Kintegra Health

Patient Enrollment
Date of Completion: _____

School: _____ **Program of Study_____** **Full-time/Part-time**

Patient's Legal Name (Last, First, Middle): Date of Birth:	Preferred Name:

Demographics:

Race: ☐ Black / African American ☐ More than one race ☐ White ☐ Asian ☐ American Indian /Alaska Native ☐ Native Hawaiian ☐ Hispanic/Latino ☐ Other - Pacific Islander ☐ Unreported /Refuse to report race	**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
Patient Phone Number: Cell: (_____) _____-_____ Disabled: ☐ Yes ☐ No Homeless: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No	Patient lives with: (physical residence) ☐ Parent(s) ☐ Roommate(s) ☐ Alone ☐ Other: _____ Legal Guardian: _____ Person Acting in Place of Parent: _____ *note **self** if patient lives independently

Patient Name:			Parent / Guardian(s) Name:		
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:	

Do you have a medical provider? ☐ Yes ☐ No **Medical Provider Name:**

Do you have a dental provider? ☐ Yes ☐ No **Dental Provider Name:**

Insurance Information: ☐ Check this box if you have 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: ☐ Mother ☐ Father ☐ Self ☐ 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.

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 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.

Sign Here **Patient 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

Consent to Treat and Confidentiality

Consent for Healthcare and Release of Medical Information: I, _____, _____,
(Patient's Name) (Patient's Date of Birth)
voluntarily consent to Behavioral Health/Mental Health treatment from 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 Clients Rights and Health Information Protection Act (Privacy Notice). I may withdraw authorization for medical or behavioral health services at any time.

Sign Here **Patient Signature:** _____ **Date:** _____

Confidential Services: Counseling often involves the disclosure of personal information. State laws and professional ethical codes dictate that the information discussed during the counseling session will be strictly confidential, if you are 18 years of age or older. I cannot and will not disclose to anyone what we discuss in session, or that you are even in counseling, without your written permission.

Exceptions: The following are legal exceptions to your right to confidentiality.

Harm to self: If there is evidence that an individual poses clear and imminent danger of harming themselves, the counselor may have to notify the hospital, school officials, law enforcement, and/or family members who may be able to assist with the matter.
Harm to others: If there is reason to believe that you will harm another person, the counselor must attempt to inform the intended victim, school officials, as well as law enforcement.
Child/ Elder Abuse or neglect: Counselors who know or reasonably suspect that a child under the age of 18 is being abused and/or neglected are legally obligated to report this information to the appropriate state agencies. This also applies in cases of elder abuse and/or neglect.
Court order: If your records are ordered by the court of law, the counselor will do what they can to protect confidentiality-within the limits of abiding by the law.

Sign Here **Patient 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 **Patient 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 you continuity of services in the event of a school closure and during the summer months.

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 patient 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.

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 student/family income and insurance plan guidelines.
- ♦ Students/Families without insurance will be charged according to the following sliding fee scale based on the Federal Poverty Level (FPL)*. Students/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.

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

- ♦ KINTEGRA will bill Medicaid, NC Health Choice and private insurance plans. Students/ 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 and/or a student's family before providing a service which may result in a charge to the student/family and will follow requirements of the student's insurance plan whenever possible.
- ♦ Students are responsible for copayments, deductibles and payment for services not covered by insurance.
- ♦ Students/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.

School Based Health Center Sliding Scale Application

Patient Name: Date of Birth: Rev. August 2022

Patient Enrollment

Patient Name: _____ Patient's Date of Birth: _____

Last First Middle (mm/dd/yyyy)

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%

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

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**

- 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 health center visits will result in billed charges.

Sign Here

Patient Signature: _____ **Date:**

_____

AUTHORIZATION FOR use OR Disclosure of PROTECTED INFORMATION:

I, _____ _____

Patient's Name Date of Birth

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:

_____ _____/_____/_____ _____

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

_____

Patient'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.

PATIENT'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 patient'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/oralcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or HIV).

_____

Patient Signature Date

Patient Name: Date of Birth: Rev. August 2022