Good Samaritan
HEALTH & WELLNESS CENTER

Patient Information

Patient's Name: _____
(Last Name) (First Name) (Middle Initial)

Mailing Address: _____
Street Apt. Number City State Zip Code

Physical Address if different from mailing: _____
Street Apt. Number City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Work Phone**: _____

Parent/Guardian Name (If patient under 18): _____

Patient DOB: _____ **Patient Social Security #**: _____

Patient (or parents) 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: _____ **Do you have an Advance Directive?**

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

Race(Check all that apply)**:** Black ❑ Asian ❑ White ❑ Alaskan/ Native American ❑ Native Hawaiian ❑
Other Pacific Islander ❑ Other ❑_____

Ethnicity: Hispanic or Latin ❑ Non-Hispanic and Non-Latino ❑ Rather Not Answer ❑

Preferred Language: English ❑ Spanish ❑ Other _____

Are you a farm worker? Migrant ❑ Seasonal ❑ No❑

Have you ever served in the Armed Forces? Yes ❑ No ❑

Housing Status: Public Housing❑ Homeless❑ (If homeless, check circumstance below.)
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? _____

If this is your first time visiting Good Samaritan Health & Wellness Center, how did you hear about us?

☐ Provider Referral ☐ Hospital Referral ☐ Friend/Family Referral ☐ Other Referral _____

☐ Billboard ☐ Radio ☐ Newspaper ☐ Internet ☐ Other _____

Patient or Guardian Signature* _____ **Date:** _____
I certify the above information is correct. I consent to be treated by the staff and providers of GSHWC. *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

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Patient Name _____ **Patient DOB** _____

Insurance Information

Primary Insurance Company:_____ Policy Holder's Name:_____ DOB:_____
Policy Holder's ID#:_____Employer: _____

Secondary Insurance Company:_____ Policy Holder's Name:_____ DOB:_____
Policy Holder's ID#:_____Employer: _____

Dental Insurance Company:_____ Policy Holder's Name:_____ DOB:_____
Policy Holder's ID#:_____Employer: _____

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.

Patient or Responsible Party's Signature* _____ **Date:**_____
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Emergency Contact Information

Emergency Contact Name: _____ **Relationship to Patient:** _____

Home Phone: _____ **Cell Phone:** _____

Permission to Verbally Discuss Protected Health Information

I, _____, hereby authorize Good Samaritan Health and Wellness Center to discuss my protected health information with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to GSHWC. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released in response to authorization or to information that GSHWC has used based on this authorization. If I have questions about the use and disclosure of information, I can contact GSHWC.

Patient or Guardian Signature* _____ **Date:** _____
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Advance Directive

Do you have an Advance Directive? ❑ Yes ❑ No If, yes, please provide a copy.

Would you like information on completing an Advance Directive? ❑ Yes ❑ No

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Application for Discounted Fee Program

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 ❑ Annually

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Name: _____ 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.

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 Applicant: _____

Signature of Applicant: _____ **Date:** _____

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Patient Rights and Responsibilities

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 3 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 state 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:_____ **Date:** _____