KONZA PRAIRIE
Community Health Center

Account Number: _____

New Patient Registration

Konza Prairie Community Health Center (KPCHC)

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

Patient Information

Last Name (Legal):	First Name (Legal):	MI:	Preferred Name:

Date of Birth (MM/DD/YYYY):	Previous Name(s):	Social Security #

Mailing Address (Apartment # if applicable):	PO Box:	City:	State:	Zip Code:

Home Phone ( ) **Cell Phone** ( ) **Work Phone** ( ) **Email:** _____

You will be opted in for clinic communication and the patient portal. Please notify the front desk if you want to opt-out.

Sex at birth: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Partner ☐ Single

Race: (Please check all that apply)

☐ Asian ☐ Chinese ☐ Korean ☐ Samoan ☐ Other: _____
☐ American Indian/Alaska Native ☐ Filipino ☐ Native Hawaiian ☐ Vietnamese ☐ Chose Not to Disclose Race
☐ Black/African American ☐ Japanese ☐ Other Pacific Islander ☐ White

Ethnicity (Do you identify as Hispanic/Latino?):

☐ Non-Hispanic/Latino ☐ Yes, Cuban ☐ Yes, Mexican, Mexican American, Chicano
☐ Decline to Specify ☐ Yes, Puerto Rican ☐ Yes, Other Hispanic/ Latino

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Do you need an interpreter? ☐ Yes ☐ No

Are you a Veteran: ☐ Yes ☐ No

Are you an Agricultural Worker? ☐ Yes ☐ No
If yes, please select a class of work ☐ Migratory ☐ Seasonal

Are you currently homeless? ☐ Yes ☐ No
***IF YES*:** are you utilizing any of the following? ☐ Transitional Housing/Shelter ☐ Street ☐ Other: _____

Number of People in Household: _____ **Annual Household Income: _____**

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 patients' needs. Patients must re-apply periodically.

Preferred Pharmacy Name and Location: (KPCHC needs a copy of all insurance cards)

☐ Konza Pharmacy – JC ☐ Konza Pharmacy - Manhattan ☐ Other Pharmacy _____

Responsible Party (Please complete for patients under 18 years of age)

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Full Name:	Social Security #

Date of Birth: (MM/DD/YYYY)	Employer:	Phone #:

Address:	City and State:	Zip Code:

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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 ☐ Billing ☐ Scheduling ☐ Emergency Contact ☐ All of the above
Name: _____ Phone: _____	Relationship:	Access to: ☐ Health Info ☐ Billing ☐ Scheduling ☐ Emergency Contact ☐ All of the above

Medical/Behavioral Health Insurance Information: (KPCHC will need a copy of all insurance cards)

☐ **Check if uninsured**		☐ **Check if patient DOES NOT have secondary insurance**	
Primary Insurance Name:		Secondary Insurance Name:	
ID #	Group #:	ID #:	Group #:
Policy Holder Full Name:	Policy Holder Phone #:	Policy Holder Full Name:	Policy Holder Phone #:
Date of Birth: (MM/DD/YYYY)	Social Security #:	Date of Birth: (MM/DD/YYYY)	Social Security #:
☐ Self ☐ Spouse ☐ Parent ☐ Other: _____		☐ Self ☐ Spouse ☐ Parent ☐ Other: _____	

Dental Insurance Information: (KPCHC will need a copy of all insurance cards)

☐ **Check if uninsured**		☐ **Check if patient DOES NOT have secondary insurance**	
Primary Insurance Name:		Secondary Insurance Name:	
ID #:	Group #:	ID #:	Group #:
Policy Holder Full Name:	Policy Holder Phone #:	Policy Holder Full Name:	Policy Holder Phone #:
Date of Birth: (MM/DD/YYYY)	Social Security #:	Date of Birth: (MM/DD/YYYY)	Social Security #:
☐ Self ☐ Spouse ☐ Parent ☐ Other: _____		☐ Self ☐ Spouse ☐ Parent ☐ Other: _____	

Consent for Minor Treatment (FOR PATIENTS UNDER 18 YEARS OF AGE)

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.

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

_____ _____

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

In my absence, I hereby authorize the following people to act on my behalf:

Name: _____ Phone Number: _____ Relationship to child: _____

Name: _____ Phone Number: _____ Relationship to child: _____

_____ _____

Parent or Guardian Signature Relationship to Patient

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KPCHC Policies and Procedures

The following information is for all patients. Please initial each section below.
Your initials certify the acknowledgement of each section.

Initials	**Consent for Treatment:** I 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. If the patient is a minor or incapacitated adult, I certify that I am the parent, legal guardian, or designated personal representative of the named patient. I have the legal authority to consent KPCHC providers and staff for medical, dental, and/or 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 staff if requested. **I understand that any adult who brings the child to appointments must be listed on the Consent for Minor Treatment section above.**
Initials	**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 to KPCHC and authorize the disclosure of medical information necessary to process insurance benefits to the Centers for Medicare Services (CMS), 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 disclosures 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 are in effect.
Initials	**Electronic Health Information Technology:** 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://kanHIT.org.
Initials	**Appointment Policy:** Patients are expected to attend all KPCHC appointments. New patients must arrive twenty (20) minutes prior to their appointment to complete 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 scheduled time will result in rescheduling your appointment.
	Financial Policies
Initials	**Assignment 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 party responsible for all outstanding charges after the insurance has covered their share. It is the patient's/responsible party's responsibility to provide KPCHC with the 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 for the Konza Schedule of Discounts 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.

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KPCHC Policies and Procedures Continued

Konza Schedule of Discounts:

I have been offered and informed of KPCHC's schedule of discounts. I understand that charges for services received 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 provide my 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.

-Accepted sources of income: Form W-2; 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.

Initials _____

Declining Income Information:

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

Initials _____

Payment Agreement:

I agree that I will quickly and in full, pay for any patient responsibility for services 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 balance due. KPCHC accepts payments in the office, by phone, mail or online.

I understand that if I do not make a payment or a payment plan on any amounts due from the date of the first payment, KPCHC may send my account to a third-party collection agency.

Initials _____

Medicare Patients:

Patients with Medicare and 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 to me by KPCHC. I authorize any medical information about me to be released to the Centers for Medicare/Medicaid Services (CMS) and its agents in order to determine benefits or the benefit payable to related services. Please note that there may be an applicable co-payment for the 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.

I understand my signature requests that payment be made and authorizes the release of medical information necessary to play 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. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Initials _____

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 HIPAA. 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 Acknowledgement 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 KPCHC.org at any time.**

I request electronic copies or links for these documents be sent to the email below.:

Email:_____

I acknowledge that I have read, understand, and fully accept all the policies, procedures and terms on this form and I have filled out the information to the best of my abilities.

Signature of Patient or Legal Guardian	**Date**

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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 of Dentist: _____
Do you feel nervous/anxious going to the dentist? ☐ No ☐ Yes When was your last dental visit? _____
Do you currently have a Primary Care Physician? ☐ No ☐ Yes Name of Physician: _____

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

Name of Doctor/ Clinic	**Type of Doctor/Clinic**

Current Medication List (Prescribed and Over the Counter):

Name:	Dosage:	Frequency:	Reason:

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

Name:	Reaction:

Sexual Orientation:
☐ Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Don't know ☐ Chose Not to Disclose ☐ Other:

Gynecological History:

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

Age of onset of menses? Date of last menstrual cycle?

Number of pregnancies? 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 Screening:	Flu Shot:	Blood Sugar/ A1C Test:
☐ FIT	Pap Smear/ Pelvic Exam:	Diabetic Eye Exam:
☐ Cologuard	Medicare Annual Wellness visit:	STD/STI/HIV Screening:
☐ Colonoscopy	PSA:	Mammography:

Have you ever been diagnosed with Cancer? ☐ No ☐ Yes If so, type: Year:

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

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

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

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

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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	☐ Tonsilitis	☐ Heart Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Chicken Pox	☐ Hepatitis	☐ Ulcers	☐ Heart Stents	☐ Thyroid Problem
☐ Arthritis	☐ Depression	☐ Hernia	☐ Seizures	☐ Kidney Disease	☐ Bleeding Disorder
☐ 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:

I have filled out the information on this health questionnaire to the best of my abilities.

Signature of Patient or Legal Guardian	Date

Administrative Use Only Below

Scanned to Chart Documents	☐ No	☐ Yes	☐ Not Applicable	Staff Initial: _____
Tocacco Education Intervention Given	☐ No	☐ Yes	☐ Not Applicable	Staff Initial: _____
PHQ-9 Completed (All Patients Annually)	☐ No	☐ Yes	☐ Not Applicable	Staff Initial: _____