Kintegra Health

Student Enrollment

Student INFORMATION DATE OF COMPLETION (mm/dd/yyyy): _____ / _____/ _____

Students 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: _____ ☐Choose 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

School:	***Grade:***	***Homeroom Teacher:***

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*
Home Phone	*Work Phone*	*Cell Phone*	*Home Phone*	*Work Phone*	*Cell Phone*
E-Mail Address	*Employer Name*		*E-Mail Address*	*Employer Name*	

Emergency Contact 1:	*Relationship*	*Home Phone*	*Cell Phone*
Emergency Contact 2:	*Relationship*	*Home Phone*	*Cell Phone*

Insurance Information: ☐ Check this box if your child has no insurance coverage or insurance deductibles/co-pays

Primary Insured's Name: Date of Birth (mm/dd/yyyy) SSN: _____-_____- _____ _____ /_____ /_____			***Secondary/Supplemental Insured's Name:*** Date of Birth (mm/dd/yyyy) SSN: _____-_____-_____ _____ /_____/_____		
Insurance Company:			*Insurance Company:*		
Claims Address (Street Address / P.O Box)			*Claims Address (Street Address / P.O Box)*		
City	*State*	*Zip*	*City*	*State*	*Zip*
Phone Number			*Phone Number*		
Policy Number	*Group Number*		*Policy Number*	*Group Number*	
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:*	

Person Responsible for Payment: ☐ Mother ☐ Father ☐ Guardian or Other: _____

Preferred Method of Communication:

☐ Postal Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Web Message

I agree to receive text communication from Kintegra Y or N Preferred Phone Number: _____

*I agree to receive email communication from Kintegra? Y or N Email address:*_____

For email and/or text communications I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately

Permission to Communicate:

So that Kintegra Health may serve you better, you have the options of providing us with a list of caregivers with whom we can discuss appointments, referrals, lab results, and any other health information you desire to share. The following people may request and receive information about my child's treatment with Kintegra.

Name: _____Relation_____ Phone _____ May we leave a voice Y or N

Name: _____Relation_____ Phone _____ May we leave a voice Y or N

Name: _____Relation_____ Phone _____ May we leave a voice Y or N

Patient Rights:

- I have the right to revoke this authorization at any time
- 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 my treatment will not be conditioned on signing it.
- **As a Kintegra Health** student I understand I am automatically enrolled in the Health Information Exchange (HPI), but at any time can opt-out by completing an Opt-Out Form provided by my provider.

- I understand that I can request additional information on the HIE and enroll/Opt-out at anytime.

_____ **Date:** _____

Signature of Patient, Parent, or Personal Representative

***Description of Personal Representative's authority:** _____

Consent to Treat and Confidentiality:

Consent for Healthcare and Release of Medical Information: I voluntarily consent to healthcare treatment (i.e., Medical Care and/or Behavioral Health) from _____ _____from the
(Child's Name) (Child's Date of Birth)
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.

This consent is renewable annually. I have been offered/received a copy of my child's Clients Rights and Health Information Protection Act (Privacy Notice). may withdraw authorization for medical or behavioral health services at any time.

_____ _____

Signature of Patient, Parent, or Personal Representative ***Date***

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 KINTEGRA and all its affiliates will make every effort to encourage my child to discuss problems and services with me.

For services not designated as confidential, I understand that I will be kept informed of my child's SHC visits and treatments. When an outside referral or services (including prescription medications) is indicated, I will be informed as well as my child's PCP. In the event my child requires urgent medical care and I cannot be reached, I request that my child be provided care to stabilize his/her condition. (Children age 11 and over may be allowed to authorize their own urgent care with the understanding that I will be contacted as soon as possible. Children age 10 and under may require a parent or other adult, chosen by the parent, to accompany the child to the visit. Names of authorized adults who may accompany my child have been shared with the student health center.)

_____ _____

Signature of Patient, Parent, or Personal Representative ***Date***

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS: I guarantee payment to KINTEGRA 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 KINTEGRA 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.

_____ _____

Signature of Patient, Parent, or Personal Representative ***Date***

_____

Print Name

_____ _____

Witness Signature **Date**

MyChart ENROLLMENT AND VIRTUAL VISITS

Upon enrollment in school-based services, you will have access to a MyChart account. This account is accessible by computer and/or mobile device (tablet/phone). MyChart will allow your child continuity of services in the event of a school closures and during the summer months. Your child's provider will issue a randomly generated password for your account. This password can be changed upon the first login to MyChart. Please select a username and list it below:

Username: _____

Please keep a copy of this username of your records. If your child is under the age of 12, you will maintain the primary account for your child. If your child is over the age of 12 (N.C. Gen. Stat. § 90-21.4), your child will maintain the primary account and you may receive proxy privileges to the account.

I voluntarily authorize the designated behavioral health provider to perform a telemedicine e-visit using secure interactive video and audio with my student during periods of school closure.

_____ _____

Signature of Patient, Parent, or Personal Representative ***Date***

FOR OFFICE USE ONLY

_____ _____

Staff Signature Date / Time

☐ Patient refused to sign

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

Rev. Jan 2020

Kintegra Health

Kintegra Health School Health Program Billing Policy Facts

Kintegra Health (KINTEGRA) works in collaboration with School Systems providing behavioral health care to students in participating schools

- No enrolled student will be denied services because of inability to pay.
- Fees are based on family income and insurance plan guidelines.
- Families without insurance will be charged according to the following sliding fee scale based on the Federal Poverty Level (FPL)*. Families must provide their total family income and the number of people in the household based on the Definition of Family for Purposes of KINTEGRA Billing* on the SHC Registration Form. The signature below the income and household information provided certifies all information is true and correct to the best of the responsible party's knowledge.

FPL	up to 300%	300 – 400%	more than 400%
% pay	0%	50%	100%

- KINTEGRA will bill Medicaid, NC Health Choice and private insurance plans. Families needing assistance with financial responsibility may quality for sliding scale, payment plans, and/or maximum out of pocket plans.
- KINTEGRA staff will make every effort to notify a student's family before providing a service which may result in a charge to the family and will follow requirements of the student's insurance plan whenever possible.
- Parents or students are responsible for copayments, deductibles and payment for services not covered by insurance.
- Families may request an explanation or reconsideration of a billing issue by contacting the KINTEGRA Business Service Administrator.

* See KINTEGRA staff for a current listing of the Federal Poverty Level schedule, Definition of Family, and for financial concerns.

North Carolina Laws Addressing the Care of Minors

§ 90-21.4. Responsibility, liability and immunity of physicians.

(a) Any physician licensed to practice medicine in North Carolina providing health services to a minor under the terms, conditions and circumstances of this Article shall not be held liable in any civil or criminal action for providing such services without having obtained permission from the minor's parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment. The physician shall not be relieved on the basis of the Article from liability for negligence in the diagnosis and treatment of a minor.

(b) The physician shall not notify a parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment, without the permission of the minor, concerning the medical health services set out in G.S. 90-21.5(a), unless the situation in the opinion of the attending physician indicates that notification is essential to the life or health of the minor. If a parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment contacts the physician concerning the treatment or medical services being provided to the minor, the physician may give information.

§ 90-21.5. Minor's consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

Kintegra Health

School-Based Health Center Registration Form

Student's Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____ Student's Sex: ☐ Male ☐ Female Current School Attending: _____

Student's Race/Ethnicity (Check **ONE** box below)									
☐ White Hispanic	☐ White Non-Hispanic	☐ Black Hispanic	☐ Black Non-Hispanic	☐ American Indian / Native Alaskan Hispanic	☐ American Indian / Native Alaskan Non-Hispanic	☐ Asian Hispanic	☐ Asian Non-Hispanic	☐ Native Hawaiian Hispanic	☐ Native Hawaiian Non-Hispanic

Parent's Name: _____
Last First Middle

Home Mailing Address: _____

City: _____ Zip Code _____

Parent's Home Phone # _____ Work # _____ Cell # _____

In the event your child becomes sick during the school day and requires a visit with our Health Center Staff, what is the best phone number where you can be reached? _____

If you are unable to be reached, please list any other adults who may accompany your child to the health center for a visit.

Name	Relationship to Student	Phone Number(s)

Preferred Method of Communication: Postal Mail ☐ Phone ☐ E-mail _____ Text ☐

May the Student Health Center Staff leave a message on your voicemail? Yes ☐ No ☐

Student's Primary Health Insurance Company (**Please bring insurance card to each visit**.): _____

PLEASE PROVIDE THE FOLLOWING INFORMATION, AND SIGN THE BOTTOM OF THE FORM
ALL INFORMATION REMAINS CONDIFENTIAL.

1. Estimated Income for Family — Count regular gross income of self, parents, stepparents, legal guardian(s), and other income such as child support, alimony, and retirement/disability benefit income.	**$_____weekly** **$_____monthly** **$_____yearly**
2. Number of People in Household — Including self, mother, father, legal guardian(s), stepparents, brothers, sisters, half-brothers, half-sisters, stepbrothers, and stepsisters.	**Total # of People**

Based on the number of family members in your household, and your total family income, the health center will determine if your child will:

- receive services without charge.
- receive services to be billed to you at 50% of established rates, with maximum out of pocket plans
- receive services to be billed to you at 100% of established rates, with maximum out of pocket plans

You will be informed by phone or mail, if it is determined that your child's health center visits will result in billed charges.

SIGN HERE **Parent's Signature:** _____ **Date:** _____

Kintegra Health

AUTHORIZATION FOR use OR Disclosure of PROTECTED INFORMATION:

I, _____ _____

Student's Legal Representative | Relationship to Student

Authorize: *Kintegra Health*
409 South Oakland Street, Gastonia, NC, 28052
704-874-9005

To disclose and exchange information:

☐ *Gaston County Public Schools*
943 Osceola St.
Gastonia, NC 28054
704-866-6100

☐ *Newton Conover City Schools*
605 North Ashe Ave.
Newton, NC 28685
828-464-3191

☐ *Catawba County Schools*
2285 N Anderson Ave.
Newton, NC 28658
828-464-8333

☐ *Hickory Public Schools*
432 4th Avenue SW
Hickory, NC 28602
828-322-2855

☐ *Davie County Schools*
220 Cherry St.
Mocksville, NC 27028
336-751-5921

Regarding:

_____ _____/_____/_____ _____

Student's Name | Student's Date of Birth | Student's Telephone Number

_____

Student's Street Address | City | State | Zip

The following protected information:

☒ *Mental Health Records (i.e., Appointment attendance; diagnoses; treatment plans)*
☐ *Barriers to care/Social Determinants of Health (i.e. Transportation, housing concerns, etc.)*
☐ *Behavioral Health Visit Notes*
☒ *School/Academic Records (i.e., Attendance records, academic grades, psychoeducational test records; special education records, discipline records)*
☐ *Substance use/treatment*
☐ Other: _____

The purpose of this disclosure is: *to provide proof of level of engagement in care and an understanding of barriers and treatment concerns in order to efficiently coordinate care and services.*

This authorization shall be in effect for 12 months from the initial date of request unless otherwise noted below.

STUDENT'S RIGHTS AND AUTHORIZED SIGNATURE:

- I have the right to revoke this authorization at any time by completing a revocation form and returning to a Kintegra staff member.
- 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 the students treatment/academics or payment or eligibility for benefits 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).

_____

Signature of Student's Authorized Representative | Date

Kintegra Health

AUTHORIZATION FOR Use OR Disclosure OF PROTECTED INFORMATION:

I, _____ _____

Student's Legal Representative | Relationship to Student

Authorize: *Kintegra Health*
409 South Oakland Street, Gastonia, NC, 28052
704-874-9005

To disclose to:

☐ Name and Address

_____
_____
_____

Regarding:

_____ _____/_____/_____ _____

Student's Name | Student's Date of Birth | Student's Telephone Number

_____

Student's Street Address | City | State | Zip

The following protected information:

☐ *Mental Health Records (i.e., Appointment attendance; diagnoses; treatment plans)*
☐ *Barriers to care/Social Determinants of Health (i.e. Transportation, housing concerns, etc.)*
☐ *Behavioral Health Visit Notes*
☐ *Psychological Testing/Evaluation (excluding psychotherapy notes)*
☐ *Psychiatric History/evaluation (excluding psychotherapy notes)*
☐ *School/Academic Records (i.e., Attendance records, academic grades, psychoeducational test records; special education records, discipline records)*
☐ *Substance use/treatment*
☐ Other: _____

The purpose of this disclosure is: *to provide proof of level of engagement in care and an understanding of barriers and treatment concerns in order to efficiently coordinate care and services.*

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_____

Signature of Student's Authorized Representative | Date

Rev. Jan 2020