Kintegra Health

Pediatrics
CONSENT FOR EVALUATION OF TREATMENT AND RIGHT TO REFUSE TREATMENT

PATIENT INFORMATION

DATE OF COMPLETION (mm/dd/yyyy): ____/____/______

Patients Legal Name (Last, First, Middle)

Preferred Name:

Demographics:

Date Of Birth (MM/DD/YYYY) ___/___/______

Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Undefined

Gender Identity: ☐ Female ☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)
☐Male ☐Transgender Male/ Trans Male/ Female-to-Male (FTM)
☐ Gender (neither exclusively male or female)
☐ Additional gender/ Other. Please specify: __________
☐Chose not to answer

Home Phone Number:

Home: (___) _____-______

Cell: (___) _____-______

The child lives with:
☐ Both Parents ☐ Parent 1 ☐ Parent 2
☐ Grandparent : ______________________
Legal Guardian: ______________________
Person Acting in Place of Parent: ______________________

Race: ☐ Black / African American ☐ More than one race ☐ White ☐ Asian
☐ American Indian /Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Unreported /Refuse to report race

Preferred Method of Communication:
☐ Postal Mail ☐ Phone ☐ Email /Text ☐ Web Message

Parent 1 / Guardian(s) Information: ☐ Emergency Contact			*Parent 2 / Guardian(s) Information:* ☐ Emergency Contact		
Date of Birth ___/___/____	*Sex:* ☐ Female ☐ Male	*SSN:* ___-___-____	*Date of Birth* ___/___/____	*Sex:* ☐ Female ☐ Male	*SSN:* ___-___-____
Address:			*Address:*		
City	*State*	*Zip*	*City*	*State*	*Zip*
ome Phone	*Work Phone*	*Cell Phone*	*Home Phone*	*Work Phone*	*Cell Phone*
E-Mail Address	*Employer Name*		*E-Mail Address*	*Employer Name*	

Additional Emergency Contact Information:

Name: ______________________ *Relationship:* ______________________

Phone Number: ______________________

Insurance Information:					
Primary:			**Secondary/Supplemental:**		
Name of Plan:			*Name of Plan:*		
Claims Address (Street Address / P.O Box)			*Claims Address (Street Address / P.O Box)*		
City	*State*	*Zip*			
Phone Number			*Phone Number*		
Policy Number	*Group Number*		*Policy Number*	*Group Number*	
Subscriber Name (If different from patient - Last, First, Middle)			*Subscriber Name (If different from patient - Last, First, Middle)*		
Effective Date:	*Expiration Date:*		*Effective Date:*	*Expiration Date:*	
Guarantor Name:	*Employer:*		*Guarantor Name:*	*Employer:*	
Co-pay Amount:	*Relationship to Patient:*		*Co-pay Amount:*	*Relationship to Patient:*	
Plan Type: ☐ Medicaid ☐ PPO ☐ HMO ☐ POS ☐ Self Pay			*Plan Type:* ☐ Medicaid ☐ PPO ☐ HMO ☐ POS ☐ Self Pay		
Person Responsible for Payment of Bill: ☐ Mother ☐ Father ☐ Guardian or Other: ____________					
HOW DID YOU HEAR ABOUT US? ____________					

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

Consent for Healthcare and Release of Medical Information: I voluntarily consent to healthcare treatment (i.e., Medical Care and/or Behavioral Health) from the Medical and Behavioral Health providers, and staff of Kintegra Health. I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work (including HIV testing), immunizations and referrals. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that Kintegra Health employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra Health providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment and healthcare operations. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can opt-out by completing an Opt-Out Form provided by my provider. I certify that I have read and understand this form.

This consent is renewable annually. I may withdraw authorization for medical or behavioral health services at any time.

Footnote: Kintegra Health, with headquarters in Gastonia, North Carolina, includes Kintegra Medical, Dental, Integrated Medicine, and Behavioral Health Practices throughout North Carolina. Affiliate: Local Health Departments: Catawba, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Mecklenburg.

CONFIDENTIAL SERVICES: I understand that North Carolina General Statutes Section 90 – 21.5 protects a minor's right to receive services relating to sexually transmitted diseases, pregnancy, drug abuse and emotional disturbances without parental consent. I understand that according to NC General Statutes 90 – 21.4 medical providers are not required to notify me about services provided in these areas unless the situation, in the opinion of the medial provider, indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so. I further understand that the GFHS and all its affiliates will make every effort to encourage my child to discuss problems and services with me.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS: I guarantee payment to Kintegra Health and its affiliates for all charges for services provided to my child unless specifically waived based on family size and income, in accordance with the Kintegra Health billing policy. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical, surgical and behavioral benefits, which would otherwise be payable to me, to GFHS for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, VVIII and/or XIX of the Social Security Act is correct.

Parent / Legal Guardian / Person Acting in Place of the Parent:
Date: ______________________________

Print: ______________________________ Signature: ______________________________

FOR OFFICE USE ONLY:

______________________________ ______________________________
Witness Signature Date / Time

☐ Patient refused to sign

☐ Patient was initially treated for an emergency. Patient was either: (Choose One)

- Given the notice after stabilization ***Or***
- Will be given the notice after transfer

If limited English proficient or hearing impaired, offer interpreter services at no additional cost:
State native language: ______________________________

☐ LEP: Interpreter accepted ____________________ ☐ LEP: Interpreter Refused: ____________________
Name / Number of Person/Services Chosen/Used

Consent to Treat- Revised Jan 2020

Authorization to Release Health Information – ROI

RELEASE FROM:

Facility/Practice Name: ____________________

Facility/Practice Address: ____________________ **City/State/Zip** ____________

Telephone #: (___)____-____ **Fax #:** (___)____-______

PATIENT INFORMATION:

Name of Patient (F,M, L)____________________ **DOB** ____/____/______

Address____________________

City, State, Zip ____________________ **Phone** (___) ____-______

INFORMATION TO BE RELEASED:

☐ **Office visit notes** ☐ **Entire record** ☐ **Financial records** ☐ **On site record review by the patient**

☐ **Marketing*** ☐ **Billing Information** ☐ **H & P Notes Dates:** ***From*** __________ ***To*** __________

☐ **Appointment Information** ☐ **Diagnostic studies (list):** ____________________

☐ **Mental Health Records (specify type):** ____________________

☐ **Substance Abuse Treatment Records (specify type):**____________________

☐ **HIV Diagnostic/Treatment Records (specify type):**____________________

☐ **Other:** ____________________

Please list specific date of service: From ______________ **To:** ______________

**Financial compensation is received for this communication.*

REASON FOR RELEASE: **(Please specify reason when requesting mental health and substance abuse records)**

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____

____

RELEASE TO:

Facility/Practice Name/Patient Name: ____________________

Address: ____________________**City/State** ____________ **Zip** ________

Telephone #: (___)____-____ **Fax #:** (___)____-______

This authorization shall be in effect for <u>six months</u> from the initial date of request unless otherwise noted below.

PATIENT'S RIGHTS AND SIGNATURE:

- I have the right to revoke this authorization at any time. I also understand that I must complete the revocation form of health information release and return to Health Information Services to change whom and how my health information is released.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that released information may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or HIV).
- For Substance Abuse Treatment Records: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

PRINT NAME (Patient/Authorized Representative): _______________ *Date*

Signature of Patient or Authorized Representative _______________ *Date*

Attach description of Authorized Representative's Authority and relationship to patient

FOR OFFICE USE ONLY:

☐ Identification Verified ☐ Copy of Authorization given to patient
Date of release: ______________________via: ☐ Mail ☐Fax ☐ Other ____________

☐ Accepted – Released information as described above
☐ Partially Accepted - Describe patient information not released: ____________________

____

Employee Name & Title: ______________________________

Employee Signature: ______________________________

Patient label

AUTHORIZATION FOR TREATMENT IN PARENT(S) ABSENCE

In the event that the parent(s) or guardian(s) of this child is unable to accompany the child to an office visit, unable to be reached, or in the case of an emergency, we the parent(s) or legal guardian(s) of ______________________, authorize the physicians of Kintegra Health to administer such medical care as indicated due to illness, (medical, behavioral, and/or surgical) and further consent that such treatment, procedures, medical consults, behavioral consults, surgical consults and operative procedures that are indicated to be carried out.

I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

Listed below are persons who are authorized to bring my child for medical care:

1) ______________________________ ______________________
Name of authorized person Relationship to the patient

2) ______________________________ ______________________
Name of authorized person Relationship to the patient

3) ______________________________ ______________________
Name of authorized person Relationship to the patient

______________________ ______________________ __________
Parent or Legal Guardian Signature of Witness Date