

School: _____

Grade: _____

Student's Legal Name (Last, First, Middle):		Date of Birth:		Preferred Name:	
Demographics:					
Race: <input type="checkbox"/> Black / African American <input type="checkbox"/> More than one race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian /Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other - Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unreported /Refuse to report race			Birth Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Undefined Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female/Trans Woman/Male-to-Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/Trans Male/Female-to-Male (FTM) <input type="checkbox"/> Non-Binary <input type="checkbox"/> Additional gender/Other Please specify: _____ <input type="checkbox"/> Choose not to answer		
Parent/Guardian Phone Number: Home: (____) ____ - ____ Cell: (____) ____ - ____ Student Phone Number: Cell: (____) ____ - ____		Student lives with: (physical residence) <input type="checkbox"/> Both Parents <input type="checkbox"/> Parent 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Grandparent(s): _____ Legal Guardian: _____ Person Acting in Place of Parent: _____ _____ *note self if student lives independently			
Parent / Guardian(s) Name:			Parent / Guardian(s) Name:		
Date of Birth: ____/____/____	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	SSN: ____-____-____	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> Female <input type="checkbox"/> 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:	
Emergency Contact 1:		Relationship:		Home Phone:	
				Cell Phone:	
Do you have a medical provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			Medical Provider Name:		
Do you have a dental provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dental Provider Name:		
Is there a CUSTODY agreement in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, list primary custodian:					

Student Enrollment

Insurance Information: <input type="checkbox"/> Check this box if your child has no insurance coverage or insurance deductibles/co-pays.					
Primary Insured's Name:			Secondary/Supplemental Insured's Name:		
Date of Birth (mm/dd/yyyy): SSN: ____ - ____ - ____ ____ / ____ / ____			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:			Effective Date:		
Guarantor Name:	Relationship to Patient:		Guarantor Name:	Relationship to Patient:	
Person Responsible for Payment: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian or Other: _____					
Preferred Method of Communication: <input type="checkbox"/> Postal Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> 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.					

Financial Responsibility and Assignment of Benefits

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 Kintegra Health 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's Signature: _____

Date: _____

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, and any other health information you desire to share. The following people may request and receive information about: Appointments Financial Treatment Referrals Other: _____

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

Student Name: _____ Date of Birth: _____ Rev. July 2022

Consent to Treat and Confidentiality

Consent for Healthcare and Release of Medical Information: I voluntarily consent to Behavioral Health/Mental Health treatment for _____ from _____
(Child's Name) (Child's Date of Birth)

Behavioral Health providers, and staff of Kintegra Health. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatments 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 behavioral/mental health 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). I may withdraw authorization for medical or behavioral health services at any time.

SIGN HERE → Parent's Signature: _____ 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 medical 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 Kintegra Health 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 health center visits and treatments.

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

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.

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

Student Name:

Date of Birth:

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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. 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.

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 patient’s vital medical information electronically to improve the quality and safety of patient care and the patient experience.

- As a Kintegra Health 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.

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

Kintegra 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 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.
- ◆ KINTEGRA will bill Medicaid, NC Health Choice and private insurance plans. Families needing assistance with financial responsibility may qualify 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 Behavioral Health Patient Navigator.

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

Student Name:

Date of Birth:

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School Based Health Center Sliding Scale Application

Student Name: _____ Student's Date of Birth: _____
 Last First Middle (mm/dd/yyyy)

Parent/Guardian Name: _____
 Last First Middle

Kintegra Health is dedicated to providing quality health care including health education and preventative case services to all members of the community regardless of financial barriers (ability to pay) through regular publication of school sliding fee scale. Kintegra Health will annually revise and re-issue its sliding scale to reflect changes in the Federal Poverty guidelines.

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

PLEASE PROVIDE THE FOLLOWING INFORMATION, AND SIGN THE BOTTOM OF THE FORM IN ORDER TO BE CONSIDERED FOR ANY ASSISTANCE IN PAYMENT OF SERVICES

ALL INFORMATION REMAINS CONFIDENTIAL

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.

Student Name:

Date of Birth:

Rev. July 2022

Student Enrollment

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

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 between:

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 student's 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).

SIGN HERE

Parent's Signature: _____

Date: _____

Student Name:

Date of Birth:

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Student Enrollment

Signature of Student’s Authorized Representative

Date

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 between:

Name and Address of Medical Provider:

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
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Signature of Student’s Authorized Representative

Date

Student Name:

Date of Birth:

Rev. July 2022