Kintegra Health

School Health Alliance FOR FORSYTH COUNTY

Keeping students healthy, fit and ready to learn.

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/MyChart

I agree to receive text communication from School Health Alliance/Kintegra Y or N Preferred Phone Number: ________________________

*I agree to receive email communication from School Health Alliance/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 School Health Alliance/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

____ **Date:** ______________________________
Signature of Patient, Parent, or Personal Representative

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

Rev. July 2020

<u>**Consent for Healthcare and Release of Medical Information:**</u> 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 School Health Alliance/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 School Health Alliance/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***

<u>**Confidential Services:**</u> 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 School Based Health Center (SBHC) visits and treatments. When an outside referral or services (including prescription medications) is indicated, me and my child's PCP will be informed. 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. <u>(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.)</u>

____ __________________________

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

<u>***FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS:***</u> I guarantee payment to School Health Alliance/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 School Health Alliance/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 School Health Alliance/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

Kintegra Health

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

Release of Information TO and FROM the School Health Alliance for Forsyth County

I, ________________________________ ________________________________

Student's Legal Representative Relationship to Student

Authorize: *School Health Alliance for Forsyth County*
P.O. BOX 573167/Medical Center Blvd.
Winston-Salem, NC 27157-3167

TO disclose and exchange:

☐ Name and Address
Students Doctor/PCP Provider
(If you do not have, write "none"
____

____

☐ 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*
☐ *Immunization Records*
☐ *Date/ Note from Last Well Child Exam*
☐ *Psychological Testing/Evaluation (excluding psychotherapy notes)*
☐ *Psychiatric History/evaluation (excluding psychotherapy notes)*
☐ *Substance use/treatment*
☐ Other: ____

The purpose of this disclosure is: *This information will be used for the purpose of coordinating and providing health/mental health care for the students as well as for providing supports to the students.*

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

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

Release of Information To and From the School Health Alliance for Forsyth County

I, ___________________________________ ___________________________________

Student's Legal Representative Relationship to Student

Authorize:

Winston/Salem/Forsyth County School
P.O. Box 2513 Winston-Salem, NC 27102-2513

To disclose to and exchange:

☒ School Health Alliance for Forsyth County
P.O. Box 573167/Medical Center Blvd.
Winston-Salem, NC 27157-3167

Regarding:

____________________________________ _____/_____/________ ____________________________

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

____

Student's Street Address City State Zip

The following protected information:

☐ *School/Academic Records (i.e., Attendance records, academic grades, psychoeducational test records; special education records, discipline records, End Of Grade (EOG) AND End of Course (EOC) test scores, other academic achievement test records, Student Assistance Team records,*

☐ *Mental Health Records (i.e., Appointment attendance; diagnoses; treatment plans)*

☐ Other: ____

The purpose of this disclosure is: *This information will be used for the purpose of coordinating and providing health/mental health care for the students as well as for providing supports to the students.*

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.
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- 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

Rev. Jan 2020

Kintegra Health

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

School-Based Health Center Program Billing Policy

The School Health Alliance (SHA) for Forsyth County is a partner and supporting organization to our WS/FCS district, operating comprehensive school-based health center clinics and programs in select schools within our school district. Services provided include medical, nutrition, behavioral health, and psychiatry.

- 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%

- SHA/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.
- SHA 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 SHA or the Kintegra Business Service Administrator.

* Check with SHA/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.

My signature below acknowledges that I have read and understand the SHA Billing Policy Facts and the NC Laws Addressing the Care of Minors as stated above.

Signature: ______________________________ Date: ________________

Name (Print): ______________________________

Form 103
(08/20)

Kintegra Health

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

Student's Grade: ______

Registration Form

Student's Name: ____
Last First Middle

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

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 present, please list any other adults who may accompany your child in person to the health center for a visit and/or authorize a virtual 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

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Authorizations for MyChart, Health Information Exchange, Virtual Visits, and Student Devices

What is MyChart?

MyChart offers patients personalized and secure on-line access to portions of their medical records. It enables you to securely use the Internet to help manage and receive information about your health. You can also view your health summary from the MyChart electronic health record, view your test results, and send secure non-emergent messages to your providers. MyChart also has a feature that allows the delivery of healthcare services and support using encrypted, secure video calls through Zoom for your telemedicine/telehealth/virtual visit appointments.

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.

What is the Health Information Exchange (HIE)?

The Electronic Health Information Exchange (HIE) allows doctors, nurses, pharmacists, other health care providers, and patients to appropriately access and securely share a patent's vital medical information electronically to improve the quality and safety of patient care and the patient experience.

- **As a School Health Alliance** student I understand I am automatically enrolled in the Health Information Exchange (HIE), 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.

____

Signature of Patient, Parent, or Personal Representative

Date: _______________________________

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

What are telemedicine/telehealth/virtual visits?

These 3 words can be used with the same meaning. Telemedicine/telehealth/virtual visits the delivery of health care services and clinical support through information and communication technologies such as computers, the Internet, and/or cell phones. These types of visits allow for the exchange of valid information for diagnosis, treatment, and prevention of disease and injuries in an effort to improve your health and well-being. Telemedicine/telehealth/virtual visits have been used for decades to provide care, and are an especially helpful way to deliver and receive care during the current pandemic.

Permission for Student Devices

I, ____(name of parent), give my permission for the School Health Alliance for Forsyth County (SHA) to contact my child, _______________________________ (name of child), on any of their student devices (including student cell phone, Chromebook/tablet/iPad, or laptop/desktop computer) to schedule or provide medical, counseling, or psychiatry services for my child.

Signature: ____ Date: _____________

Name (Print): ____

School Health Alliance
FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

Parent/Guardian Questionnaire

CONFIDENTIAL

Staff will keep your answers private. We will not share the information obtained from you unless we have your written permission. Please return the questionnaire in the sealed envelope provided.

Date ____________ Student's Name ____ Student's Date of Birth ____________

Student Health History Current Grade: __________________

Medication allergies: ☐None	**Reaction:**
Other allergies: ☐None	**Reaction:**

Daily Medications: ☐None	**Reason for taking:**	**Dose/times:**

Preferred Pharmacy: **Location:**

Chronic Medical Conditions for your child (Check (✓) all that apply.)

Diabetes .... ☐	Attention Deficit Disorder (ADD/ADHD)....... ☐	Asthma ....☐	Heart Problems .... ☐
Kidney Disease.......... ☐	Mental Illness/Depression .... ☐	Migraines ....☐	Other .... ☐
Seizures .... ☐	Sickle Cell Disease.................................... ☐	Anemia ....☐	________________________

Has there been any change in your child's health in the past year? ☐ Yes ☐ No If yes, explain ____________________________
____

Has your child had a **complete physical exam** in the past year? ☐ Yes ☐ No
If yes, Date ____________________ Name of physician/practice ____

Has your child been to the emergency department in the past year? ☐ Yes ☐ No If yes, describe ___________________________

Has your child been hospitalized overnight for medical or mental health reasons? ☐ Yes ☐ No If yes, describe the issue and age at hospitalization ____

Date of last dental exam: _______________ Name of dentist/practice ____

Has your child ever had any serious sports-related injuries? ☐ Yes ☐ No If yes, describe the injury, age at time of injury. ________
____

Household Information

Please name the people living in your household and their ages: Example: Father (40), Stepmother (40), Sisters (6 & 8), Uncle (50), etc.

Is there a gun in your household? ☐ Yes ☐ No

Does anyone in your household smoke? ☐ Yes ☐ No

Family Medical History

Does anyone in your child's *immediate* family have any current health concerns?

Family Member	Age	Health Concern?
• Mother	________	☐None; Yes, *(Please specify)* ____________________________
• Father	________	☐None; Yes, *(Please specify)* ____________________________
• Siblings	________	☐None; Yes, *(Please specify)* ____________________________
• Other____________________	________	☐None; Yes, *(Please specify)* ____________________________

Parental/Guardian Concerns

Please review the topics listed below and check (✓) if this is a concern you have about *your* son or daughter.

Mental health .... ☐	Choice of friends ....☐	School performance ....☐
Weight/eating.. ☐	Sleep...☐	Smoking/Vaping ....☐
Relationships with family member............. ☐	Sexual behaviors.......................................☐	Drug use ....☐

Form-258
(01/18)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.