

School Name: _____

Student Information			
Student's Legal Name (Last, First, Middle):		Date of Birth: ____/____/____	Preferred Name:
Student Phone Number:		Student Email Address:	
Preferred Method of Communication: <input type="checkbox"/> Postal Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Web Message			
Student's Social Security Number: _____-____-____		Other: <input type="checkbox"/> Disabled <input type="checkbox"/> Homeless <input type="checkbox"/> Veteran	Student Birth Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Undefined
Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female/ Trans Woman/ Male-to-Female (MTF) <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/ Trans Male/ Female-to-Male (FTM) <input type="checkbox"/> Gender Fluid (neither exclusively male or female) <input type="checkbox"/> Additional gender/Other: _____ <input type="checkbox"/> Choose not to answer		Student Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported/Chose Not to Disclose	
Student Ethnicity: <input type="checkbox"/> Mexican/Mexican American/Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic/Latino(a)/Spanish Origin <input type="checkbox"/> Hispanic/Latino(a)/Spanish Origin/Combined <input type="checkbox"/> Non-Hispanic/Latino(a) <input type="checkbox"/> Unreported/Chose Not to Disclose			
Student Address:		City	State Zip
Emergency Contact Name:	Relationship:	Emergency Contact Phone Number:	
Do you have a medical provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medical Provider Name:	
Do you have a dental provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental Provider Name:	
Student Insurance Information			
<input type="checkbox"/> 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:	Policy Number:	Group Number:	
Insurance Company's Claim's Address:		City:	State: Zip:
Insurance Company's Phone Number:		Effective 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

Name: _____ Relation: _____ Phone: _____ Voicemail - Y or N
Name: _____ Relation: _____ Phone: _____ Voicemail - Y or N

Consent for Healthcare and Release of Personal Health Information

I voluntarily consent to healthcare treatment ☐ 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, staff members, and school personnel 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. This consent is renewable annually. I may withdraw authorization for services at any time.

Initial _____**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** _____

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.

Student Signature _____**Date** _____**Telehealth Services**

The purpose of Telehealth Services is to provide you 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 the 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.

Student Signature _____**Date** _____

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.

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.

<p align="center">PLEASE PROVIDE THE FOLLOWING INFORMATION, AND SIGN THE BOTTOM OF THE FORM IN ORDER TO BE CONSIDERED FOR ANY ASSISTANCE IN PAYMENT OF SERVICES</p> <p align="center">ALL INFORMATION REMAINS CONFIDENTIAL</p>	
<p>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.</p>	<p>\$ _____ weekly</p>
	<p>\$ _____ monthly</p>
	<p>\$ _____ yearly</p>
<p>2. Number of People in Household — Including self, mother, father, legal guardian(s), stepparents, brothers, sisters, half-brothers, half-sisters, stepbrothers, and stepsisters.</p>	<p>Total # of People</p>

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.

Student Signature

Date _____