Kintegra Health

Adult – Consents

Patient Name: _____ Date of Birth: _____

Consent for Healthcare and Release of Personal Health Information:

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care, and/or Behavioral Health) from the providers and staff of Kintegra Health, Inc. and all it's affiliates. 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 is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that Kintegra employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra 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. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. 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. This consent is renewable annually. I may withdraw authorization for services at any time. **Initial** _____

Notice of Privacy Practice Acknowledgement:

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows: http://www.kintegra.org, by writing to Kintegra Health Privacy Office, 200 E. Second Ave, Gastonia, NC 28052, or by requesting one at any Kintegra Health Provider locations. **Initial** _____

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Kintegra Health and its affiliates for all charges for services provided to me 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 health 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, VIII, and/or XIX of the Social Security Act is correct. **Initial** _____

_____ _____

Signature of Patient or Authorized Person Date

_____ _____

Insured Party or Financial Guarantor (if different from above) Date

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

Kintegra Health

ADULT- Patient Information

PATIENT DEMOGRAPHICS **DATE OF COMPLETION** (mm/dd/yyyy): _____

Legal Name (Last, First, MI):	***Preferred Name:***	***Primary Doctor:***

Date of Birth (mm/dd/yyyy): _____/_____/_____

SSN: _____-_____-_____

Birth Sex:
☐ Female ☐ Male ☐ Other ☐ Undefined

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

Ethnicity:
☐ Hispanic ☐ Non- Hispanic

Sexual Orientation –
☐ Straight or Heterosexual
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Something else
☐ Don't know
☐ Choose not to answer

Marital Status:
☐ Single ☐ Married
☐ Divorced
☐ Separated ☐ Widow / Widower

Gender Identity: (Check one):
☐ Male ☐ Female
☐ Transgender Male/ Trans Man/
☐ Female-to-Male (FTM)
☐ Transgender Female/ Trans Woman/
☐ Male-to-Female
☐ GenderQueer
(neither exclusively male nor female)
☐ Additional gender category/ Other.
Please specify: _____
☐ Chose not to answer

Disabled: ☐ Yes ☐ No Homeless: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

Home Address:	***City***	***State***	***Zip code***

Home Phone:	***Cell Phone:***	***Work Phone:***	***Email Address:***

Preferred method of communication: ☐ Postal Mail ☐ Phone ☐ Email / Text

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

Responsible Party:	***Relationship:***	***Date of Birth*** (mm/dd/yyyy): _____/_____/_____	**SSN:** _____-_____-_____

Responsible Party Home Address:	***City***	***NC***	***Zip code***

Employer / School:

Would you like information on advance directives? (Living Will, Health Care Power of Attorney, etc.) ☐ Yes ☐ No

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INSURANCE INFORMATION

Primary Insured's Name: _____ ***Date of Birth (mm/dd/yyyy)*** | ***SSN:*** _____-_____-_____ _____/_____/_____		***Secondary Insured's Name:*** _____ ***Date of Birth*** (mm/dd/yyyy) | **SSN:** _____-_____-_____ _____/_____/_____	
Primary Insurance:	***Employer:***	***Secondary Insurance:***	***Employer:***
Insurance ID Number:	***Group Number:***	***Insurance ID Number:***	***Group Number:***

Primary Insurance Address:	***City***	***NC***	***Zip code***
Secondary Insurance Address:	***City***	***NC***	***Zip code***

Signature of Patient or Authorized Person: _____ ***Date/Time*** _____

Insured Party or Financial Guarantor (if different from above): _____ ***Date/Time*** _____

FOR STAFF 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 at no additional cost:

☐ LEP: Interpreter accepted _____ ☐ LEP: Interpreter Refused: _____

Name / Number of Person/Services Chosen/Used

Kintegra

Family Medicine

Please take time to fill out this form.
Thank you for trusting us with your care.

Date Completed_____
Name_____ Date of Birth_____
Form Completed by □Self □Other:_____
Preferred Pharmacy_____
Reason for Visit_____
Email address _____
Preferred method of communication:
□ Email □ Phone □ Mail

PATIENT MEDICAL HISTORY

□ Blood Disease	□ Heart Disease	□ Osteoporosis
□ Breast Disease	□ High Blood Pressure	□ Rheumatology/Arthritis
□ Cancer	□ HIV	□ Skin Problems
□ Diabetes/Thyroid Problems	□ Kidney Problems	□ Stroke/Seizures
□ Female Problems	□ Lung Problems (COPD, Asthma)	□ Stomach Problems
□ Head, Eyes, Ear, Nose, Throat	□ Male Problems	□ STI/STD
	□ Mental Illness	□ Other

LAST SPECIALTY VISIT/HOSPITALIZATION/SURGERY

Reason Date

_____

_____

□ None

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Don't Know
Bleeding Problems	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□
Diabetes/Thyroid Problems	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□
Kidney Problems	□	□	□	□	□	□	□
Mental Illness /Depression	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□
Stroke/Seizures	□	□	□	□	□	□	□
Substance Abuse	□	□	□	□	□	□	□

PREGNANCY HISTORY

Currently Pregnant □ Yes □No □Not Applicable

Past Pregnancies #_____ Dates (Month/Year)_____ Abortions/Miscarriages # _____

MEDICATION

List any prescription and non-prescription medication you take regularly (include OTC, herbals, vitamins, etc.)

_____

_____

_____

_____

ALLERGIES

Allergies	Reaction

□ No Known Allergies

IMMUNIZATION (SHOT) HISTORY

	Date (Mo/ Yr)	Where
□ Flu		
□ Pneumonia		
□ Tetanus		
□ Hep A		
□ Hep B		

WELL CARE

	Date (Mo/Yr)	Results		Where
Last Menstrual Cycle				
Last PAP test		□ Normal	□ Abnormal	
Last Mammogram		□ Normal	□ Abnormal	
Colonoscopy		□ Normal	□ Abnormal	
Prostate Cancer Screening		□ Normal	□ Abnormal	
TB Screening		□ Normal	□ Abnormal	
HIV Screening		□ Normal	□ Abnormal	
Hep C Screening		□ Normal	□ Abnormal	

HEALTH HABITS

□ Tobacco	□ Cigarettes ____ packs/day □ Interest in stopping	□ Cigars/Pipes □ No interest in stopping	□ Chew/Dip
□ Alcohol	Amount _____ _____/day		
□ Physical Activity	Minutes_____/day	# Days____/week	
□ Caffeine	Cups_____/day		
□ Sexual Activity	□ Inactive	□ One Partner	□ More than one partner
□ Seatbelt use	□ Always	□ Sometimes	□ Never
Are you satisfied with your eating habits?		□ yes	□ no

SOCIAL CONSIDERATIONS

Are there any religious/ cultural consideration regarding your care? □ yes □ no
If yes, please explain _____
Are you having any experiences at home that make you feel unsafe? □ yes □ no
If yes, please explain _____
Preferred Language _____

LEARNING NEEDS ASSESSMENT

Do you have any of the following?

Learning disabilities	□ yes	□ no
Visual limitations	□ yes	□ no
Hearing limitations	□ yes	□ no

If yes, please explain _____
Required Accomodations_____

Permission to Communicate - Authorization for Release of Information

Name of Patient _____ Date of Birth (MM/DD/YYYY) _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Facility Name

So that Kintegra Health may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss your appointments, referrals, test, lab results and any other health information you desire us to share.

Describe how information will be received. Check each person/entity that you approve to receive information.	**Describe the information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Mail	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other_____
☐ Other person(s): Name / Phone Number / Relationship _____ _____ _____	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other _____
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ *For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

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 that my treatment will not be conditioned on signing.
- 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.

This authorization will remain in effect until revoked by the patient.

_____ Date _____
Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

☐ I am revoking my authorization to disclose the previously requested protected health information.

_____ Date _____
Signature of Patient or Personal Representative