KONZA PRAIRIE Community Health Center

Patient Registration

Konza Prairie Community Health Center (KPCHC)
Any space left blank will be considered "Refuses to answer".

PATIENT INFORMATION

First Name (Legal)	Last Name (Legal)	Preferred Name

Date of Birth (MM/DD/YYYY)	Social Security #	Previous Name	Gender at Birth: ☐ Female ☐ Male

Marital status
☐ divorced ☐ legally separated ☐ married ☐ partner ☐ single ☐ widow(er)

Home address (# of apartment-if applicable)	PO Box (if applicable)	City	State	Zip code

Cell phone number	Home phone number	Email Address	Appointment reminders preference (select 1):
			☐ Phone call ☐ Text message ☐ Network portal (see page 4)

Working status
☐ Active-duty military ☐ Retired ☐ Disabled
☐ Independent employee ☐ Full-time ☐ Student
☐ Part-time ☐ Unemployed

Level of education:
☐ < 12 years ☐ High school
☐ High school ☐ College: no degree
☐ Associates degree ☐ Bachelor's degree or higher

Are you a veteran? ☐ No ☐ Yes	Are you a migrant or seasonal agricultural worker? ☐ No ☐ Yes	Are you Homeless? ☐ No ☐ Yes
Are you a refugee? ☐ No ☐ Yes		

Ethnicity:
☐ Asian
☐ Native Hawaiian
☐ Other/ Pacific Islander
☐ Black/ African American
☐ American Indian/Alaska Native
☐ White
☐ More than one ethnicity

Gender identity:
☐ Male
☐ Female
☐ Transgender male (M to H)
☐ Transgender woman (H to M)
☐ Other: _____

Ethnic group: ☐ Hispanic/Latino ☐ I am not Hispanic/Latino

Sexual preference:
☐ Lesbian or gay
☐ Heterosexual
☐ Bisexual
☐ I do not know

Main language:
☐ English ☐ Spanish ☐ Other: _____

Do you need an interpreter? ☐ Yes ☐ No

Do you have an ADVANCE DIRECTIVE (living will or a DO NOT RESUSCITATE order?
☐ No ☐ Yes

IF NOT, are you interested in more information?
☐ No ☐ Yes

Do you currently have a primary dentist?
☐ No ☐ Yes, _____

Do you currently have a primary care physician?
☐ No ☐ Yes, _____

Preferred pharmacy:

MEDICAL INSURANCE INFORMATION

Primary Health Insurance			Primary Dental Insurance		
Company Name	ID Number	Group number	Company Name	ID Number	Group number
Name of Policy Holder	Date of birth (MM/DD/YYYY) Social security #	Patient Relationship	Name of Policy Holder	Date of birth (MM/DD/YYYY) Social security #	Patient Relationship

Secondary Health Insurance			Secondary Dental Insurance		
Company Name	ID Number	Group number	Company Name	ID Number	Group number
Name of Policy Holder	Date of birth (MM/DD/YYYY)	Patient Relationship	Name of Policy Holder	Date of birth (MM/DD/YYYY)	Patient Relationship

GUARANTOR INFORMATION

The guarantor is always the patient unless the patient is a minor or incapacitated.	What is the patient's relationship with the guarantor?	Name of the guarantor

Social security #	Date of birth (MM/DD/YYYY)	Phone number	Address		
	Gender ☐ Female ☐ Male	☐ Other: _____	City	State	Zip code
	☐ ☐	☐			

I, certify that the above information is true, and that I have read, fully understand, and accept all the terms of the above guidelines.

SIGNATURE OF THE PATIENT OR LEGAL GUARDIAN	DATE

KONZA PRAIRIE Community Health Center

Last Name, First Name: _____

Patient Registration

Date of birth (MM/DD/YYY): _____

Konza Prairie Community Health Center (KPCHC)
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EMERGENCY CONTACTS (MUST BE SOMEONE OTHER THAN YOU)

Name of the person in case of emergency	Phone number
Relationship with the patient	

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION (Optional)

I authorize the Konza Prairie Community Health Center (KPCHC) to disclose my personal health information to the individuals listed below. I understand that this authorization is **VOLUNTARY.** I understand that once my information is disclosed, the recipient may re-disclose it and the information may not be protected by federal privacy laws or regulations. I understand that this consent will remain in effect until I cancel it in writing. Additionally, I may include person(s) with my consent with the Disclosure of Information form.

Name	Patient Relationship	☐ Health info	☐ Billing	☐ Scheduling	☐ All
Name	Patient Relationship	☐ Health Info	☐ Billing	☐ Scheduling	☐ All
Name	Patient Relationship	☐ Health Info	☐ Billing	☐ Scheduling	☐ All

PAYMENT AGREEMENT

I agree that I will quickly and in full pay the bill for the services received at KPCHC. I understand that I will be responsible for any unpaid charges for my insurance. I understand that I am responsible for checking with my insurance provider to see what services are covered. I understand that delinquent accounts are subject to collection activities, including referral to a collection agency.

CO-PAYMENTS AND NON-COVERED SERVICES

As your medical, dental and/or behavioral health provider, our relationship is with you and not your health coverage. KPCHC will report your claim to your insurer, **but you are the sole responsible party for all outstanding charges after the insurer has covered your share.**

In the event that you do not stipulate KPCHC with current medical coverage, the accrued charges will be from the patient and/or the responsible party. **All co-payments, co-insurance, and discount program fee, nominal payment will be paid before you are given the service.** This payment does not guarantee full payment. The invoice will be mailed for charges that exceed the down payment made.

For Medicare or Medicaid patients, please note that there may be an applicable co-payment for retained services. If we do not have a contract with your insurance company, you will be 100% responsible for payment at the time of service.

PAYMENT ARRANGEMENTS

At KPCHC we want to work with you to meet your healthcare needs at affordable costs. Please call front desk if you need to arrange a payment arrangement for overdue account balances. KPCHC accepts payments in the office or by phone.

NON-PAYMENT FOR SERVICES

If you have not made any payments or arrangements in any overdue amount since the date of the first statement, KPCHC will send your account to a third-party collection agency. If you refuse to pay your bill, you may run the risk of being discharged from KPCHC.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize direct payment to KPCHC of all insurance payments or third-party payers.

DISCOUNT FEE PROGRAM

I have been offered and informed of KPCHC's discount rate program. I understand that medical charges may be adjusted based on my income. If I have no income, I will work with the staff to determine the discount. You are expected to pay a minimum fee for most services. Staff will request current annual income to determine discount. I agree to provide the income when requested or when my financial situation changes. If I do not give income, I understand that discounts will not be applied to my fees. I understand the inability not to pay, it will not be a barrier to KPCHC services.
Accepted Sources of Income: Form W2, Federal Taxes, (3) Most Recent Check Stubs, Employer Letter Including Letterhead, Pension Statement, Workforce Center Letter, One Day Income Statement, Child Support/Alimony Letter, Government Assistance Letter, Financial Award Letter, Letter from Another Party Declaring Financial Assistance.

AUTHORIZATION TO RELEASE INFORMATION

I authorize KPCHC to disclose any health information that may be necessary for medical treatment, third-party payments, and health center operations. I request payment of authorized Medicare/Medigap/Medicaid benefits from Konza Prairie Community Health Center and authorize the disclosure of medical information necessary to process insurance benefits to the Centers for Medicare and Medicaid and other insurance agents.
Please see our "Notice of Privacy Practices" which can be found on our website. The notice informs you of the ways in which we may use and disclose information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. KPCHC is required by law to do the following: ensure that health-related information that identifies you is kept private; provide you with this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is in effect.

I certify that the above information is true, and that I have read, fully understand, and accept all the terms of the above guidelines.

PATIENT SIGNATURE OR LEGAL GUARDIAN	DATE

KONZA PRAIRIE Community Health Center

Last Name, First Name: _____

Patient Registration

Date of birth (MM/DD/YYY): _____

Konza Prairie Community Health Center (KPCHC)

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CONSENT FOR TREATMENT

I request consent for professional health care from KPCHC providing medical, dental, and/or behavioral health services (or to my minor child) including Family Planning, Early Detection Functioning, and other sponsored services. All services are voluntary and require no prerequisites. I understand that I may choose to stop services when you decide.

If the patient is a minor or incapacitated adult, I authorize that I am the parent, legal guardian, or designated personal representative of the named patient. I have the legal authority to consent to KPCHC providers and staff consent for medical, dental, behavioral health treatment deemed necessary for the patient. No court orders are prohibiting me from signing this consent. I will have to present the proper legal documentation to KPCHC if staff requests.

I understand that if there are other adults who bring the child to appointments, I will have to fill out the Consent for Children/Minors form.

APPOINTMENT POLICY

Patients are expected to attend all KPCHC appointments. New patients must arrive twenty (20) minutes prior to their appointment to fill out necessary documents. Established patients or same-day visits must arrive fifteen (15) minutes prior to their appointment.

Arriving more than ten (10) minutes after your appointment will result in rescheduling of your appointment.

If the patient is unable to attend their appointment, they must notify KPCHC 24 hours **before** their appointment to cancel or reschedule. Failure to cancel, notify, or attend your appointment will result in a No Call/No Show. If a patient No Call/No Shows (4) four appointment in 12 consecutive months, they may be discharged from care and will be notified by certified mail.

If there is a barrier preventing you from attending to your appointments, please inform the staff.

PATIENT PORTAL AUTHORIZATION

I authorize KPCHC to give me access to a secure patient portal that will be used to contain and communicate protected health information. I understand that the secure patient portal will not be used to report life-threatening emergencies or obtain medical advice from a provider. I have listed my email (child's email, if applicable), as an agreement.

Email:

Child email (if applicable):

Other email (please identify):

DOCUMENTS

I acknowledge that I received copies of the following documents. I had the opportunity to ask questions and received answers to my satisfaction.

- Patient Rights and Responsibilities
- Patient Acknowledgement of KPCHC Policies
- Notice of Privacy Practices

Initial here ☐

-Or-

I am rejecting a paper copy of the documents listed in this time. I understand that I can get a copy at the facility or on the website at any time.

Initial here ☐

I am requesting electronic copies or links for these documents be sent to email address below:

Email:

PATIENT ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and understand KPCHC's Notice of Privacy Practices, which describes how my health information will be used, disclosed, and how I can access this information. I have been given the right to review and secure a copy of the Notice of Privacy Practices, which includes a detailed description of the use and disclosure of my protected health information and my rights under HIPPA. I understand that KPCHC reserves the right to change these terms from time to time. I may contact KPCHC at any time to obtain the most current copy of this notice.

I acknowledge that I have read, understand, and fully accept all the terms of the guide and policies above.

SIGNATURE OF THE PATIENT OR LEGAL GUARDIAN	**DATE**

KONZA PRAIRIE Community Health Center

Last Name, First Name: _____

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Have you ever had any of the following conditions? Circle if yes			Have you ever had any of the following surgeries or procedures? Circulate if so		
Anemia	Depression	HIV/AIDS	Appendectomy	Gallbladder	Stomach
Arthritis	Type 1 diabetes	Kidney disease	Bariatric	Hernia repair	Thyroid
Asthma	Type 2 diabetes	Seizures	Brain	Hysterectomy	Tonsillectomy
Blood clots	GERD	Stroke	Breast	Knee/Hip	Wisdom Teeth
Cancer	Glaucoma	Thyroid disease	Carotid	Lower Back Surgery	
COPD	Heart attack	Ulcerative colitis	Cataract	Mastectomy	
CHF	Heart valve stents	Other:_____	C-Section	Pacemaker	
Dry Mouth	Hepatitis		Colectomy	Prostatectomy	Other:_____
Crohn's	High blood pressure		D&C	Spine	

Do you currently take prescription or over-the-counter medication?

MEDICATION NAME	DOSAGE	FREQUENCY

Do you have any allergies to medicine, food, latex, vaccines, etc.?

NAME	REACTION

Do you currently see a specialist outside of KPCHC? (e.g., OB/GYN, GI, Cardiologist, Therapist, etc.)

NAME OF DOCTOR/CLINIC	TYPE OF DOCTOR /CLINIC

Additional information...

ANSWER ALL QUESTIONS.

Are you currently pregnant? Are you currently breastfeeding or pumping?	Do you take medicine(s) for: Osteoporosis Anticoagulants
Do you drink alcohol? If so, how often?	Do you feel nervous/anxious going to the dentist?
Do you use tobacco? If so, what kind and frequency?_____	When was the last time you went to the dentist?

Indicate here anything else you would like to share with your provider