

**Patient's Name:** \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

**Patient DOB:** \_\_\_\_\_ **Patient Social Security #:** \_\_\_\_\_

**GSHWC is a Federally Qualified Health Center that receives government funding. The funding for your health center is based on information you provide and is necessary for us to better serve you, our patient. Please answer each of the following questions for reporting purposes.**

**Birth Sex:** M  F  **Sexual Orientation:** Straight  Lesbian/Gay  Bisexual  Other  \_\_\_\_\_

**Gender Identity:** Male  Female  Transgender Male (Female to Male)  Transgender Female (Male to Female)  Other  \_\_\_\_\_

**Race:** White  Asian  Black  Alaskan/ Native American  Native Hawaiian  Other Pacific Islander  Other  \_\_\_\_\_

**Ethnicity:** Are you Hispanic or Latino Yes  No  **Preferred Language:** English  Spanish  Other \_\_\_\_\_

**Does the minor have an Advance Directive?**  Yes  No **Would you like information on Advance Directives?**  Yes  No

**Does the minor have medical insurance?** Yes  No  **Does the minor have dental insurance?** Yes

### **Guarantor/Responsible Party Information**

If other than Mother or Father, please provide a copy of custody paperwork.  
We consider the person completing this form to be financially responsible for patient.

**Person Completing This Form:** Mother  Father  Legal Guardian  Other (specify): \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
Street Apt. Number City State Zip Code

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employment Status:** Employed Full-time  Employed Part-time  Self-employed  On Active Military Duty   
Retired  Not Employed  Student Full-time  Student Part-time

**E-mail address:** \_\_\_\_\_

**Marital Status:** Married  Single  Widowed  Divorced  Partner  Separated

**Are you a farm worker?** Migrant  Seasonal  No  **Have you ever served in the Armed Forces?** Yes  No

**Housing Status (if applicable):** Public Housing: Yes   
Homeless: Doubling up  Street  Transitional  Homeless Shelter  Other \_\_\_\_\_

**Annual Wage:** ≤\$12,060  \$12,061-15,075  \$15,076-18,090  \$18,091-21,105  \$21,106-24,120  ≥\$24,121

**How many people live in your household?** \_\_\_\_\_

I certify that the above information is correct. I authorize payment of medical benefits to GSHWC and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

I hereby authorize employees and agents, including physicians, dentists, physician assistants, nurse practitioners, and other healthcare practitioners of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the providers; including consultants, associates and assistants of the provider's choice. I authorize Good Samaritan Health & Wellness Center to secure my prescription history from external sources. \*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

**Parent/Responsible Party's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Patient DOB** \_\_\_\_\_

Good Samaritan Health & Wellness Center provides discounts for medical, dental and behavioral health services to qualified patients. The discount is based on the number of persons in the household and the combined **GROSS** income of all persons in the household. Income verification must be provided before the sliding fee discount will be applied.

The following can be provided for **GROSS** income verification:

1. Three current pay stubs, OR
2. Most recent Federal Income Tax Return/W-2's, OR
3. Documentation from Social Security, OR
4. Letter from your employer stating the average hours worked in a week and the hourly rate of pay. This must be on the employer's letterhead, OR
5. Income Verification Form.

**Please list ALL persons (adults and children) in the Household:**Name: \_\_\_\_\_ Amount of **Gross** Income \_\_\_\_\_  Weekly  Monthly  AnnuallyName: \_\_\_\_\_ Amount of **Gross** Income \_\_\_\_\_  Weekly  Monthly  AnnuallyName: \_\_\_\_\_ Amount of **Gross** Income \_\_\_\_\_  Weekly  Monthly  AnnuallyName: \_\_\_\_\_ Amount of **Gross** Income \_\_\_\_\_  Weekly  Monthly  AnnuallyName: \_\_\_\_\_ Amount of **Gross** Income \_\_\_\_\_  Weekly  Monthly  AnnuallyName: \_\_\_\_\_ Amount of **Gross** Income \_\_\_\_\_  Weekly  Monthly  Annually**Total Number of People Living in the Household:** \_\_\_\_\_ **Total Household Income:** \_\_\_\_\_

**You are required to update this information annually and at any time there is a change in income or persons living in the household, or if you become eligible for insurance.**

**We are not a free clinic and payment of services is required at the time of your visit. Payments include insurance co-payments, sliding scale fee or full payment. Cash, debit cards and major credit cards are accepted.**

I understand and agree to all rules of the discounted fee/sliding fee program. I confirm that all information provided above is correct and accurate. I understand that providing inaccurate or false information will result in automatic loss of eligibility for discounts.

I understand that it is my responsibility to supply all required information to Good Samaritan Health & Wellness Center. I understand that, if I do not have the required information by my second visit, I will be taken off the sliding fee program and will be required to pay 100% of the fees due. I agree to inform Good Samaritan Health & Wellness Center if there is any change in my household income, persons living in the household, or any change in health insurance coverage.

**Printed Name of Parent/Responsible Party:** \_\_\_\_\_**Signature of Parent/Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## As a patient, you have the right to:

- Take part in your health care and treatment
- Know the names of the people caring for you
- Be treated with respect and dignity in a safe and private setting
- Be informed about your illness and treatment, including options for your care
- Change medical providers at GSHWC
- Get another opinion about your illness or treatment
- Privacy of your health records
- Talk with the Chief Medical Officer about questions or problems with your care
- Respect for your cultural, social, spiritual and personal values and beliefs
- Know about legal reporting requirements
- Ask for special arrangements if you have a disability
- Refuse treatment, care and services as allowed by law
- Know the cost of your care and ways you may pay for your care
- Ask for help with Advanced Directives or Durable Power of Attorney for Healthcare

## As a patient, you have the responsibility to:

- Notify the clinic of changes in residence or phone number
- Bring all medication bottles from all doctors to your appointment at GSHWC
- Tell your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both caregivers and other patients
- Use medications or medical devices for yourself only
- Inform the medical provider if you become worse or you have an unexpected reaction to a medication
- Give written permission to release your other health records to GSHWC when necessary
- Provide GSHWC a copy of your Advanced Directive and Durable Power of Attorney for Healthcare
- Call and make appointments at least 2 weeks prior to running out of medications
- Call the pharmacy (where you currently get your prescriptions filled) 1 week prior to needing refills
- **Cancel or reschedule appointments so that another person may have that time slot**
- **Make payment when services are rendered or prescriptions are picked up**
- Inform us when your household income or occupancy number changes
- Notify the center of changes in insurance coverage or eligibility, including private insurance, Medicaid, Medicare, PeachCare for Kids, Amerigroup, WellCare or Veteran's Choice

## Loss of Services:

**Should you fail to comply with the above stated responsibilities, the center reserves the right to reschedule your appointment, suspend your services, refer you to another practice, or dismiss you from our practice.**

## Prescriptions:

The clinic has a strict policy on the prescribing of class 2 medications, such as Opioids (pain pills) and Benzodiazepines (sedatives). The medications are only given in accordance with guidelines and at the providers' discretion.

Prior to any ADD or ADHD medication for pediatric or adults being prescribed, documentation of a formal diagnosis from a psychologist or psychiatrist is required. The patient may schedule an appointment with our psychologist for testing.

**Signature of Parent/Responsible Party:** \_\_\_\_\_

**Date:** \_\_\_\_\_