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 its 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. I understand that my medical information could include medical history or information regarding diagnosis and treatment for a communicable disease (such as a sexually transmitted infection, HIV/AIDS or hepatitis), mental illness, alcohol or substance use. 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.Nov. 2022

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**:

Race:
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Koren
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race
- ☐ Unreported/Chose Not to Disclose

Ethnicity:
- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic/Latino(a)/Spanish Origin
- ☐ Hispanic/Latino(a)/Spanish Origin/Combined
- ☐ Non-Hispanic/Latino(a)
- ☐ Unreported/Chose Not to Disclose

Birth Sex:
- ☐ Female
- ☐ Male
- ☐ Other
- ☐ Undefined

Sexual Orientation:
- ☐ Straight or Heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Chose Not to Answer

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

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

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

Home Address:	***City***	***NC***	***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:

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***_____

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

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_____

Behavioral Health Questionnaire (PHQ-2)

Please help us provide you with the best medical care by answering the questions below.

	Not At all	Several Days	More Than Half the Days	Nearly Every Day
During the past two weeks, how often have you been bothered by little interest or pleasure in doing things?	0	1	2	3
During the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?	0	1	2	3

Drug & Alcohol Screening

Are you currently in recovery for alcohol or substance use? _____ No _____ Yes
(0) (1)

Alcohol: One drink =

12 oz. Beer

5 oz. Wine

1.5 oz. Liquor (One Shot)

		None	1 or more
Men < 65	How many times in the past year have you had 5 or more drinks in a day?	0	1
Women (& Men > 65)	How many times in the past year have you had 4 or more drinks in a day?	0	1

Drugs: Recreational drugs include cannabis (marijuana, pot), cocaine, stimulants (Ritalin, Concerta, Adderall), methamphetamine (speed, crystal), inhalants (paint thinner, aerosol, glue), sedatives (Valium, Xanax, Rohypnol), hallucinogens (LSD, mushrooms, ecstasy), street opioids (heroin). Prescription opioids include fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine.

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	0	1

Office Use Only PHQ-2 _____ *Screen + if Score >2* D&A Screen_____ *Screen + Score >0*

Height_____Weight_____BMI_____WC_____

BP_____ Pulse_____ Resp_____ Temp_____

INR_____ BS_____HbgA1C_____O2Sat_____

Patient Code of Conduct

Patient Name: _____

We at Kintegra Health are committed to providing the highest quality care to our patients. We expect our patients to behave in a manner that is respectful to our staff and other patients. In order to ensure a safe and comfortable environment for everyone, we ask that you abide by the following code of conduct:

Respect
Patients should respect the healthcare professionals treating them, as well as other patients in the facility. This includes refraining from any type of verbal or physical abuse, discriminatory language, or any other behavior that may be offensive to others. Patients should also respect the privacy and confidentiality of other patients, as well as their own.

Communication
Patients should communicate openly and honestly with their healthcare providers. This includes providing accurate information about their medical history, symptoms, and any medications or treatments they are currently receiving. Patients should also ask questions and seek clarification, when necessary, to ensure they have a clear understanding of their diagnosis, treatment plan, and any other medical issues.

Compliance
Patients should follow the treatment plan prescribed by their healthcare provider. This includes taking medications as directed, attending scheduled appointments, and following any other instructions or recommendations provided by their healthcare team. Patients should also inform their healthcare provider of any changes in their health or medical condition.

Safety
Patients should take responsibility for their own safety and well-being. This includes informing their healthcare provider of any allergies or adverse reactions to medications, reporting any incidents or concerns related to safety, and following all safety guidelines and protocols established by the healthcare facility.

Environment
Patients should respect the healthcare facility and its resources. This includes keeping the facility clean, following all rules and regulations, and using resources appropriately.

Appointments
Patients should keep all scheduled appointments or notify the practice 24 hours in advance if there is a need to cancel. Excessive No-Shows may lead to discharge from Kintegra Health services.

We reserve the right to refuse service to any patient who does not comply with this code of conduct. We appreciate your cooperation in helping us maintain a safe and respectful environment for everyone.

Acknowledgement

I have read Kintegra Health's Patient Code of Conduct and I understand and agree to abide by the COC.

_____ _____
Patient Printed Name Patient Date of Birth

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (If applicable) Date

Patient Label
Or

Printed Name_____

Date of Birth _____

MRN _____

Kintegra Health Communication Consent

I give permission to Kintegra Health to contact me on my cell phone, home and/or work phone using prerecorded messages, artificial voice messages, automatic dialing devices or other computer assisted technology, or by e-mail, text messaging, or by any other form of electronic communication, based on my communication preferences. Standard messaging rates may apply. Information sent via these methods may include billing and payment, appointment, and/or medical information.

I understand that for e-mail and/or text communication that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive e-mail and/or text communications.

This disclosure form is in effect until changed or revoked by me. Only I can change who is named on this form to communicate with Kintegra Health about my health information. At the time of change or revocation, I will complete a new form. Emergency contacts are not included in this consent.

I understand that the release of copies of my medical records requires a specific authorization form signed by myself or my legal representative. These communications may occur when the identified person(s) joins me at my visit, or communicates for me by telephone, e-mail, or other electronic method.

I give permission for Kintegra Health to communicate with the following person(s) regarding:

- ☐ My billing and payment information.
- ☐ Appointment management, including scheduling, cancelling, and rescheduling of appointments.
- ☐ Medical information, including diagnosis, results, and treatment plans.

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

- ☐ I decline any communication with others outside of myself or legal guardian(s).
- ☐ I opt out of any communication except for appointment reminders.

Signature: _____ Date: _____
(Patient or person legally authorized to sign for patient)

Printed Name: _____