Kintegra Health

Pediatric – 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) for my child 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. **I understand that North Carolina 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. 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

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

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
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 ☐ 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: _____					

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

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

_____ _____

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

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.	**Describe the information to be released.**
Check each person/entity that you approve to receive information.	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_____

Please sign on the back

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