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| **Patient Information** |
| **Patient’s Legal Name (Last, First, Middle):**  | **Date of Birth:****\_**\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | **Preferred Name:** |
| **Patient Phone Number:**  | **Patient Email Address:**  |
| **Preferred Method of Communication:**  🞏 Postal Mail 🞏 Home Phone 🞏 Cell Phone 🞏 Email 🞏 Text 🞏 Web Message |
| **Patient Social Security Number:****\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_** | **Other:** 🞏 Veteran 🞏 Disabled 🞏 Homeless 🞏 Migrant/Seasonal Worker | **Patient Birth Sex**: 🞏 Female 🞏 Male 🞏 Other 🞏 Undefined |
| **Patient Address** | **City** | **State Zip** |
| **Patient 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  | **Patient Race:**🞏 American Indian/Alaska Native 🞏 Asian Indian🞏 Black/African American 🞏 Chinese 🞏 Guamanian or Chamorro 🞏 Filipino 🞏 Japanese 🞏 Korean 🞏 More than one race           🞏 Unreported/Chose Not to Disclose       | 🞏 Native Hawaiian 🞏 Other Asian 🞏 Other Pacific Islander 🞏 Samoan   🞏Vietnamese  🞏 White       |
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| **Parent/Guardian Name:** |
| **Address:** |
| **City:**  | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** |
| **E-Mail Address:** |

**Emergency Contact** Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Emergency Contact Phone:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Patient Insurance Information (Medical and/or Dental)** |
| 🞏 **Check this box if you have no insurance coverage or insurance deductibles/co-pays.** |
| **Primary Insured’s Name** | **Primary Insured’s Date of Birth****\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | **Primary Insured’s SSN:****\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_** |
| **Insurance Company’s Name:** **Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Policy Number:****Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Group Number:** **Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Insurance Company’s Claim’s Address: City: State: Zip:** **Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Insurance Company’s Phone Number:****Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Effective Date:** **Medical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Current Medical Provider Name:** | **Current Dental Provider Name:** |

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| **Permission to Communicate** |

So that Kintegra Health may serve you better, you have the option 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

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Voicemail - Y or N**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Voicemail - Y or N**

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| **Consent for Healthcare and Release of Personal Health Information** |

I voluntarily consent to healthcare treatment: Medical Dental, and/or Optometry for my child from the providers and staff of Kintegra Health, Inc. and all its affiliates. (Applicable only for services offered at your school.) 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, staff members, and school personnel involved in my child’s care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about my child for treatment, payment, and healthcare operations. If covered by Medicare or Medicaid, I certify that the information provided about my child, 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 my child is automatically enrolled in the Health Information Exchange, but at any time can opt-out by completing an Opt-out form provided by the 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 \_\_\_\_\_\_\_**

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| **Notice of Privacy Practices** |

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 \_\_\_\_\_\_\_**

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| **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 \_\_\_\_\_\_\_**

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**Patient/Parent/Guardian/ Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Patient/Parent/Guardian**

**School Based Health Center Sliding Scale Application**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                              Last                              First                       Middle             (mm/dd/yyyy)

**Every student can complete the Sliding Scale Application, regardless of insurance status.**  This application serves to help determine if there is any discounted rate for services.  **No enrolled student will be denied services because of inability to pay.** Fees are based on family income and insurance plan guidelines.  Students without insurance will be charged according to the following sliding fee scale based on the Federal Poverty Level (FPL)\*.  Students 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.  **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.**  Students are responsible for copayments, deductibles and payment for services not covered by insurance.  Students may request an explanation or reconsideration of a billing issue by contacting the Kintegra Billing Department at (704)730-7003.

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| **FPL**  | 0-100% | 101-133% | 134-166%  | 167 - 200%  | 201% +  |
| **Nominal Fee**  | $0  | $0.25 | $0.50 | $0.75 | Full Charge  |

\***Out of pocket maximum for students is $100.00 per month**.\*

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| **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 you 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 health center visits will result in billed charges.

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**Patient/Parent/Guardian Signature** **Date**

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| **Telehealth Services** |

The purpose of Telehealth Services is to provide you, or your child, with care in certain situations, such as when you become ill at school or during periods of school closure. By signing below, you are acknowledging that you understand the risks and benefits of receiving treatment through school-based health service and you give consent for us to treat you virtually by telehealth. Telehealth is the use of electronic information and communication technologies by a health care provider (using interactive audio, video, or data communications) to deliver services to you when you are at school (or out of school) and the provider is located at a different place. Not every condition can be treated by telehealth. If your treatment provider believes you would be better served by in-person treatment you will be notified and referred to an in-person setting for further care. If your condition is determined to be emergent, the school and/or the provider may send you to the hospital. Telehealth encounters are subject to the requirements of the HIPAA privacy rule that apply to protected health information (outlined in the release of information section). If you text or email us with patient information in an unsecured manner, you understand that patient information could be viewed by someone other than us. There is a risk that treatment provided using telehealth could be disrupted due to technical failures.

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Patient/Parent/Guardian Signature Date**

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| **Medication Consent – \*For Schools with Medical Services Only\*** |

I give Kintegra Health permission to administer the following medications to my child as needed. Please initial beside the medication listed below that apply:

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| **Medication (Over the Counter)** | **Initial Here** | **Medication (Over the Counter)** | **Initial Here** |
| Tylenol (acetaminophen) |  | Benadryl or Zyrtec (Allergies) |  |
| Advil (ibuprofen) |  | Neosporin (cuts or scratches) |  |
| Tums (calcium carbonate) |  |  |  |