Kintegra Health

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

Date of Completion: _____

School: _____ **Grade:** _____

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

Demographics:

Race:
- ☐ Black / African American
- ☐ White
- ☐ Asian
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Native Hawaiian
- ☐ Other - Pacific Islander
- ☐ Unknown
- ☐ Refuse to report race

Ethnicity:
- ☐ Hispanic or Latino/a
- ☐ Non-Hispanic/Latino/a
- ☐ Patient refused
- ☐ Unknown

Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Undefined

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Transgender Female/Trans Woman/Male-to-Female
- ☐ Transgender Male/Trans Male/Female-to-Male
- ☐ Additional gender/Other

Please specify: _____
- ☐ Choose not to answer

Parent/Guardian Phone Number:
Home: (_____) _____-_____
Cell: (_____) _____-_____

Student Phone Number:
Cell: (_____) _____-_____

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

Parent / Guardian(s) Name:			Parent / Guardian(s) Name:		
Date of Birth: ____/____/_____	Sex: ☐ Female ☐ Male	SSN: _____-_____-_____	Date of Birth: _____/_____/_____	Sex: ☐ Female ☐ Male	SSN: _____-_____-_____
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:
E-Mail Address:	Employer Name:		E-Mail Address:	Employer Name:	
Emergency Contact 1:	Relationship:		Home Phone:	Cell Phone:	
Emergency Contact 2:	Relationship:		Home Phone:	Cell Phone:	

Do you have a medical provider? ☐ Yes ☐ No **Medical Provider Name:**

Do you have a dental provider? ☐ Yes ☐ No **Dental Provider Name:**

What services do you request? Check all that apply: ☐ Health Assessment ☐ Vaccines ☐ Sports physical ☐ Mental health ☐Sick visit/Other

Insurance Information: ☐ Check this box if your child has no insurance coverage or insurance deductibles/co-pays.					
Primary Insured's Name:			**Secondary/Supplemental Insured's Name:**		
Date of Birth (mm/dd/yyyy): _____/_____/_____ SSN: _____-_____- _____			Date of Birth (mm/dd/yyyy): _____/_____/_____ SSN: _____-_____- _____		
Insurance Company:			Insurance Company:		
Claims Address (Street Address / P.O Box):			Claims Address (Street Address / P.O Box):		
City:	State:	Zip:	City:	State:	Zip:
Phone Number:			Phone Number:		
Policy Number:	Group Number:		Policy Number:	Group Number:	
Effective Date:			Effective Date:		
Guarantor Name:	Relationship to Patient:		Guarantor Name:	Relationship to Patient:	

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

Preferred Method of Communication:
☐ Postal Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Web Message

I agree to receive text communication from Kintegra: ☐ Yes ☐ No Preferred Phone Number:_____

I agree to receive email communication from Kintegra: ☐ Yes ☐ No Email Address:_____

For email and/or text communications I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately.

School Based Care Sliding Scale Attestation:
Kintegra Health is dedicated to providing quality health care including health education and preventative care services to all members of the community regardless of financial barriers (ability to pay) through regular publication of school sliding fee scale. Kintegra Health will annually revise and re-issue its sliding scale to reflect changes in the Federal Poverty guidelines.

FPL	up to 300%	300 – 400%	more than 400%
% pay	0%	50%	100%

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 – include self, mother, father, legal guardian(s), stepparents, brothers, sisters, half-brothers, half-sisters, stepbrothers, and stepsisters.	Total # _____

Based on the number of family members in your household, and your total family income, the health center will determine if your child will: (A) Receive services without charge, (B) receive services to be billed to you at 50% of established rates, with maximum out of pocket plans, (C) 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. will result in billed charges.

Parent's Signature: _____ **Date:** _____

Kintegra Health

Patient Name: _____ Date of Birth: _____

Consent for Healthcare and Release of Personal Health Information:

I voluntarily consent to comprehensive healthcare treatment including medical, nutrition, and behavioral health services for my child from the providers and staff of Kintegra Health, Inc. and all its affiliates. These services may be provided in-person or virtually. I consent to all necessary treatment of illness and injuries and preventative care including screenings, surveys, analyses, evaluations, 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 _____**

For services not designated as confidential, I understand that I will be kept informed of my child's school health center visits and treatments. When an outside referral or services (including prescription medications) is indicated, I will be informed as well as my child's PCP. In the event my child requires urgent medical care and I cannot be reached, I request that my child be provided care to stabilize his/her condition. (Children age 11 and over may be allowed to authorize their own urgent care with the understanding that I will be contacted as soon as possible. Children age 10 and under may require a parent or other adults, chosen by the parent, to accompany the child to the visit. Names of authorized adults who may accompany my child have been shared with the Student Health Center.) 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.

Kintegra Health

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

Release of Information To and From the School Health Alliance for Forsyth County

I, _____ _____

Student's Legal Representative | Relationship to Student

Authorize:

Winston/Salem/Forsyth County Schools
P.O. Box 2513
Winston-Salem, NC 27102-2513

To disclose to and exchange:

School Health Alliance for Forsyth County
2000 West 1st Street, Suite 505
Winston-Salem, NC 27104

Regarding:

_____ _____/_____/_____ _____

Student's Name | Student's DOB | Telephone Number

_____

Student's Address | City | State | Zip Code

School ID# (Lunch number): _____

The following protected information:

- ☐ School/Education Records (including, but not limited to, attendance records, grade reports, psychoeducational test records, special education records, discipline records, End of Grade (EOG) AND End of Course (EOC) test scores, Student Assistance Team records, enrollment, promotion/retention, and classroom performance and behavior over time
- ☐ Mental Health Records (i.e., appointment attendance, diagnoses, treatment plans)
- ☐ Other: _____

Agreement to Information release for Research Purposes:

☐ I authorize School Health Alliance to disclose my student's participation, and/or other program information collected, with The Data Sharing Project team for research purposes. I understand this information will never be published in a way that will lead to the identification of my student and will be used to improve SHA services over time.

The purpose of this disclosure is: This information will be used for the purpose of coordinating and providing health/ mental health care for the students as well as for providing support to the students.

This authorization shall be in effect for 12 months from the initial date of request unless otherwise noted below.

STUDENT'S RIGHTS AND AUTHORIZED SIGNATURE:

- I have the right to revoke this authorization at any time by completing a revocation form and returning it to a Kintegra/ SHA staff member.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that the student's treatment/academics, payment, or eligibility for benefits will not be conditioned on signing.
- I understand that released information may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS or HIV).

_____

Signature of Student's Authorized Representative | Date