KONZA PRAIRIE Community Health & Dental Center

Junction City Medical
361 Grant Avenue
Junction City, KS 66441
Ph: 785.238.4711
Fax: 866.309.8893

Junction City Dental
361 Grant Avenue
Junction City, KS 66441
Ph: 785.238.1829
Fax: 877.671.5661

Manhattan Medical
2030 Tecumseh Rd.
Manhattan, KS, 66502
Ph: 785.320.7134
Fax: 866.807.7393

Manhattan Dental
2030 Tecumseh Rd.
Manhattan, KS, 66502
Ph: 785.320.7134
Fax: 866.534.5933

CHECKLIST FOR KONZA PRAIRIE CHC

NOTE: WE MUST HAVE ALL OF THE FOLLOWING TO MAKE YOUR INITIAL APPOINTMENT

1. FILL OUT A NEW PATIENT PACKET

2. BRING WITH YOU THE FOLLOWING, ALONG WITH THE PATIENT PACKET:
    a. PHOTO I.D.
    b. PROOF OF ADDRESS (IF NOT INCLUDED ON YOUR PHOTO I.D.)
    c. PROOF OF INSURANCE (INSURANCE CARD)

3. IF APPLYING FOR SLIDING FEE SCALE, **ALSO BRING**:
    a. LAST 3 COPIES OF CURRENT PAYSTUBS FOR ALL WORKING MEMBERS IN YOUR HOUSEHOLD
    b. PROOF OF ANY INCOME RECEIVED (e.g. CHILD SUPPORT, TANF, SSI, SOCIAL SECURITY, ALIMONY, ETC)

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL US AT THE APPROPRIATE NUMBER LISTED ABOVE

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MEDICAL/DENTAL PATIENT INFORMATION FORM

(Please Print)

Today's Date: PRIMARY CARE PHYSICIAN:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Race:	Ethnicity:	Marital Status:

Street Address/PO Box:	City:	State:	County:	Zip Code:

Is this your legal name? O Yes O No	If not, what is your legal name?	Former Name (if applicable):	Birth Date / /	Age:	Sex: O M O F

Social Security Number:	Home Phone Number:	Cell Phone Number:	Email Address:

Receive Text/Phone Appointment Reminders: O Yes O No	Best Time to Contact: O Morning O Afternoon O Evening	Preferred Pharmacy:

Occupation:	Employer:	Employer Phone Number:

Languages Spoken:	Veteran? O Yes O No	Agricultural Worker? O Yes O No	Homeless? O Yes O No

Parent/Guardian Name (if applicable):	Phone Number:	Email Address:

IN CASE OF EMERGENCIES

Name of Local Friend or Relative:	Relationship to Patient:	Home Phone Number:	Work Phone Number:

Street Address/PO Box:	City:	State:	County:	Zip Code:

RECORDS RELEASE

Do you have Advanced Directive or Living Will? O Yes O No	Authorized to release information? O Yes O No

If the authorized party for records release <u>is different</u> from the emergency contact, please fill in their information below

Name of Authorized Party:	Relationship to Patient:	Home Phone Number:	Work Phone Number:

Street Address/PO Box:	City:	State:	County:	Zip Code:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Konza Prairie Community Health Center or my insurance company to release any information required to process my claims.

_____ _____

Patient Signature Date

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INSURANCE INFORMATION FORM

(Please Print)

MEDICAL PRIMARY INSURANCE INFORMATION

Please give your subscriber card to the receptionist

Subscriber Name:	Subscriber Birth Date: / /	Subscriber Home Phone:	Subscriber Social Security Number:
Is this person a patient here? O Yes O No	Patient's Relationship to Subscriber: O Self O Spouse O Child O Other (please specify) _____		
Insurance Name:	ID Number:	Group Number:	
Insurance Address:	City:	State:	Zip Code:

DENTAL PRIMARY INSURANCE INFORMATION

Please give your subscriber card to the receptionist

Subscriber Name:	Subscriber Birth Date: / /	Subscriber Home Phone:	Subscriber Social Security Number:
Is this person a patient here? O Yes O No	Patient's Relationship to Subscriber: O Self O Spouse O Child O Other (please specify) _____		
Insurance Name:	ID Number:	Group Number:	
Insurance Address:	City:	State:	Zip Code:

SECONDARY INSURANCE INFORMATION (if applicable)

Please give your subscriber card to the receptionist

Subscriber Name:	Subscriber Birth Date: / /	Subscriber Home Phone:	Subscriber Social Security Number:
Is this person a patient here? O Yes O No	Patient's Relationship to Subscriber: O Self O Spouse O Child O Other (please specify) _____		
Insurance Name:	ID Number:	Group Number:	Type of insurance? O Medical O Dental
Insurance Address:	City:	State:	Zip Code:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Konza Prairie Community Health Center or my insurance company to release any information required to process my claims.

_____ Patient Signature

_____ Date

MEDICAL/DENTAL CLINIC MEDICAL HISTORY

PATIENT NAME: _____ DOB: _____/_____/_____

Do you have a history of any of the following? (Check all that apply)

	Y	N		Y	N
Allergic to local anesthetic			Arthritis		
Blood/Clotting disorders			Depression		
Hardening of the arteries			Skin diseases		
Chest pain			Prosthetic joint/valves		
Swollen ankles			Chemo/Radiation therapy		
High blood pressure			Bisphosphonate therapy		
Heart problems			Cancer		
Heart murmur			Anemia		
Rheumatic heart disease/fever			Seizures		
Stroke			Latex allergy		
Prolonged bleeding			Steroid medication		
Tuberculosis			Organ transplant		
Emphysema			Urinary tract problems		
Fainting/Dizziness			Recreational drug use		
Ear/Nose/Throat problems			Vision problems		
Frequent headaches			Asthma		
Hearing problems			Aspirin therapy		
Kidney disease			Persistent cough		
Diabetes			Seasonal allergies		
Thyroid disease			Chronic mental illness		
Liver disease			Glaucoma		
Hepatitis			Surgery with rods/pins/screws		
Sexually transmitted disease			Allergy to medication		
HIV/AIDS			Other:		
Shortness of breath					
Stomach/Intestinal problems					

CURRENT MEDICATIONS

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you have any diseases not listed? ○ Yes ○ No

If yes, please explain: _____

_____

_____

Has any blood relative suffered any of the following (CHECK WHICH ILLNESS AND INDICATE WHICH RELATIVE):

○ Heart disease ○ Hypertension ○ Stroke ○ Lung disease ○ Glaucoma

○ Cancer ○ Diabetes ○ Asthma ○ Seizures

○ Blood Disease ○ Kidney Disease ○ Sickle Cell ○ Migraine

Any disease of reproductive organs?

Males (prostate, testicles, penis) ○ Yes ○ No If yes, please specify: _____

Females (uterus, ovaries, cervix) ○ Yes ○ No If yes, please specify: _____

When were you last immunized against…

Tetanus? _____ Pneumonia? _____

OB HISTORY (WOMEN ONLY)

Number of pregnancies? _____ Number of living children? _____

Date of last menstrual period? _____ Diabetes or blood pressure? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of her/his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

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PATIENT PORTAL AUTHORIZATION FORM

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history and visitation dates
- Receive reminders through your email
- View current and past statements

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by a KPCHC

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 10 failed log in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 8:00 am - 5:00 pm Monday-Thursday and 8:00 am - 2:00 pm on Fridays. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

_____

Secure email address

_____ _____

Patient's Name (Please Print) DOB

_____ _____

Patient Signature Date

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

_____ _____

Full Name (Please Print) Signature

_____ _____

Relationship to Patient Date

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STATEMENT OF FINANCIAL RESPONSIBILITY AND CONSENT TO TREATMENT

PATIENT NAME: _____ DOB: _____/_____/_____

The staff at Konza Prairie CHC (KPCHC) appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Insurance Policy

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Consent for Treatment and Authorization to Release and Retrieve Information

I hereby authorize KPCHC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I agree to release KPCHC from any and all liability from actions pertaining and relating to the administration of immunizations to my child.

I authorize KPCHC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment as required by law.

I authorize KPCHC to retrieve my prescription history, including my external prescription history.

Cancellation / No Show Policy

I understand that I am expected to call 24-hours prior to my appointment if I wish to cancel. If I no show for four (4) consecutive appointments in a year, I understand I may be discharged from care. The clinic will notify me in writing, via certified mail, if I am discharged from care.

Self-Pay

If you are a self-pay patient, you agree to the following: I do not have health insurance and will be responsible for services rendered here at KPCHC. I agree to pay the full and entire amount for treatment given to me or to the above named patient. I also understand that I will be considered as a "full-pay" patient until proof of income is provided for the sliding fee scale.

Acknowledgement of Receipt of Privacy Practices

I hereby acknowledge that I have received a copy of the KPCHC's Notice of Privacy Practices, effective June 16, 2015.

I have read the above policy regarding my financial responsibility to KPCHC for providing medical/dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to KPCHC the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

_____ _____
Patient Signature Date

_____ _____
Guarantor Signature (if not the patient) Date

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KPCHC CLIENT RIGHTS / PATIENT RIGHTS & RESPONSIBILITIES

YOUR RIGHTS AS A PATIENT

1. You have the right to considerate and respectful care regardless of race, color, age, gender, religion, national origin, handicap status, or the existence of Advance Directive.
2. You have the right to a safe and private environment for patient care. This includes both personal privacy and informational confidentiality. Case discussion, consultation, examination, and treatment are to be carried out with discretion.
3. You have the right to information regarding your medical care and treatment. Konza Prairie Community Health Center will rely on the provider and/or nurse to keep you informed concerning your progress, diagnosis and treatment modality. You, and when necessary, your surrogate decision-maker, should participate in decisions relating to your care.
4. You have the right to receive from your provider the information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. You have the right to know the name of the person responsible for the procedure and/or treatment.
5. You and your surrogate decision-maker have the right within legal boundaries, to refuse treatment and be informed of the medical consequences of your action.
6. You have the right to request information and assistance to prepare Advance Directives consistent with Kansas Law.
7. You have the right to expect that within its capacity, Konza Prairie Community Health Center will make reasonable response to your request for services. The Health Center will provide evaluation services, and/or referral as indicated by the urgency of the case.
8. You have the right to consent or refuse to participate in experimental, investigational, educational, or research activity related to your care.
9. You have the right to have explained to you the Konza Prairie Community Health Center rules, regulations, policies, procedures, and charges that relate to your care.
10. You have the right to express concerns, complaints, or care-related concerns. You have the right to access Konza Prairie Community Health Center's Ethics Committee when necessary.

In many situations, Konza Prairie Community Health Center will not release patient-identifiable medical information outside this institution without your written authorization. You may revoke your authorization at any time by notifying Konza in writing. However, in circumstances defines by law, health care providers are required to report information to the appropriate persons. For example, it must be reported when there are suspicions of child abuse or neglect, or threat of harm to self or others.

YOUR RESPONSIBILITIES AS A PATIENT

1. You are responsible to provide accurate and complete information about your present and past health problems and illnesses, hospitalizations, medications, and your response to current treatment.
2. You are responsible to learn about your illness and care, to ask about care alternatives including the risks and benefits of each and to make your preference clear to the health professionals involved in your care.
3. You are responsible to follow the treatment plan recommended by medical personnel attending your care. Your are responsible for the consequences for failure to follow instructions for refusal of treatment or for failure to follow recommendations for your continuing care when referred from Konza Prairie Community Health Center to a specialty medical service provider.
4. You are responsible to follow Konza Prairie Community Health Center rules and regulations affecting patient care and personal conduct.
5. You are responsible to be respectful and considerate of the rights of other patients and Konza Prairie Community Health Center's personnel and property.
6. You are responsible to express concerns, complaints, or care-related conflicts to your provider or a member of Konza Prairie Community Health Center staff.
7. The undersigned and guarantees payment in accordance with clinic payment policies.

I understand the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all the conditions for treatment at Konza Prairie Community Health Center as described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions of Treatment on the patient's behalf.

_____ _____

Patient Signature Date