



Enrollment and Consent for School Health Medical/Dental/Optometry Services
School Name: _____

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		
Parent/Guardian Name:		Emergency Contact Name: _____ Emergency Contact Phone: _____ Relation: _____		
Address:				
City:	State:			Zip:
Home Phone:	Cell Phone:			
E-Mail Address:	Date of Birth:			
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: Medical: _____ Dental: _____	City:	State:	Zip:	
Insurance Company's Phone Number: Medical: _____ Dental: _____	Effective Date: Medical: _____ Dental: _____			
Current Medical Provider Name:		Current Dental Provider Name:		
Permission to Communicate				



Enrollment and Consent for School-Based Health Medical/Dental/Optometry Services

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

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 _____

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. Initial _____

Patient/Parent/Guardian/ Signature _____

Date _____

Printed Name of Patient/Parent/Guardian _____

School Based Health Center Sliding Scale Application

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.

Patient/Parent/Guardian Signature _____

Date _____

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:

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)			