KONZA PRAIRIE Community Health Center

Patient Registration

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

PATIENT DEMOGRAPHIC INFORMATION

First Name (Legal):	M.I.	Last Name (Legal):	Preferred Name:

Date of Birth:	Social Security #:	Previous Names:

Marital Status:
□ Married □ Divorced
□ Partner □ Legally Separated
□ Single □ Widow(er)

Patient Pronouns:
□ She/Her
□ He/Him
□ They/Them

Mailing Address (# of an apartment if applicable):

PO Box:	City:	State:	Zip code:

Appointment Reminders and Health Promotions: □Text □Email: _____
(Please see Communication Preferences on Page 6)

Konza Prairie Community Health Center is a Federally Qualified Health Center (FQHC). We receive federal funding and grants. As part of this funding, we are required to collect income data on all patients at least once a year. This information is used to set up programs to meet our patient's needs. Patients must be re-certified on or before their sliding fee anniversary date to receive a discount for services.

Reason for Visit: □ Medical □ Dental □ Behavioral Health □ Other | Provider Requested:

INSURANCE INFORMATION

Primary Health Insurance		Primary Dental Insurance	
Company Name	Group Number	Company Name	Group Number
ID Number	DOB:	ID Number	DOB:
Policyholder:	SSN:	Policyholder:	SSN:
Secondary Health Insurance		**Secondary Dental Insurance**	
Company Name	Group Number	Company Name	Group Number
ID Number	DOB:	ID Number	DOB:
Policyholder:	SSN:	Policyholder:	SSN:

EMERGENCY CONTACT INFORMATION

Name:	Phone Number:
Relationship:	□ Grant access to: Release of PHI (Access to all medical, billing, and scheduling information)
Name:	Phone Number:
Relationship:	□ Grant access to: Release of PHI (Access to all medical, billing, and scheduling information)

Working Status:
□ Active Duty Military
□ Retired
□ Disabled
□ Migrant: Has temporary home
□ Seasonal: Doesn't establish a temporary home
□ Student
□ Part-Time
□ Full Time
□ Unemployed
□ Independent Employee

Gender Identity:
□ Female □ Male
□ Transgender Male (F to M)
□ Transgender Female (M to F)
□ Other:
□Do Not Disclose

Level of Education:
□ < 12 years
□ High School
□ Associate's degree
□ College (no degree)
□ Bachelor's or Higher

Sexual Preference:
□ Lesbian or Gay
□ Heterosexual
□ Bisexual
□ I do Not Know
□ Do Not Disclose
□ Do Not Disclose

Race:
□ Asian
□ Native Hawaiian
□ Other/Pacific Islander
□ Black/African American
□ American Indian/Alaska Native
□ White
□ Other:
□ Other Asian
□ Filipino
□ Samoan
□ Chinese
□ Guamanian or Chamorro
□ More than One Race

Main Language:
□ English
□ Spanish
□ Other
□ Other:

Do you need an interpreter?
□ No □ Yes

Ethnic Group:
□ Hispanic/Latino
□ Not Hispanic/Latino

Are you a Veteran?
□ No
□ Yes

Are you a registered voter?
□ No □ Yes

Would you like more information on voting?
□ No □ Yes

Are you a refugee? □ No □ Yes
Are you homeless? □ No □ Yes

KONZA PRAIRIE Community Health Center

Last Name First Name:	
DOB:	

Patient Registration

Konza Prairie Community Health Center (KPCHC)

Any space left blank will be considered "Refuses to answer".

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION/HIPAA

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 in the Disclosure of Information form.

Name: Phone:	Relationship:	Access to:	☐ Health Info ☐ Scheduling	☐ Billing ☐ All
Name: Phone:	Relationship:	Access to:	☐ Health Info ☐ Scheduling	☐ Billing ☐ All
Name: Phone:	Relationship:	Access to:	☐ Health Info ☐ Scheduling	☐ Billing ☐ All

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.

Initials

FINANCIAL POLICIES

ASSIGMENT OF BENEFITS

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

Initials

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 submit a claim to your insurance as a courtesy, but you are the sole responsible party for all outstanding charges after the insurance has covered their share.
It is the patient/responsible party's responsibility to provide KPCHC with current insurance information. If insurance is not provided, the patient/responsible party is responsible for the accrued charges. Providing your correct, current insurance in a timely manner is critical. If the insurance is provided after the insurance timely filing requirements, the patient/responsible party is responsible for the accrued charges.
All Co-Payments, Co-Insurance and nominal payments from our sliding fee discount program are to be paid at the time of service. All other charges left to patient responsibility or not paid at the time of service, will be billed to the patient/responsible party.

Initials

DECLINING INCOME REPORTING

I decline to disclose income documentation at this time. I understand that if I do not provide proof of income, I will be billed at **FULL PRICE** for all services rendered, after insurance is filed.

Initials

PAYMENT AGREEMENT

I agree that I will quickly and in full, pay for any patient responsibility for services received at KPCHC. If I am insured, it is my responsibility to check with my insurance company to see what services are covered.

At KPCHC, we want to work with you to meet your healthcare needs at affordable costs. Please call the billing department to arrange a payment plan for any balances due. KPCHC accepts payments in the office, by phone or mail.

Initials

I understand that if I do not make a payment or a payment plan on any amounts due from the date of the first statement, KPCHC may send my account to a third-party collection agency. Refusal to pay your bill, with KPCHC or the third-party collection agency, could result in being discharged as a patient from KPCHC.

KONZA PRAIRIE Community Health Center

Last Name First Name:	
DOB:	

Patient Registration

Konza Prairie Community Health Center (KPCHC)

Any space left blank will be considered "Refuses to answer".

DISCOUNT FEE PROGRAM

I have been offered and informed of KPCHC's discount fee 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. I am 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 services at KPCHC will still be available to me, regardless of my ability to pay.

Initials

▫ 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.

GUARANTOR INFORMATION (Financially Responsible Individual)

Guarantor is: ☐ Patient ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Company/Employer

Name:			
SSN:	DOB:	Gender:	
Address:	City:	State:	Zip:
Phone Number:	Email Address:		

MEDICARE PATIENTS

Patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. I authorize Medicare benefits be made either to me or on my behalf to Konza Prairie Community Health Center for any services furnished me by KPCHC. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefit payable to related services. 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.

Initials

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

KPCHC POLICIES

PATIENT CONSENT FOR SCRIBE AND TELEHEALTH SERVICES

I understand that KPCHC provides telehealth services and uses audio scribe services. I give my permission to be audio recorded during my visits, should my provider utilize such services. I acknowledge that my participation is voluntary and that I may revoke this consent at any time providing KPCHC a 30-day written notice.

Initials

COMPLAINTS AND GRIEVANCES

If patients have concerns regarding their treatment/care, KPCHC staff, or the condition of the facility, patients have the ability and the right to complete a Confidential Comment/Grievance Form. The form can be obtained from the front desk, at various locations throughout the facility and on the KPCHC website.

Initials

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 Works, and other sponsored services. All services are voluntary, prohibit coercion, 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 prohibit 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 at the top of page 4.**

Initials

KONZA PRAIRIE Community Health Center

Last Name First Name:	
DOB:	

Patient Registration

Konza Prairie Community Health Center (KPCHC)

Any space left blank will be considered "Refuses to answer".

CONSENT FOR MINOR TREATMENT

FOR PATIENTS UNDER AGE 18 ONLY

I, _____, am the parent, guardian, or personal representative of:

Child's Name | **Child's Date of Birth**

There are no court orders that prohibit me from signing this consent. I do hereby request and authorize the healthcare provider and practice staff to perform the necessary services for the child named above, including (but not limited to) labs and treatment, which are deemed advisable by the healthcare provider and practice staff. I will assume full responsibility for payment of services rendered. In my absence, I hereby authorize the following persons to act on my behalf:

Name & Relationship to Parent/Child | Phone Number

Name & Relationship to Parent/Child | Phone Number

ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Initials

KPCHC participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIO's are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all your information through an HIO (except by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. You cannot restrict access to certain information only; your choice is to permit or restrict access to all your information. If you have questions regarding HIT or HIO's, please visit http://www.KanHIT.org.

APPOINTMENT POLICY

Initials

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 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 appointments in 12 consecutive months, they may be discharged from care and will be notified by certified mail.

PATIENT ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

Initials

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

- ▫ Patient Rights and Responsibilities
- ▫ Patient Acknowledgment of KPCHC Policies
- ▫ Notice of Privacy Practices

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

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

Email:

COMMUNICATION PREFERENCES

KPCHC is committed to protecting your information. KPCHC will send you important information about your healthcare using the methods below. Please check the box next to the forms of communication you authorize KPCHC to use with you.

- ☐ Email (NECESSARY - to sign up for the Patient Portal, use Telemedicine, receive appointment reminders and important health updates).
- ☐ Text Message (NECESSARY - to perform check-in for your visits on your phone and receive mobile appointment reminders).
- ☐ Patient Portal (NECESSARY - to communicate securely and electronically with your care team-**MUST AUTHORIZE EMAIL**).

KPCHC will never share your information with any outside organization. You may opt out of receiving electronic communication at any time by contacting KPCHC Front Desk. I understand the Patient Portal is a secure method, but text, email and voicemail may be considered unsecure.

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

Signature of Patient or Legal Guardian	Date

KONZA PRAIRIE Community Health Center

Last Name First Name:	
DOB:	

Patient Registration

Konza Prairie Community Health Center (KPCHC)

Any space left blank will be considered "Refuses to answer".

PATIENT HEALTH QUESTIONNAIRE

Do you have an Advance Directive for healthcare, 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 **Name:**

Do you feel nervous/anxious going to the dentist? ☐ No ☐ Yes When was your last dentist visit?

Do you currently have a Primary Care Physician? ☐ No ☐ Yes **Name:**

Preferred Pharmacy (Name/Location):

Have you seen any providers outside of KPCHC in the past 2 yrs? (ie. PCP OB/GYN, GI, etc.) ☐ No ☐ Yes

Name of Doctor/Clinic	Type of Doctor/Clinic

CURRENT MEDICATION LIST (PRESCRIBED & OVER THE COUNTER)

Name	Dosage	Frequency	Reason

Please list below any current allergies to medicine, food, latex, vaccines, contrast dye, etc?

Name	Reaction

Gynecological History

Are you currently pregnant? ☐ No ☐ Yes If yes, are you breastfeeding or pumping?

Age at onset of menses:	Number of Pregnancies:
Date of last menstrual cycle:	Living Children: Miscarriages:

Have you had any menstrual issues (please explain):

Have you had any post-menopausal bleeding?

Have you had any of the following screenings? Please indicate month/year

Colon Screenings:	Flu Shot:	Blood Sugar/A1c Test:
☐ FIT	Pap Smear/Pelvic Exam:	Diabetic Eye Exam:
☐ Cologuard	COVID Vaccine & Type:	STD/STI/HIV Screening:
☐ Colonoscopy	PSA:	Mammography:

Habits

Do you drink alcohol? If so, how often? ☐ No ☐ Yes

Do you use tobacco, smokeless tobacco, or vaping products? If so, what kind and frequency? ☐ No ☐ Yes

Do you use any recreational drugs? If so, what kind and frequency? ☐ No ☐ Yes

Have you had any exposure to toxic chemicals? If so, what chemical(s)? ☐ No ☐ Yes

KONZA PRAIRIE Community Health Center

Last Name First Name:
DOB:

Patient Registration

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

PATIENT HEALTH QUESTIONNAIRE CONTINUED

Have you had any of these conditions in the past year?

□ AIDS/HIV	□ COPD	□ Goiter	□ Polio	□ Diabetes - Type 1	□ Psychiatric Care
□ Alcoholism	□ CHF	□ Gonorrhea	□ Stroke	□ Diabetes - Type 2	□ Rheumatic Fever
□ Anemia	□ Crohn's	□ Gout	□ Tonsillitis	□ Heart Disease	□ Scarlet Fever
□ Appendicitis	□ Chicken Pox	□ Hepatitis	□ Ulcers	□ Heart Stents	□ Thyroid Problem
□ Arthritis	□ Depression	□ Hernia	□ Seizures	□ Kidney Disease	□ Bleeding Disorders
□ Asthma	□ Dry Mouth	□ Herpes	□ Gallstones	□ Liver Disease	□ Tuberculosis
□ Breast Lump	□ Emphysema	□ Measles	□ Blood Clots	□ Multiple Sclerosis	□ Typhoid Fever
□ Bronchitis	□ Epilepsy	□ Migraines	□ Chronic Pain	□ Pacemaker	□ Vaginal Infections
□ Cancer	□ Glaucoma	□ Mono	□ Recurring UTI's	□ Pneumonia	□ Ulcerative Colitis
□ Cataracts	□ GERD	□ Mumps		□ Prostate Problem	□ High Blood Pressure

Have you had any of the following procedures or surgeries:

☐ Bariatric	☐ Knee/Hip	☐ Cosmetic	☐ Appendectomy
☐ Brain	☐ Mastectomy	☐ Eye	☐ Gallbladder
☐ CABG (Bypass)	☐ Spine	☐ Colon	☐ Hysterectomy
☐ Carotid	☐ Stomach	☐ Hernia	☐ Lower Back Surgery
☐ Cataract	☐ Thyroid	☐ Joint Replacement	☐ Prostatectomy
☐ C-Section	☐ Wisdom Teeth	☐ Vasectomy	☐ Tonsillectomy/Adenoidectomy

Please indicate here if there is anything further to share with your provider:

Reviewed by Clinical Staff	**Date**

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

Signature of Patient or Legal Guardian	**Date**

Administrative Use Only Below

Scanned to Chart Documents	**□ No □ Yes ☐ Not Applicable**	**Staff initials:**
Tobacco Education Intervention Given	**□ No □ Yes ☐ Not Applicable**	**Staff Initials:**
PHQ-9 Needed (All Patients Annually)	**□ Yes**	**Staff Initials:**