользоваться бесплатными услугами перевода. Звоните 1-844-802-3926.

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-844-372-8338.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-802-3929.

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-372-8340.

हिंदी (Hindi)
ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएँ मुफ़्त में उपलब्ध हैं। 1-844-372-8344 पर कॉल करें।

Mercy

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-372-8347 تماس بگیرید.

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-477-7622.

Italiano (Italian)
ATTENZIONE: Se parlate italiano, potete usufruire di servizi di assistenza linguistica totalmente gratuiti. Chiamate il numero 1-844-802-4021.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-477-7617まで、お電話にてご連絡ください。

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε στον αριθμό 1-844-477-7620.

Srpsko-hrvatski (Serbian/Croatian/Bosnian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-477-7623.

Kajin M̧ajōļ (Marshallese)
LALE: Ñe kwōj kōnono Kajin M̧ajōļ, kwomaroñ bōk jerbal in jipañ ilo kajin n̤e aṃ ejjeļọk wōṇāān. Kaalọk 1-844-865-1243.

Português (Portuguese)
ATENÇÃO: se você fala português, tem à sua disposição serviços linguísticos gratuitos. Ligue para 1-844-477-7618.

Hmoob (Hmong)
LUS CEEV: Yog hais tias koj hais lus Hmoob peb muaj cov kev pab cuam hais ua koj hom lus pub rau koj yam tsis xam tus nqi hlo li. Hu rau 1-844-477-7621.

ကြမာစဉ် (Burmese)
သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-844-477-7624 သို့ ခေါ်ဆိုပါ။

Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-372-8349.

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-372-8350.

Oroomiffa (Oromo)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-372-8351.

አማርኛ (Amharic)
አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነጻ ይቀርብልዎታል። ወደ ሚከተለው ቁጥር ይደውሉ 1-844-372-8355.

tsalagi gawonihisdi (Cherokee)
Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-844-372-8357.

Kiswahili (Swahili)
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-701-0309.