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

Dear Kaniksu Patient,

Welcome to Kaniksu Health Services (KHS)! As a Community Health Center we provide quality and affordable medical, pediatric, dental, behavioral health and veteran care, regardless of a patient's ability to pay, as well as offering better access to care through longer hours and more services. For your convenience, we have locations in:

- Bonners Ferry
- Ponderay
- Priest River
- Sandpoint VA
- Sandpoint Pediatrics

Our goal is to help you and the people you love stay healthy or return to good health. Since our first family health center opened in 2002, Kaniksu Health Services has provided our patients with timely, affordable and quality care; because to us, you are not just people in a waiting room. You are part of our family.

Please take a moment to learn about our services and how we can help you and your family reach your health goals.

Your first step as a patient with KHS is to select a primary care physician (PCP)
Your Kaniksu PCP will work with your healthcare team to coordinate your care so that you have the ability to access a wide variety of health services, including preventive care. We understand that from time to time it is necessary to see specialists outside of Kaniksu. When you do, make sure you alert the specialist/ hospital that you are a patient of KHS and the name of your PCP to ensure excellent care transitions.

The Kankisu Patient-Centered Medical Home (PCMH)
A PCMH is not a building or place, but a team of Kaniksu health professionals working together to coordinate care to help you become as healthy as possible. Our focus is you! We treat the whole you, from preventive care to complex health issues; we personalize your care and guide you through the healthcare system.

A Few Things You May Not Expect
Clinical Pharmacist - Kaniksu Health Services has a clinical pharmacist on staff who works as part of your healthcare team to review medications, make recommendations to help with the management of chronic diseases, and certify each medication is appropriate and achieving desired outcomes.

Medication Assistance - We offer our patients better access to prescriptions at discounted prices at many Bonner and Boundary county pharmacies. Ask your provider for a list of participating pharmacies. Additionally, some patients may be eligible for FREE medications. Ask to speak to our Medication Assistance Specialist to see if you qualify.

Dental
Our **dental** team offers full care for Idaho Smiles (Medicaid) patients. This includes: pregnant women, children 19 years of age and under, and eligible special needs adults. Emergency services are available for residents of Boundary and Bonner Counties. For those meeting income guidelines a sliding scale applies.

Behavioral Health
We believe that truly meaningful health care addresses all aspects of a person, including behavioral and emotional needs. As a key component of our integrated, patient-centered model our **behavioral health** team works alongside your medical team to deliver services utilizing a varied team of professionals.

Insurance - There are many new opportunities to get coverage with health and dental insurance, either through Medicaid, Medicare or through the insurance marketplace. If you have any questions about the Affordable Care Act, Medicare or Medicaid, or need assistance enrolling in the Health Insurance Marketplace, contact us at (208) 263-7101 and our Outreach & Enrollment Specialist will be happy to help you.

Patient Portal - The patient portal allows 24-hour access to your personal health information from anywhere with an Internet connection. Using a secure username and password, patients can:

- Update Contact Information
- Securely Message your Care Team
- Review Lab Results & Immunizations
- View and Request Prescription Renewals

When to visit the Emergency Room - Before you find yourself sitting for hours in a hospital emergency room, or end up with medical fees that are not fully covered by your health plan, here are some things you should know. You should first try to contact your Kaniksu PCP. We are available by phone 24/7 for assistance. (208) 263-7101 for family medicine, or (208) 265-2242 for pediatrics. Still not sure? Here are a few guidelines for determining if you should go to the ER:

- Excessive bleeding that won't stop
- When breathing is very hard or you have chest pain with shortness of breath/sweating/pain that spreads to your jaw, arms or neck. Antacids will not help with a heart attack!
- After a serious accident

Community Resources - Navigating the health care system and accessing available resources can be challenging. Our Patient Assistance Specialist will help connect you with the services you need more – FREE of charge.

Sincerely,

Your KHS Care Team

Patient Registration Form

Kaniksu Health Services does not discriminate in its services, treatments, programs, activities, or employment regardless of race, color, religion, national origin, age, physical or mental disability, veteran status, or sex, including gender identity and sexual orientation.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Birth Date:	Social Security #	Sex at Birth: M / F	
Cell Phone #:	Home Phone #:		
Email:	Preferred method of contact:		
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Life Partner			

EMERGENCY CONTACT INFORMATION		
Contact Full Name:		Birth Date:
Primary Phone #:	Relationship to Patient:	

INSURANCE INFORMATION (please circle Medical or Dental)		
Medical/Dental Insurance:	Policy Holder Name:	Birth Date:
☐ No Health Insurance		

As a Federally Qualified Health Center, we are required to collect the following information for statistical purposes only. No individual information is submitted. Your cooperation helps us improve healthcare for all. Thank you.

Family Income	Our annual household income before taxes is: $_________________. There are _______ people in my household		
Ethnicity	Are you Hispanic/Latino? ☐ Yes ☐ No		
Race	☐ White ☐ Black/ African American ☐ Native Hawaiian / Other Pacific Islander ☐ Asian ☐ American Indian/Alaska Native ☐ Other		
Language	What is your preferred language, including sign language?____		
Farmworkers	In the past 2 years, have you or a member of your family worked in agriculture (fields, orchards, etc.) seasonally as the primary source of income?	☐ Yes	☐ No
	If yes, does this person change residence as a part of their work?	☐ Yes	☐ No
	Have you or a member of your family stopped migrating to work in agriculture due to disability or old age?	☐ Yes	☐ No
Veteran	Are you a Veteran?	☐ Yes	☐ No
Living Situation	☐ Rent/Own a Home ☐ Homeless ☐ Other (please describe)______________________		
Sexual Orientation	☐ Straight ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Don't Know ☐ Choose not to disclose ☐ Something else (please describe)________________________________		
Gender Identity	☐ Male ☐ Female ☐ Transgender (Male/ Female to Male) ☐ Other ☐ Choose not to disclose ☐ Transgender (Female/ Male to Female)		

Reduced Fees	Are you interested in participating in our sliding fee scale program? (Could result in reduced fees, even for insured) ☐ Yes ☐ No	**Please Initial __________**

*The sliding fee scale program is in place to meet the needs of the uninsured or underinsured, providing reduced costs on most services for those who qualify.
No one will be denied access to services at KHS , as services are offered regardless of insurance status or ability to pay.

I hereby agree that the above information is true and correct to the best of my knowledge. 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 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 **Guardian (if applicable)** **Date**

Kaniksu Health Services

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Comprehensive Adult New Patient Health History Questionnaire

Name ______________________________ Nickname: ____________________ Birth Date________________

Gender ___________ Occupation__________________________________ Highest grade level achieved_________

How would you rate your health? (circle one) Excellent / Good / Fair / Poor

What are your health goals for the next year? ____

____

Please list medications/supplements/herbs you take every day: **Pharmacy:**________________

Medication Name	Dose	frequency

Allergies to medications or foods:

Medication/Food	Type of Reaction	Severity

Medication/Food	Type of Reaction	Severity

Do you have any of the following medical problems?

Acid reflux	Yes	No
Anemia	Yes	No
Arthritis (Location) ________	Yes	No
Asthma	Yes	No
Blood disorder/Clots	Yes	No
Cancer (Location) ________	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Epilepsy/Seizures	Yes	No
Glaucoma	Yes	No
Heart Disease	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
HIV/AIDS	Yes	No
Kidney Problems	Yes	No
Lung Disease	Yes	No
Sexually transmitted disease	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Ulcers	Yes	No
Artificial valves/stents	Yes	No

When was your last (please include date & location)?

Annual Exam _________where? _____________ Pap Smear _________where? _____________

Mammogram _________where? _____________

Colonoscopy or stool test for colon cancer _________where?___________

Bone density test _________where? ____________ Tetanus Shot _________where? _____________

Flu Shot _________where? _____________ Pneumonia Shot(s) _________where? _____________

Please list any surgeries or hospitalizations you have ever had (please include date & location):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Social History: **Yes or No (circle one)**

Are you now or have you ever used nicotine products? Y / N If yes, please specify: ______________

If yes, how much? _____ For how long? _____

If yes, what age did you start? _____ Quit Date (year): _____ Age Stopped: _____

Do you vape? Y / N If yes, how many mg/day? __________

Do you use recreation drugs? Y / N If yes, please specify: ______________

Do you drink alcohol/wine/beer? Y / N How much/how long: ______________

If yes, have you ever blacked out? Y / N

How often do you drink soda pop, energy drinks, or caffeine? ______________________________

Do you follow any special diet? Y / N If yes, please specify: ______________

Have your sexual partners been (please circle): Male / Female / Both

Do you have any particular religious/spiritual beliefs that may influence your medical decisions? Y / N

Do you have a family history of:

			Relationship to you:	**Maternal or Paternal?**	**Alive? Yes / No**	**Age of Onset:**	**Cause of death? Yes / No**
Cancer _________	Yes	No	_______________	M / P	Y / N	______	Y / N
Depression	Yes	No	_______________	M / P	Y / N	______	Y / N
Dementia	Yes	No	_______________	M / P	Y / N	______	Y / N
Diabetes	Yes	No	_______________	M / P	Y / N	______	Y / N
Genetic Disorder	Yes	No	_______________	M / P	Y / N	______	Y / N
Heart Disease	Yes	No	_______________	M / P	Y / N	______	Y / N
Heart Attack	Yes	No	_______________	M / P	Y / N	______	Y / N
High Blood Pressure	Yes	No	_______________	M / P	Y / N	______	Y / N
Mental Illness _________	Yes	No	_______________	M / P	Y / N	______	Y / N
Stroke	Yes	No	_______________	M / P	Y / N	______	Y / N
Substance Abuse	Yes	No	_______________	M / P	Y / N	______	Y / N
Sudden death at an early age	Yes	No	_______________	M / P	Y / N	______	Y / N

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KHS Bonners Ferry Clinic: 6615 Comanche Street, Bonners Ferry, ID 83805
KHS Sandpoint Clinic: 30410 Hwy 200, Ponderay, ID 83852
KHS Sandpoint Pediatric Clinic: 420 N. Second Ave, Sandpoint, ID 83864
KHS Priest River Clinic: 6509 Hwy 2 Suite 101, Priest River, ID 83856

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Kaniksu Health Services to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). *(The Notice of Privacy Practices provide by KHS describes such uses and disclosures more completely.)*

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kaniksu Health Services reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Program Coordinator

CEO: Kevin Knepper
PO Box 2160
Sandpoint, ID 83864

With this consent,
KHS may call or text me at the number provided, my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, KHS may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. KHS may also fax any PHI upon my signed approval.

With this consent, KHS may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that KHS restricts how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow KHS to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, KHS may decline to provide treatment to me.** If I would like to request to change my communication preferences or decline to be contacted via text or email, I may call or speak with the front desk at any time.

Signature	Date	Relationship to Patient

Print Patient's Name	Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form

Kaniksu Medical Health Services

KHS Bonners Ferry Clinic: 6615 Comanche Street in Bonners Ferry
KHS Sandpoint Clinic: 30410 Highway 200 in Ponderay
KHS Sandpoint Pediatrics Clinic: 420 N Second Ave. in Sandpoint
KHS Priest River Clinic: 6509 Highway 2 Suite 101 in Priest River

Cancellations, No-Show and Late Arrival

Dear Patient:

Welcome to Kaniksu Health Services, we look forward to serving your health care needs. To help coordinate your care, please review the following instructions for scheduling appointments: ** please place your scheduled appointment care with date in a visible place!!*

A KHS staff member will make every attempt to make a courtesy call to confirm your appointment the day previous to your scheduled appointment or on Friday for a Monday appointment.

Please be aware that on the day of your appointment, you will need to arrive **15 minutes early** for all routine care appointments and **30 minutes early** for a new patient exam appointment. Please be sure to bring your insurance information, Medicaid or Medicare information and co-pay if covered.

If you arrive more than **15 minutes late** for your scheduled appointment, you may be given one of the following options: re-schedule the appointment or wait until an opening in the schedule for that day will permit the previously scheduled care to be completed.

If an appointment needs to be cancelled, please call the receptionist at least 24-hours in advance. Patients who **fail to cancel three scheduled appointments in advance and do not show up will not be allowed to make another appointment for routine care for six months.** Emergency care only will be available during this period of "appointment hold".

We look forward to working with you.

Sincerely,

Kaniksu Health Center Staff

Patient's Name (please print): ____

____ _______________
Patients / Guardians Signature Date

Kaniksu Health Services
...providing its communities with affordable and accessible healthcare.

AUTHORIZATION TO RECEIVE AND/OR RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Birth Date:	Social Security #		
Phone #:			
Address:	City:	State:	Zip:

I request and authorize Kaniksu Health Services (fax: 208-263-7198 or ______________________, P.O. Box 2160, Sandpoint, ID 83864) to

☐ **Release To:** ☐ **Obtain From:**

Organization or Person:		
Address:		
City/State/Zip:	Phone:	Fax:

☐ Medical/Dental records from the most recent two years. **Includes sensitive information (as consented to below).

OR

☐ Medical/Dental records from date:____________to date:___________. **Includes sensitive information (as consented to below).

OR

Specific records (checked below), from date: ________________________ to date: ____________________________

☐ Immunizations
☐ Medication List
☐ X-Ray/Diagnostic Imaging
☐ Other ___________________________________
☐ Billing Records
☐ Chart Notes
☐ Lab Results (Specify: _____________________________)

Disclosure Method

☐ Fax Records ☐ Electronically Transmit Records ☐ Pick Up Paper Records ☐ Mail Paper Records

Are you transferring care to another Provider/Entity?: ☐ No ☐ Yes

****Sensitive Information (Requires Your Consent to Disclose - Check any/all that you consent to disclose).**

☐ HIV/AIDS Related Records
☐ Birth Control/Pregnancy Records
☐ Mental Health Records
☐ Sexually Transmitted Disease Records
☐ Drug/Alcohol Abuse Diagnosis/Records
☐ Genetic Testing Records

Patient may revoke this authorization at any time prior to expiration by notifying Kaniksu Health Services in writing. Unless revoked earlier, this authorization will expire 1 year from the date of signing. I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_________________________ _________________________ __________

Signature **Parent/Guardian (if minor)** **Date**

Office Use Only
Identity of Patient verified with: ☐ Photo ID ☐ Other:_____________________________
Verified by: ______________________________ Date: ____________________
Request Completed By: ______________________________ 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).

Kaniksu Health Services

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Patient Portal Security Questions (Only Need to Pick 5)

Have access to your Health Care Team 24/7. Request and Review documents such as lab results, immunization records and visit summaries.

What is your mother's maiden name?

What is your maternal grandmother's first name?

What is your maternal grandfather's name?

What is your paternal grandmother's name?

What is your paternal grandfather's name?

In what city were you born in?

In what city was your mother born in?

In what city was your father born in?

What is your mother's middle name?

What is your father's middle name?

What was the first name of your best man/maid of honor?

Who was your favorite childhood super hero?

What was the name of your first boyfriend/girlfriend?

In what city did you spend your honeymoon?

In what city was your high school?

In what city did you meet your spouse for the first time?

In what city were you married?

In what city is your vacation home in?

Name of your first child?

What is your favorite hobby?

What is your pet's name?

Who is your favorite singer?

What school did you attend 6th grade?

What was the make and model of your first car?

With what company was your first job?

What was your childhood phone number?

Your oldest sibling's nickname?

Who was your best friend in elementary school?

What is the name of your first college roommate's name?

Username: ____________________________

Password: **KHSpatient01!**

Go to NextMD.com to access your account and log in.

Medical, Dental, Behavioral Health, Pediatrics: 6615 Comanche Street, Bonners Ferry, ID 80805, (208) 267-1718
Medical, Dental, Behavioral Health, Pediatrics: 30410 Hwy 200, Ponderay, ID 83852, (208) 265-6252
Medical, Behavioral Health, Pediatrics: 6509 Hwy 2, Priest River, ID 83865, (208) 448-2321
Pediatrics, Behavioral Health: 420 N. 2nd Ave, Sandpoint, ID 83864, (208) 265-2242
VA Clinic: 420 N. 2nd Ave, Sandpoint, ID 83864, (208) 263-0450
Administrative Offices: 301 Cedar St #206, P.O. Box 2160, Sandpoint, ID 83864, (208) 263-3410
www.kaniksuhealthservices.org