KONZA PRAIRIE Community Health 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

Welcome to Konza Prairie Community Health and Dental (KPCHC). We are honored to be a trusted partner in your health care. KPCHC serves everyone, and fees may be reduced depending on household income and size. For more information, please contact the Junction City or Manhattan offices.

Mission:
Providing affordable, quality, comprehensive medical, dental, and behavioral healthcare for all in a courteous, professional, and personalized manner.

Vision:
Konza Prairie Community Health Center. Our Community. Our Healthcare.

Konza Prairie offers a variety of services to meet your healthcare needs

- Patient centered medical care for all ages
- Dental services
- Behavioral health
- Prenatal care
- Infant care
- Full-service pharmacy
- Lab
- Radiology
- ECG
- Immunizations
- High school clinic at JCHS
- Smoking cessation counseling
- Nutrition counseling
- Diabetes care and management
- Insurance assistance including Medicaid

As you prepare for your first appointment:

- Arrive 30 minutes early to complete new patient paperwork
- Bring photo ID, proof of address if different than your ID, and all health insurance cards
- If applying for reduced fees, please bring last 3 paystubs for everyone working in your home and any other income in the home (ex. child support, cash assistance, disability, social security, alimony, etc.)

Thank you for choosing KPCHC for your medical and dental needs

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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:	Social Security Number:	Marital Status:

Street Address	City:	State:	County:	Zip Code:
Mailing Address (if different from above)/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** / /	**Sex on Birth Certificate:** Male O Female O Refuse to answer O

What is your current gender identity check all that apply:
O Male O Female
O Female to Male (FTM) Transgender Male/Trans Male
O Male to Female (MTF) Transgender Female/Trans Woman
O Genderqueer, neither exclusively male or female
O Decline to Answer - Please explain why_____
O Additional Gender Category (other), specify _____

Race:
O Asian O Native Hawaiian
O Other Pacific Islander O Black/African American
O White O Hispanic/Latino

Ethnicity:
O Hispanic/Latino
O Non-Hispanic/Latino

Cell Phone Number: Home Phone Number

Sexual Orientation:
0 Straight/Heterosexual
0 Lesbian, Gay or Homosexual 0 Bisexual
0 Do not know 0 Chose not to disclose
0 Something else _____

Language Spoken:	Receive Text/Phone Appointment Reminders: O Yes O No	Best Time to Contact: O Morning O Afternoon O OEvening	Email Address:
Translator Needed: OYes ONo			

Occupation:	Employer:	Employer Phone Number:

Preferred Pharmacy:	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:

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

RELEASE OF HEALTH INFORMATION

List the names of family and/or friends we may release information about your healthcare to:
This consent shall remain in effect until a new list is provided or until revoked, in writing.

NAME	PHONE NUMBER	RELATIONSHIP

Patient or Legal Guardian Signature:_____ Date: / /

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.

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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?	Patient's Relationship to Subscriber:
O Yes O No	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?	Patient's Relationship to Subscriber:
O Yes O No	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?	Patient's Relationship to Subscriber:
O Yes O No	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 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

AUTHORIZATION FOR RELEASE OF INFORMATION

Kansas Department of Health and Environment
Family Health Comprehensive System

Service providers in your community are partnering to improve the services you may need. We do that by sharing information with each other. This means we know what services you need. It also makes it faster and easier for you to access those services.

If you agree to let us share your and your child(ren)'s protected health information between service providers, it will be stored in a secure electronic system that only other service providers in your community can access. All providers with access to the system are required to keep your information secure. We will only use your and your child(ren)'s information to coordinate services, make referrals through the Integrated Referral and Intake System (IRIS) and share information among service providers within your community.

If you agree, information that will be shared in the system includes:

- Protected health information (Ex: name, gender, date of birth).
- Information about services you receive (Ex: health screening, education, home visits).
- Information about assessments you receive as part of a service (Ex: answers to questions about housing needs, tobacco use, prenatal care).

If you do not agree, your information will not be shared with other community providers to coordinate services. Please know it will be uploaded in the Health Resources and Services Administration Healthy Start Data System (HSMED) as required for Federal funding that supports these services.

Do you agree to allow Family Health service providers in your community to share your information to provide better services?

□ **Yes,** my / my family's protected health information can be shared with only other community-based Family Health service providers who will also secure my information. I understand that I can revoke my agreement at any time by notifying a participating service provider.

□ **No**, my / my family's protected health information cannot be shared. (If you select this option, your information will not be shared with other service providers in your community). I understand that my / my family's information will be included in the system, but my protected health information will not be shared between providers.

Signature _____ Date _____

Printed Name _____

Signature of Program Staff/Witness _____ Date _____

Participating Agency/Program _____

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Konza Prairie Community Health & Dental Center (KPCHC)

Patient's Acknowledgement & Consent Form

Patient name:_____ DOB:____/____/____

Request & Consent to Receive Services: I give my permission to KPCHC to provide services to me (or 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 I may stop services whenever I choose.

Assignment of Benefits & Release of Information: I authorize the release of any medical, dental, mental health, alcohol and drug, or other relevant information needed for the KPCHC to file insurance claims on my behalf. I agree medical benefit payments will be paid to KPCHC**.** I agree to notify KPCHC immediately of any changes in my insurance.

Retrieval of Information: I authorize KPCHC to retrieve my prescription history, including my external prescription history.

Financial Policy: I understand I am expected to pay for the services at the time completed, and if I have insurance, it will be billed for the cost of services. I understand insurance payments may not reduce the cost billed to me. If I fail to provide necessary insurance information, I will be charged for the services received. If an insurance authorization has not been obtained or has been denied by my insurance, I will be responsible to pay the balance beyond my insurance co-payments. I understand my health insurance may not cover some or all the services provided by KPCHC. I acknowledge any balance not covered or paid by my insurance is my legal responsibility. I agree it is my responsibility to understand my insurance coverage.

Reduced Fee: I have been informed of KPCHC's reduced fee policy. I understand I may still be expected to pay a minimum fee for services and must report my gross family income annually to remain eligible for reduced fees. I agree to provide new information to KPCHC when requested or at the time my financial situation changes. I also understand my inability to pay will not be a barrier to receiving services at KPCH. I understand Title X Family Planning services may be provided without a fee.

Notice of Privacy Practices: I have been provided a copy of the Notice of Privacy Practices June 18, 2015 and acknowledge a paper copy was made available to me. Policy can be found posted in the lobby and on our website. Initials Declined paper copy.

Cancelation/No Show/Late Policy: I understand I am expected to call 24-hours prior to my appointment to cancel. If I no show for four (4) consecutive appointments in a year, I may be discharged from care. I will be notified by certified mail, if I am discharged from care. If I arrive more than 10 minutes late for my appointment, the appointment will be rescheduled.

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

Mandatory Reporting: KPCHC employees are required by law to report possible abuse, neglect, or unsafe situations affecting protected people. I understand KPCHC may report abuse, neglect, or unsafe situations. I understand this reporting may include disclosure of my protected health information. I understand services will be provided to me even if I choose not to answer questions about safety or the age of my sexual partner.
Protected people include:

- Children and adolescents under the age of 18 years
- Persons over the age of 65
- Persons on Social Security Disability
- Persons in state-funded mental health services (including services provided by KPCHC) who report being victims of abuse or neglect, including domestic violence

I acknowledge the above information and consent.

_____ _____
Patient or Legal Guardian Signature Date

_____ _____
Patient or Legal Guardian Printed Name Date

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Konza Prairie Community Health & Dental Center (KPCHC)

Patient's Rights & Responsibilities

Patient name:_____ DOB:____/____/____

As a patient, you have the right to:

1. Considerate and respectful care regardless of race, color, age, gender, religion, national origin, handicap status, or advance directives
2. Safe and private environments including personal and informational confidentiality
3. Information regarding your medical care, diagnosis, and treatment to keep you informed and make informed consent prior to any procedure and/or treatment
4. Request or refuse any care, treatment, or services, except as otherwise provided by law
5. Request information and assistance to prepare Advance Directives consistent with Kansas law
6. Consent or refuse to participate in educational, experimental, investigational, or research care
7. Request services and/or referrals within a reasonable time as indicated by the urgency of the case
8. Information regarding the rules, regulations, policies, procedures, and charges
9. Express care-related concerns, complaints, or conflicts and have access KPCHC's Quality Assurance Coordinator to address these issues
10. Revoke or change your medical release of information at any time by notifying KPCHC in writing

As a patient, you are responsible to:

1. Attend appointments on time and observe KPCHC late policy.
2. Provide accurate and complete information about your present and past health problems, illnesses, hospitalizations, medications, and treatment
3. Learn about your medical conditions/care and ask about medical alternatives including the risks and benefits
4. Participate in medical care decisions and communicate preference to your provider
5. Follow your provider's treatment and referral recommendations and are responsible for the consequences of failure to follow treatment and referral recommendations
6. Treat other patients, KPCHC staff, and property with respect and consideration
7. Notify your provider or other KPCHC staff about any care-related concerns, complaints, or conflicts
8. Pay your bill in accordance with KPCHC payment policies

I understand the information above. I had the opportunity to ask questions and received answers to my satisfaction. I agree to KPCHC patient's rights and responsibilities as described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions on the patient's behalf.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Patient or Legal Guardian Printed Name 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 passphrase 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