English

Patient Intake Form / Información Sobre el Paciente

Good Samaritan Clinic
Clínica el Buen Samaritano
St. Joseph's/Candler

Today's Date (Fecha): ____ - ____ - ____
MM / DD / YYYY

New Patient? (¿Paciente Nuevo?) Yes ☐ No ☐

First Name (Nombre)	**Middle** (Nombre **Compuesto**)	**Last Name** (Apellido)

- -	- -	Male ☐ Female ☐
Social Security Number/ITIN (Número Seguro Social)	**Date of Birth – MM / DD / YYYY** (Fecha de Nacimiento)	**Sex** (Sexo)

Home Address (Dirección)	**City** (Ciudad)	**Zip Code** (Código Postal)

Home Phone (____) ____ - ____ (Teléfono Hogar)

Cell Phone (____) ____ - ____ (Teléfono Celular)

Name & Number of Emergency Contact ____ (____) ____ - ____
(Nombre y número de una persona que podemos contactar en caso de una emergencia)

Country of Origin ____ (País de Origen) **County of Residence** ____ (Nombre del Condado donde vive) **Language**: English/Spanish

Race: ___White___Black___Asian /Pacific Islander___American Indian/Alaskan Native
(Raza)

Ethnicity: Hispanic/Non-Hispanic
(Idioma Principal)

Marital Status: (Estado matrimonial)	**Married** ☐ (Casado)	**Single** ☐ (Soltero)	**Separated** ☐ (Separado)	**Divorced** ☐ (Divorciado)	**Widowed** ☐ (Viudo)

Name of Spouse: (Nombre de Esposo/Esposa): ____

Employed? (¿Empleado?) Yes ☐ No ☐ **Occupation** (Ocupación) ____

How were you referred to our clinic? (¿Quién lo refirió a la clínica?) ____

What is the reason for your appointment? (¿Cuál es la motivación para su cita?)

____

Do you have any chronic health conditions? (¿Tiene problemas crónicos de la salud?)

____

Where have you been receiving your health care up until now? Have you seen a specialist for your condition? (¿Donde estaba recibiendo su cuidado medico hasta ahora? ¿Ha visto a un especialista por su condición?)

____

____

Georgia Volunteer Health Care Program (GVHCP)
Georgia Department of Public Health
Financial Eligibility Form

Clinic/Program/Provider:

FILL OUT

SECTION I – PATIENT DEMOGRAPHIC INFORMATION

Patient Name:

_____ _____ _____
(Last Name) (First Name)
(Middle Initial)

Address:

_____ _____ _____ _____
(Street) (City/State) (Zip Code) (County)

Telephone/Contact number: _____ **Name of contact if other than yourself:**

_____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black ☐ Asian /Pacific Islander ☐ American Indian/Alaskan Native

SECTION II - INSURANCE INFORMATION/FINANCIAL ELIGIBILITY

Do you have insurance that covers? ☐ Health ☐ Vision ☐ Dental ☐ No Insurance

Do you currently have Georgia Medicaid? ☐ Yes ☐ No

I meet one of the following program eligibility categories: ☐ **Uninsured** ☐ **Underinsured**

Your income must be at or below 200% of the Federal Poverty Level to be eligible to receive services under the GVHCP. Please provide gross family earned and unearned monthly income: $_____ and your family size _____.

SECTION III – LEGAL ACKNOWLEDGEMENTS

I understand that I am being referred to a volunteer health care provider who will provide care to me or to someone for whom I are legally responsible. My participation in this referral process is voluntary. The care I receive from the volunteer health care professional will be provided at no charge. I understand that the Volunteer is acting as an employee of the State of Georgia by treating me pursuant to the "Georgia Volunteer Health Care Program." I acknowledge that the exclusive remedy for any injury or damage suffered as a result of any act or omission of a health care provider acting within the scope of duties pursuant to that Program is a lawsuit under the State Tort Claims Act, O.C.G.A. § 50-21-20 *et seq.*, and that a remedy for injury or damage suffered as a result of any act or omission of a health care provider acting outside the scope of those duties shall be as provided for under general tort or other applicable law.

The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I understand that any failure to update this information to the Department upon change in my financial or health insurance status may disqualify me from receiving health or dental care under the GVHCP. I further understand that making false statements or representations on this form may be punishable under O.C.G.A. Section 16-10-20 by a fine of not more than $1,000 or by imprisonment for not less than one or more than five years, or both.

Signature of Patient/Parent or Guardian	**Printed Name of Person Signing**	**Relationship to Minor (If applicable)**
Signature of Eligibility Specialist	**Printed Name of Eligibility Specialist**	**Date**

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NO SHOW Policy
Good Samaritan Clinic & St. Mary's Health Center

NO SHOW

1. You are considered a NO SHOW if you do not show up for an appointment and do not call to inform the office of your inability to keep the scheduled day and time.

2. You are considered a NO SHOW if you do not inform the office of a need to **change your day or time by 2:00pm the day before** your scheduled appointment.

3. If you are called into work, you must present a note from your work supervisor stating that you were called in; only upon receiving the Supervisor's Note will the NO SHOW be erased.

If you NO SHOW:

- **First No Show**: Office Coordinator calls you asking reason and asking what we or you could do so it does not happen again. We will try to work with you to alleviate barriers.
- **Second No Show**: RN Team Leader calls you explaining again why the policy is important asking YOU what help is needed for your compliance.
- **Third No Show**: YOU, the patient, receive a formal "Discharge Letter"
  Letter states too many **No Shows** as reason for dismissal
  Letter gives you contact info for JC Lewis & Curtis Cooper as a possible medical home. We will ensure you have enough medicine to last two months until you are in a new medical home. Letter states the exact month and year you can reapply as a new patient. (12 months from dismissal date). Letter scanned into your medical record.

Specialty Care Appointments (includes Mammogram, Eye Exam)

We try very hard to refer you to doctors who will offer you a reduced rate, a payment plan or possibly write off your charge(though rare) These doctors receive hundreds of dollars just for an appointment – so they are offering you a great gift! Their expertise is very expensive! They give up a spot of a highly paying patient to see you. If you No Show, it gives you and the clinic a bad reputation. That doctor may not be willing to help another patient who has no insurance or very little money. We are counting on YOU to keep this great gift going! Show Up and pass it on!

If YOU, the patient, No Shows a SPECIALTY CARE PHYSICIAN appointment, YOU will not be rescheduled for another appointment with that doctor for 9 months.

If YOU No Show a second time for any specialty care, you will not receive ANY other specialty care appointment.

I understand the No Show Policy. It was explained to me and I agree to follow this important policy.

_____ _____

Date Signature

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Patient Agreement: Expectations and Responsibilities

- I understand that this is a Free Clinic, no charges for services that are performed in this clinic. The Providers are volunteers and their services are given free of charge. I understand that appointments are scheduled and I will have a wait time for any of my services.
- I understand that I need to update my financial information on a yearly basis, if I do not update this information I will not be scheduled for any specialty services until I have updated my income.
- I understand that I will not use any other free clinic or other medical provider unless advised by the Good Samaritan Clinical Manager/Provider with the exception of emergency care cases.
- I understand that I need to give the clinic **24 hours' notice** if I am unable to keep my scheduled appointment. If I "no-show" on 2 occasions, I will become ineligible for services at the Good Samaritan Clinic (GSC). I understand that I need to give **24 hours' notice** if I am unable to attend an **imaging, eye clinic or other specialty referral appointment**; if I do not call it will be marked as a "no show" and I will become ineligible for services at GSC.

I understand that I play an important role in my own care, it is my responsibility to:

- ✓ Schedule annual primary care visits along with routine lab work for my care.
- ✓ Follow through on testing and treatments ordered by the medical personnel at the Clinic.
- ✓ Use disease prevention and management tools that the Clinic makes available to me in order to actively participate in my care.
- ✓ Failure to comply with my treatment plan will make me ineligible for continued care at the Clinic.

- I understand that if I am referred to a doctor outside of the clinic for additional tests, imaging or specialty care or need to go to the emergency room at St. Joseph's or Candler hospital, **I will be responsible for any fees or charges associated with those visits and the Good Samaritan Clinic will not pay for those services.**
- I will inform the clinic as soon as possible of any changes in my phone number, address, income or insurance coverage.
- If I take a prescription for a chronic condition, I will have my pharmacy fax a **refill request** to the **clinic's fax, 912-964-1825** at least **7 days prior** to the end of my prescription medication. Once the request is received, GSC may take up to 72 hours to approve and refill any medications. **The Good Samaritan Clinic does not prescribe medication for any Chronic Pain Management, Male enhancements, Oral Contraceptive therapy if not medically necessary or Fertility treatments or procedures.**

Refills of certain medications are dependent upon completing required lab work

- I understand that if I am uncooperative, verbally or physically abusive to clinic staff, volunteers or other patients, intoxicated or otherwise behave in an inappropriate manner, I will not be eligible for services at GSC.
- I will contact the clinic if I have any questions concerning my health care.

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Copy given to patient:

_____
Patient Initials

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Good Samaritan Clinic
Clínica el Buen Samaritano
St. Joseph's/Candler

Consent for Treatment

Consent to Receive Medical Services

I consent to receive medical, dental or other services and treatment by one who has agreed to provide such treatment without compensation as provided under Section 33-55-210 of the Georgia Code of Law, voluntary and non-voluntary health care providers.

Patient Signature:_____ Date:_____

Consent to Receive Notification

I authorize Good Samaritan Clinic to contact me or leave a message at a phone number, address, e-mail or other method I provide to them.

Patient Signature:_____ Date:_____

Consentimiento Para Recibir Tratamiento

Consentimiento Para Recibir Servicios Médicos

Yo doy mi consentimiento de recibir tratamiento medico, educacional u otro servicio a la persona que voluntariamente ha aceptado ofrecer estos servicios sin pago alguno, bajo la sección 33-55-210 del Código Legal de Georgia.

Firma del Paciente:_____ Fecha:_____

Autorizo Ser Notificado

Yo autorizo Buen Samaritano Clínica en contactar conmigo o dejar un mensaje a un número de teléfono, dirección, e-mail u otro método que proporciono a ellos.

Firma del Paciente:_____ Fecha:_____

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Good Samaritan Clinic
Clínica el Buen Samaritano

St. Joseph's/Candler

ACKNOLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Privacy Practices of Good Samaritan Clinic.
Con mi firma abajo, reconozco que he recibido una copia de la Prácticas Privadas de la Clínica el Buen Samaritano.

_____
Signature of Patient or Legal Representative
Firma del Paciente o Representante

_____
Printed name of Patient or Legal Representative
Nombre Escrito del Paciente o Representante

_____
Date
Fecha

_____
Staff Signature
Firma del personal

Good Samaritan Clinic
Clínica el Buen Samaritano
St. Joseph's/Candler

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize **Good Samaritan Clinic** and its entities, its officers or agents to permit inspection, copying, and/or release of information compiled in the ordinary course of business in connection with the following:

Patient Name: _____ Date of Birth: _____
(Nombre de Paciente) (Fecha de Nacimiento)

Address: _____ Telephone #: _____
(Direccion) (Numero de Telefono)

_____ Social Security # _____
(Numero de Seguro Social)

I further understand and acknowledge that in complying with my request for release, such disclosure will require **Good Samaritan Clinic** to disclose, as provided under applicable federal law, Protected Health Information, as defined in 42. C.F.R. § 160 et seq. Information to be disclosed and faxed to **912-964-1825**

- ☐ **Complete Health Record - for 1 YEAR from date of** _____
- ☐ Radiology Reports
- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Abstract/Pertinent Information
- ☐ Emergency Department Record
- ☐ Laboratory Tests
- ☐ Other (Please Specify) _____

I UNDERSTAND THIS MAY INCLUDE INFORMATION RELATING TO THE FOLLOWING UNLESS EXPRESSLY EXCLUDED BY CHECKING THE BOX(ES) BELOW:

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- ☐ Psychiatric Care (Behavioral Health)[1]
- ☐ Treatment for Alcohol and/or Drug Abuse[2]
- ☐ Genetic Testing
- ☐ Sexually Transmitted Diseases (STDs)

This information is to be disclosed to:
(Information para revelarse a): _____

_____

_____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. A photocopy or FAX of this document is valid as the original.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein:

Signature of Patient or Legal Representative: _____ Date: _____
(Firma de Paciente o Representante Legal) (Fecha)

Witness: _____ Date: _____

[1] Except psychotherapy notes as provided under federal and state laws.

[2] **PROHIBITION OF REDISCLOSURE:** This information has been disclosed from records whose confidentiality is protected by federal and state law. Federal Regulations (42 CFR Part 2) prohibit the receiver of these records from making any further disclosure of this information except with the specific written consent of the person who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

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FINANCIAL ELIGIBILITY FORM

Good Samaritan Clinic
Clínica el Buen Samaritano
St Joseph's/Candler

Do you have insurance that covers your health or dental condition? Yes_____ No_____

Family size: Adults _____ Under 18 _____ Students 18-21 _____ Unborn _____ Total # _____

Section 1 ****Use current year Federal Poverty Guidelines for income determination.****

FAMILY MEMBERS NAMES	AGE	EMPLOYER	INCOME LAST 4 WEEKS
SELF:			$
SPOUSE:			$
CHILD:			$
CHILD:			$
CHILD:			$
CHILD:			$
CHILD:			$
TOTALS			$
Note: Family income is used to determine eligibility, not household income. (Example: A husband, wife, and their 2 children that live with the husband's brother, but receive no money from him, should not include the brother's income in the family income.)			TOTAL INCOME $_____

Section 2

Budget Computation (To be completed if family income is above Federal Poverty Level.)	
Step 1: "Total Family Income" for family unit (Earned income)	$
Step 2: Subtract $90 for EACH employed member of the family unit.	- $
SUB TOTAL	$
Step 3: Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2)	- $
SUB TOTAL	$
Step 4: Subtract up to $50 per month of total child support received	- $
TOTAL NET INCOME	$

Do you receive any other assistance from family or friends? If your family had no income for the last 4 weeks, please explain how you have been meeting your basic expenses (for example groceries, rent, gas for your car, etc?)

_____

_____

_____

The information I have given is true and accurate to the best of my knowledge. If it is discovered that I have been untruthful, I will no longer be eligible for services at Good Samaritan Clinic.

La información que he proporcionado con respecto a mis ingresos es verdad y completa con el mejor de mi conocimiento. Entiendo que la falsificación de esta información va a dar lugar a mi inhabilidad para recibir servicios en la clínica el buen samaritano.

_____ _____

Signature of Patient/Parent or Guardian Signature of GSC Volunteer Date

(Valid for 1 year) Expiration Date: _____

Rev. April 2013

FINANCE INFORMATION

PATIENT NAME:_____ AGE ____ ~~EMPLOYER~~_____

NAME OF SPOUSE:_____ AGE____ EMPLOYER _____

CHILDREN NAMES Under 18

_____ AGE _____

_____ AGE _____

_____ AGE _____

_____ AGE _____

_____ AGE _____

PLEASE CIRCLE YES OR NO FOR EACH QUESTION.

1.DO YOU HAVE INSURANCE? YES OR NO?

2. DO YOU RECEIVE FOOD STAMPS? YES OR NO?

3.DO YOU RECEIVE MEDICAID? YES OR NO?

4. DO YOUR CHILDREN RECEIVE FOOD STAMPS? YES OR NO?

5. DO YOUR CHILDREN RECEIVE MEDICAID? YES OR NO?

6.DO YOU RECEIVE FINANCIAL HELP FROM FAMILY, FRIENDS OR YOUR CHURCH?

YES OR NO?