

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:
<p>Konza will automatically send BRIEF voice messages with general information about your visit and clinic communication. If you would like to receive more detailed EXTENDED voice messages – including procedure information, date/time, location, fees, and care instructions – please check the box below your phone number to OPT-IN to EXTENDED messages.</p>				
Home Phone () <input type="checkbox"/> EXTENDED	Cell Phone () <input type="checkbox"/> EXTENDED	Work Phone () <input type="checkbox"/> EXTENDED	Email: _____ You will be enrolled in the patient portal. Please tell the front desk if you want to OPT-OUT.	
Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner <input type="checkbox"/> Single		
Race: (Please check all that apply)				
<input type="checkbox"/> Asian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other: _____
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Chose Not to Disclose Race
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White	
Ethnicity (Do you identify as Hispanic/Latino?):				
<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Yes, Cuban	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano		
<input type="checkbox"/> Decline to Specify	<input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> Yes, Other Hispanic/ Latino		
Primary Language:		Do you need an interpreter?		
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you an Agricultural Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select a class of work <input type="checkbox"/> Migratory <input type="checkbox"/> Seasonal		
Are you currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No				
IF YES: are you utilizing any of the following? <input type="checkbox"/> Transitional Housing/Shelter <input type="checkbox"/> Street <input type="checkbox"/> 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)				
<input type="checkbox"/> Konza Pharmacy – JC <input type="checkbox"/> Konza Pharmacy - Manhattan <input type="checkbox"/> Other Pharmacy _____				
Responsible Party (Please complete for patients under 18 years of age)				
Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____				
Full Name:			Social Security #	
Date of Birth: (MM/DD/YYYY)		Employer:	Phone #:	
Address:		City and State:	Zip Code:	

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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.

<p>_____</p> <p>Initials</p>	<p><u>Consent for Treatment:</u></p> <p>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.</p>
<p>_____</p> <p>Initials</p>	<p><u>Authorization to Release Information:</u></p> <p>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.</p>
<p>_____</p> <p>Initials</p>	<p><u>Electronic Health Information Technology:</u></p> <p>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. I authorize KPCHC to record my visits with health care providers for treatment and operational purposes using AI technology. These recordings may be shared with business associates for troubleshooting and product improvement. Recordings will be kept for up to 7 days for validation before being destroyed.</p>
<p>_____</p> <p>Initials</p>	<p><u>Appointment Policy:</u></p> <p>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.</p>
Financial Policies	
<p>_____</p> <p>Initials</p>	<p><u>Assignment of Benefits:</u></p> <p>I hereby assign and authorize direct payment to KPCHC of all insurance payments or third-party payers.</p>
<p>_____</p> <p>Initials</p>	<p><u>Co-payments and Non-covered Services:</u></p> <p>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.</p>

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KPCHC Policies and Procedures Continued

Initials	<p><u>Konza Schedule of Discounts:</u> 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.</p>
Initials	<p><u>Declining Income Information:</u> 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.</p>
Initials	<p><u>Payment Agreement:</u> 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.</p>
Initials	<p><u>Medicare Patients:</u> 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.</p>
Initials	<p><u>Patient Acknowledgement and Notice of Privacy Practices:</u> 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 _____ 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. Initials I request electronic copies or links for these documents be sent to the email below.: Email: _____</p>

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? <input type="checkbox"/> No <input type="checkbox"/> Yes If not, are you interested in more information? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you currently have a primary Dentist? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Dentist: _____ Do you feel nervous/anxious going to the dentist? <input type="checkbox"/> No <input type="checkbox"/> Yes When was your last dental visit? _____ Do you currently have a Primary Care Physician? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Physician: _____			
Have you seen any providers outside of KPCHC in the past two (2) years? (ie. PCP, OB/GYN, GI, etc.) <input type="checkbox"/> No <input type="checkbox"/> 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:			
<input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't know <input type="checkbox"/> Chose Not to Disclose <input type="checkbox"/> Other: .			
Gynecological History:			
Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> 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:	
<input type="checkbox"/> FIT	Pap Smear/ Pelvic Exam:	Diabetic Eye Exam:	
<input type="checkbox"/> Cologuard	Medicare Annual Wellness visit:	STD/STI/HIV Screening:	
<input type="checkbox"/> Colonoscopy	PSA:	Mammography:	
Have you ever been diagnosed with Cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, type: _____ Year: _____			
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, how often?			
Do you use tobacco, smokeless tobacco, or vaping products? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, what kind and frequency?			
Do you use any recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, what kind and frequency?			
Have you had any exposure to toxic chemicals? <input type="checkbox"/> No <input type="checkbox"/> 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?					
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> COPD	<input type="checkbox"/> Goiter	<input type="checkbox"/> Polio	<input type="checkbox"/> Diabetes- Type 1	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> CHF	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes- Type 2	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Gout	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heart Stents	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hernia	<input type="checkbox"/> Seizures	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Herpes	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Measles	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraines	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mono	<input type="checkbox"/> Recurring UTI's	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Cataracts	<input type="checkbox"/> GERD	<input type="checkbox"/> Mumps		<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> High Blood Pressure
Have you had any of the following procedures or surgeries:					
<input type="checkbox"/> Bariatric	<input type="checkbox"/> Knee/Hip	<input type="checkbox"/> Cosmetic	<input type="checkbox"/> Appendectomy		
<input type="checkbox"/> Brain	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Eye	<input type="checkbox"/> Gallbladder		
<input type="checkbox"/> CABG (Bypass)	<input type="checkbox"/> Spine	<input type="checkbox"/> Colon	<input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Carotid	<input type="checkbox"/> Stomach	<input type="checkbox"/> Hernia	<input type="checkbox"/> Lower Back Surgery		
<input type="checkbox"/> Cataract	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Prostatectomy		
<input type="checkbox"/> C-Section	<input type="checkbox"/> Wisdom Teeth	<input type="checkbox"/> Vasectomy	<input type="checkbox"/> 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable	Staff Initial: _____
Tobacco Education Intervention Given	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable	Staff Initial: _____
PHQ-9 Completed (All Patients Annually)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Applicable	Staff Initial: _____