Kintegra Health

Pediatric – Patient Informaton

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.

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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

The child lives with:

☐ Both parents ☐ Parent 1 ☐ Parent 2

☐ Grandparent: _____

Legal Guardian: _____

Person Acting in Place of Parent: _____

Parent 1/Guardian Information:

Name: _____

DOB: ____/____/_____ **SSN:** ____-_____-_____ **Sex:** ☐ Female ☐ Male

Address:_____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Employer Name: _____

Parent 2/Guardian Information:

Name: _____

DOB: ____/____/_____ **SSN:** ____-_____-_____ **Sex:** ☐ Female ☐ Male

Address:_____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Employer Name: _____

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

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

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

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

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

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:***		
Relationship to Patient:		***Relationship to Patient:***			
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 Parent/Legal Guardian: _____***Date/Time***_____

Printed Name of Parent/Legal Guardian : _____

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

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: _____