KONZA PRAIRIE Community Health Center

Account Number: _____

Patient Information Update

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 Information ☐ Emergency Contact ☐ Family Member ☐ Guardian ☐ All of the above
Name: _____ Phone: _____	Relationship:	Access to: ☐ Health Information ☐ Emergency Contact ☐ Family Member ☐ Guardian ☐ 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 ONLY)

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

KONZA PRAIRIE Community Health Center

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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

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.

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

Patient Acknowledgement and Notice of Privacy Practices:

I acknowledge that I have reviewed and understand KPCHC's Notice of Privacy Practices, which described 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 the website 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**