Kintegra Health

Enrollment and Consent for School-Based Behavioral Health

School Name: _____

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

Student Demographics

Race:

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

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

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: _____

Student Email Address: _____

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

Student Social Security Number: _____

Parent / Guardian Name:			**Insurance Subscriber Name:**		
Date of Birth: ____/____/___	Sex: ☐ Female ☐ Male	SSN: ___-___-_____	Date of Birth: ____/____/_____	Sex: ☐ Female ☐ Male	SSN: ___-___-_____
Address:			Insurance: ☐Yes ☐No Insurance Company Name: Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:	Cell Phone:		Phone:	Effective Date:	
E-Mail Address:	Employer Name:		Policy Number:	Group Number:	
Emergency Contact 1:	Relationship:		Guarantor Name:	Relationship to Patient:	

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 (Mandatory field):**

Person Responsible for Payment: ☐ Mother ☐ Father ☐ Guardian or Other: _____

Financial Responsibility and Assignment of Insurance Benefits

I guarantee payment to Kintegra Health 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.

_____ _____

Parent/Guardian Signature **Date**

Permission to Communicate

Preferred Method of Communication:

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

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

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 understand and agree that the program may use information from my child's services, with all names and identifying details removed, to review outcomes, improve services, and report on how well the program is working. This information will be used only for these purposes and will not identify my child. No identifying information will be shared without separate permission, unless allowed or required by law. 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. **Initial _____**

Consent for Healthcare and Release of Personal Health Information

I voluntarily consent to behavioral health treatment for my child from the providers of Kintegra Health, Inc. I consent to any necessary behavioral health surveys, screenings, and referrals as a part of my childs treatment. I am aware that the delivery of mental/behavioral health treatment is not an exact science. No guarantees have been made to me regarding the results or outcomes of treatment. 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 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 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 _____**

Telehealth Services

The purpose of Telehealth Services is to provide care to your child in certain situations, during periods of school closure, and patient preference. By signing below, you are acknowledging that you understand the risks and benefits of your child receiving treatment 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 your child when he/she is 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 child's treatment provider believes your child would be better served by in person treatment you will be notified and referred to an in person setting for further care. If your child's condition is determined to be emergent, the school and/or the provider may send him/her 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. For telehealth services occurring via MyChart, 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.

_____ _____

Parent/Guardian Signature **Date**

School Based Sliding Scale Application

Student Name: _____ Student's Date of Birth: _____
Last First Middle (mm/dd/yyyy)

Parent/Guardian Name: _____
Last First Middle

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. 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. **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.** 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 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.***

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.

_____ _____

Parent/Guardian Signature **Date**