Kaniksu Health Services

.....providing its communities with affordable and accessible healthcare

Dear Valued Veteran:

It is indeed an honor for Kaniksu Health Services to have this opportunity to provide primary health care services to the veterans living in our north Idaho communities. We recognize the personal sacrifices you have made on our behalf by serving our country.

As a federally qualified community health center, Kaniksu Health Services participates with HRSA/Bureau of Primary Health Care and the Veterans Administration in collaborating together to provide affordable primary care to rural communities.

With that partnership, there is a requirement to report and track some specific demographic data. This data helps demonstrate the local need for these primary health care services. Additionally, by reporting this data we can ensure that our patients can continue to receive the care they need close to home.

In an effort to do this, we are asking you to please complete the attached form.

We will also be working closely with you in scheduling your "annual physical exam" in a timely way to ensure your continued eligibility. Thank you in advance for your support of our "Community-based VA Outreach Clinic".

If you have any questions or concerns or if you have ideas which can help us improve our services, please do not hesitate to contact me personally by e-mail at Vicki@kaniksuhealthservices.org or by calling our corporate office at 208-263-3410.

Sincerely,

Victoria McClellan King, CEO
Kaniksu Health Services

KHS- Bonners Ferry Clinic	KHS- Sandpoint Clinic	KHS-Sandpoint Pediatrics	KHS – Priest River Clinic	KHS Corporate Office
6615 Comanche Street	30410 Highway 200	420 N Second Ave	6509 Hwy 2 Suite 101	301 Cedar St Suite 206
Bonners Ferry, ID 83805	Ponderay, ID 83852	Sandpoint, ID 83864	Priest River, ID 83856	Sandpoint, ID 83864
208-267-1718—phone	208-263-7101 – phone	208-265-2242 - phone	208-448-2321—phone	208-263-3410 - phone
208-267-9197 - fax	208-263-7198 – fax	208-265-8214 - fax	208-448-1317 - fax	208/-255-4842 - fax

Mailing Address: Kaniksu Health Services, PO Box 2160 Sandpoint, ID 83864

Kaniksu Health Services

KHS Bonners Ferry Clinic: 6615 Comanche Street - Bonners Ferry, ID 83805 208-267-1718
KHS Sandpoint Clinic: 30410 Highway 200 – Ponderay, ID 83852 208-263-7101
KHS Sandpoint Pediatric Clinic: 420 N Second Ave – Sandpoint ID 83864 208-265-2242
KHS Priest River Clinic: 6509 Hwy 2 Suite 101, Priest River, ID 83856 208-448-2321

Patient:
Last name ____________________________________ **First name** __________________________ **Middle** _______________ **M / F**

Date of Birth____________ **Age**______ **SS#**_____________________ **Home Ph. #**________________**Alternate Ph. #**______________

E-mail Address: _________________________________ **Preferred Method of Contact**____________________________

Mailing Address ____ **City**_____________________ **State**___________ **Zip** __________

Employment ❐Year-round ❐Seasonal ❐Self Employed ❐Retired ❐Unemployed ❐Disabled ❐Student

Are you or any member of your family a migrant or agricultural worker ❐ Yes ❐ No
Veteran ❐Yes ❐ No **Homeless** ❐Yes ❐ No **Do you have insurance?** ❐ Yes ❐ No **(**Please give cards to receptionist for copying)

Insurance Carrier Name: _______________________________ **Policy Holder Name:** ___________________________________

Patient Primary Doctor: ____

How did you hear about us? ❐Friend/relative ❐Website ❐Social Media ❐Newspaper ❐Magazine ❐Other:

❐Parent / ❐Guardian / ❐Spouse / ❐ Emergency Contact **❐Single / ❐Married / ❐Widowed**

Last Name_______________________________ **First Name**________________________ **Middle**_________________________ **M / F**

Relationship to patient __________________ **Home Ph. #** ______________ **Date of Birth**:______________________

Please circle "Size of Family Unit" and the "Total Household Income" on the chart below:

1	$12,140	$12,141 to $16,389	$16,390 to $18,210	$18,211 to $24,159	$24,160
2	$16,460	$16,461 to $22,221	$22,222 to $24,690	$24,691 to $32,755	$32,756
3	$20,780	$20,781 to $28,053	$28,054 to $31,170	$31,171 to $41,352	$41,353
4	$25,100	$25,101 to $33,885	$33,886 to $37,650	$37,651 to $49,949	$49,950
5	$29,420	$29,421 to $39,717	$39,718 to $44,130	$44,131 to $58,546	$58,547
6	$33,740	$33,741 to $45,549	$45,550 to $50,610	$50,611 to $67,143	$67,144
7	$38,060	$38,061 to $51,381	$51,382 to $57,090	$57,091 to $75,739	$75,740
8	$42,380	$42,381 to $57,213	$57,214 to $63,570	$63,571 to $84,336	$84,337
9	$46,700	$46,701 to $63,045	$63,046 to $70,050	$70,051 to $92,933	$92,934

If household size and income exceeds what is on this chart please fill in Annual income $__________

I hereby agree that the above information is true and correct to the best of my knowledge.

Signature of Patient/Guardian____**Date**________________

******Sliding Fee Waiver of Participation******

I decline participation in the Sliding Fee Discount Program and I understand that I am responsible for the entire bill or any portion that remains after insurance payments.

Signature of Patient/Guardian____**Date**________________

Race ❐White (Not Hispanic or Latino) ❐African American (Not Hispanic or Latino) ❐Native American
❐Native Alaskan ❐Pacific Islander ❐Asian ❐Native Hawaiian ❐ Other ___________________________

Ethnicity ❐Hispanic/ Latino ❐ Non-Hispanic/ Latino ❐ Unknown **Primary language spoken in household** ❐ English ❐ Spanish ❐ Other__________

I hereby authorize Kaniksu Health Services to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied. In the event that insurance benefits are paid directly to me, I will endorse to KHS all checks for such payments. I also authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby agree that I am financially responsible for all charges incurred for the services provided.

_________________________________ _________________________________ _______________
Signature **Parent/Guardian (if minor)** **Date:**

Kaniksu Health Services

Consent to Share Confidential Medical/Dental Information

To be valid, this form must be filled out COMPLETELY, including
what information you are giving us permission to share.

Patient's Legal Name: ____________________________________ Date Of Birth: __________________

I HEREBY AUTHORIZE KANIKSU HEALTH SERVICES TO SHARE THE FOLLOWING INFORMATION:

□ My general medical/dental information.

- My lab results (note: checking this box does NOT mean we will share results of STD or HIV/AIDS test)
- My appointment times, dates and reasons for the visits
- The medications I am taking
- The following information (specify) ____

□ Sensitive health information including (please check all that apply to consent):

- Sexually transmitted disease (STD) testing and treatment
- Mental health diagnoses and treatment
- Drug and alcohol use history and treatment
- HIV/AIDS testing and treatment *****
- Pregnancy testing and prenatal care *
- Birth control/family planning *

WITH THE FOLLOWING PEOPLE:

Full Name: ____ Relationship: ______________________

Full Name: ____ _ Relationship: ______________________

Full Name: ____ Relationship: _______________________

I understand that I may cancel this consent at any time (by writing to Kaniksu Health Services Medical Records), but that cancelling it will not affect any information that has already been released.

This authorization will automatically expire in one year from the date signed unless I choose to cancel it, in writing prior to expiration.

Signature: ____ Date: ___________________________

Relationship to minor patient (if parent or legal guardian)* ____

If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

*A minor patient's signature is **require**d for us to share information about care for: (1) conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases (age 14 and above); (2) alcoholism and/or drug abuse (age 13 and above); and (3) mental health conditions (age 13 and above).