Kintegra Health

Student Enrollment

School: _____ **Grade: _____**

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

Student Demographics

Student Race: ☐ Black / African American ☐ More than one race ☐ White ☐ Asian ☐ American Indian /Alaska Native ☐ Native Hawaiian ☐ Other - Pacific Islander ☐ Hispanic/Latino ☐ Unreported /Refuse to report race	**Student lives with: (physical residence)** ☐ Both Parents ☐ Parent 1 ☐ Parent 2 ☐ Grandparent(s): _____ **Legal Guardian:** _____ Person Acting in Place of Parent: _____ _____ *note **self** if student lives independently
Student Phone Number: Cell: (_____) _____-_____ **Student Email Address:** _____	**Student Birth Sex**: ☐ Female ☐ Male ☐ Other ☐ Undefined **Student Social Security Number:** _____

Parent / Guardian(s) Information **Name:**			**Parent / Guardian(s) Information** **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:	Cell Phone:		Home Phone:	Cell Phone:	
E-Mail Address:	Employer Name:		E-Mail Address:	Employer Name:	
Emergency Contact 1:	Relationship:		Emergency Contact 1:	Relationship:	

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

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

Is there a CUSTODY agreement in place? ☐ Yes ☐ No **If so, list primary custodian:**

Insurance Information: ☐ 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: ☐ Mother ☐ Father ☐ Guardian or Other: _____

Preferred Method of Communication:

☐ Postal Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Web Message

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 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 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 _____**

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

_____ _____

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

Student Name: Date of Birth: Rev. July 2022

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.

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.

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.

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:** _____

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

_____

Signature of Student's Authorized Representative Date