**Patient Registration Form** Patient Number ____________________

**Name:** ______________________ ______ ________________________
FIRST MI LAST

**Date of Birth:** ______/ ______/ ______ **Sex at Birth:** ( ) Male ( ) Female
PLEASE CHECK ONE

**Social Security Number:** __________ - ____ - ________

**Street Address:** ________________________________________ **PO Box:** ________

**City:** ________________________ **State:** ________ **Zip Code:** ______________

**Home Telephone:** ( _____ ) ______________ **Work Phone:** ( _____ ) ______________

**Cell Phone:** ( _____ ) ______________ **Email Address:** ________________________

**Marital Status:** ____________________ **Student Status:** ( ) Full Time ( ) Part Time
PLEASE CHECK ONE IF APPLICABLE

**Spouse's Name:** ________________________ **Date of Birth:** ______/ ______/ ______

**Patient's Employer:** ____________________ **Spouse's Employer:** ____________________

**Emergency Contact**: ____________________ **Telephone:** ( _____ ) ______________

---

Responsible Party Information: (Who Pays the Bills?) **Guarantor Name:** ____________________

**Telephone:** ( _____ ) ______________ **Work Phone:** ( _____ ) ______________

**Relationship to Patient:** ____________________ **Date of Birth:** ______/ ______/ ______

**Street Address:** ________________________________________ **PO Box:** ________

**City:** ________________________ **State:** ________ **Zip Code:** ______________

**Social Security Number:** ________ - _____ - ________ **Employer:** ____________________

---

**If Patient is a Minor:** **Parent/Legal Guardian of Minor (1)**

**Name:** ______________________ ______ ________________________
FIRST MI LAST

**Relationship to Patient:** ____________________ **Date of Birth:** ______/ ______/ ______

**Telephone:** ( _____ ) ______________ **Work Phone:** ( _____ ) ______________

**Parent/Legal Guardian of Minor (2)** *[If Applicable]*

**Name:** ______________________ ______ ________________________
FIRST MI LAST

**Relationship to Patient:** ____________________ **Date of Birth:** ______/ ______/ ______

**Telephone:** ( _____ ) ______________ **Work Phone:** ( _____ ) ______________

*****IMPORTANT NOTICE: The Parent/Legal Guardian information Listed is Not Authorization and/or Designation of a Personal Representative*****

***Please Continue on Next Page***

**Patient Registration Form (Page 2)** Patient Number ______________________

## Demographic Characteristics

***Characteristics – Special Populations*** (Data used by Goshen Medical Center due to being a Federally Qualified Health Center which offers the Sliding Fee Discount based on family size and income.)

**Primary Medical Insurance ( )** None **( )** Private **( )** Medicaid **( )** Medicare **( )** Dually Eligible

**( )** CHIP **( )** Other Public Insurance CHIP **( )** Other Public Insurance (Non-CHIP) (Specify: _____________)

**Ethnicity** (CHECK ONE)**: ( )** Cuban **( )** Mexican, Mexican American, or Chicano/a **( )** Puerto Rican
**( )** Hispanic, Latino/a, or Spanish Origin, Combined **( )** Another Hispanic, Latino/a, or Spanish Origin
**( )** Not Hispanic, Latino/a, or Spanish Origin **( )** Choose Not to Disclose Ethnicity

**Race** (CHECK ONE)**: ( )** American Indian/Alaska Native **( )** Black/African American **( )** White
**( )** Asian Indian **( )** Chinese **( )** Filipino **( )** Japanese **( )** Korean **( )** Vietnamese **( )** Other Asian
**( )** Guamanian or Chamorro **( )** Native Hawaiian **( )** Samoan **( )** Other Pacific Islander
**( )** More than one race **( )** Choose Not to Disclose Race

**Primary Language: ____________________**

**How long have you lived in the United States?** _______ years, ______ months

**Are you a US Veteran? ( )** Yes **( )** No

**Persons In Household** (PLEASE CIRCLE) 1 2 3 4 5 6 7 8 9 10 Other ____________

**Household Income Range** (PLEASE CIRCLE):

*<$11,500* *$11,501-15,000* *$15,001-20,000* *$20,001-30,000* *$30,001-40,000*

*$40,001-50,000* *$50,001-60,000* *$60,001-70,000* *$70,001-80,000* *$80,001-90,000* *>$90,000*

**Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? ( )** Yes **( )** No **If yes, which applies?** (PLEASE SEE BELOW)
**( )** Year Round Employment (permanent residence in area)
**( )** Migrant (establishes temporary residence in area)
**( )** Seasonal (permanent residence in area)

**Type of Housing for patient or patient's parent/guardian if a minor** (CHECK ONE)**:**
**( )** Public Housing **( )** Homeless Shelter **( )** Doubled Up (live with another person or family unit)
**( )** Rent or own Home **( )** Street **( )** Transitional (live place to place) **( )** Other ___________________

Is this visit due to an Accident/Injury: Yes_____No_____ If yes, Date of Injury: _____ / ______ / ______

I certify that the information given above is true and correct ______________________________
(Patient Signature)

______________________________
(Parent/Guardian signature if patient a minor)

______________________________
(Print Name)

_____ / ______ / ______
(Date)

**NOTE:** Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.

OCT2025REV

Goshen Dental Services

# No-Show Policy

Effective October 26, 2022

**Any dental patient who misses their appointment at any of our offices will be given a warning for the 1st failed appointment. There will be a $30.00 no-show fee for each missed appointment after. This payment needs to be paid on or before your next appointment.**

We will still be willing to see patients in this situation, however, it will then become the patient's responsibility to call when they know they can come, to see if we can accommodate them into our schedule within the next day or two. Every effort will be made to see a patient in this situation, but if the patient is not willing to do this, it will then be necessary for them to find another office.

**We will accept walk-ins for emergency situations regardless of the no-show fee payment. Examples of emergency situations include a restoration (filling) comes out, swelling, pain, sensitivity, or any discomfort in the mouth.**

We consider a missed appointment as any appointment a patient fails to show up for or calls and cancels without giving our office a 24-hour notice to fill the patient's appointment slot. Therefore, if it becomes necessary to cancel an appointment, please call our office as soon as possible. We recommend at least two days in advance.

**Any patient who arrives later than their appointment time may be considered to have failed their appointment.**

We always try to call and remind patients of their appointments as a courtesy, but **this is not guaranteed.**

**WE WILL NOT MAKE EXCEPTIONS TO THIS POLICY.**

________________________________________ ____________________

Signature of Patient or Guardian Date

## Do you have any of the following diseases or problems

**Active Tuberculosis** ○ Yes ○ No

**Persistent cough greater than a 3 week duration** ○ Yes ○ No

**Cough that produces blood** ○ Yes ○ No

**Been exposed to anyone with tuberculosis** ○ Yes ○ No

## Medical History

**Are you now under the care of a physician?** ○ Yes ○ No

**Physician Name** ______

**Phone (including area code)** ______

**Address/City/State/Zip** ______

**Are you in good health?** ○ Yes ○ No

**Has there been any change in your general health within the past year?** ○ Yes ○ No

**If yes, what condition is being treated?** ______

**Date of last physical exam** ______

**Have you had a serious illness, operation or been hospitalized in the past 5 years?** ○ Yes ○ No

**If yes, what was the illness or problem?** ______

**Are you taking or have you recently taken any prescription or over the counter medicine(s)?** ○ Yes ○ No

**If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements**

______

**Do you wear contact lenses?** ○ Yes ○ No

**Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement?** ○ Yes ○ No

**Date** ______

**If yes, have you had any complications?** ______

**Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?** ○ Yes ○ No

**Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?** ○ Yes ○ No

**Date Treatment began** ______

**Do you use controlled substances (drugs)?** ○ Yes ○ No

**Do you use tobacco (smoking, snuff, chew, bidis)?** ○ Yes ○ No

**If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED** ______

**Do you drink alcoholic beverages?** ○ Yes ○ No

**If yes, how much alcohol did you drink in the last 24 hours?** ______

**If yes, how much do you typically drink in a week?** ______

## WOMEN ONLY. Are you:

**Pregnant** ○ Yes ○ No

**Number of weeks** ______

**Taking birth control pills or hormonal replacement?** ○ Yes ○ No

**Nursing?** ○ Yes ○ No

## Allergies, Are you allergic to or have you had any reaction to

**Local anesthetics** ○ Yes ○ No

**Penicillin or other antibiotics** ○ Yes ○ No

**Barbiturates, sedatives, or sleeping pills** ○ Yes ○ No

**Sulfa drugs** ○ Yes ○ No

**Codeine or other narcotics** ○ Yes ○ No

**Metals** ○ Yes ○ No

**Latex (rubber)** ○ Yes ○ No

**Aspirin** ○ Yes ○ No

**Iodine** ○ Yes ○ No

**Hay fever/seasonal** ○ Yes ○ No

**Animals** ○ Yes ○ No

**Food** ○ Yes ○ No

**Other** ○ Yes ○ No

**If Other, please specify:**

______

## Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

- **Artificial (prosthetic) heart valve** ○ Yes ○ No
- **Previous infective endocarditis** ○ Yes ○ No
- **Damaged valves in transplanted heart** ○ Yes ○ No
- **Congenital heart disease (CHD)** ○ Yes ○ No
- **Unrepaired, cyanotic CHD** ○ Yes ○ No
- **Repaired (completely) in the last 6 months** ○ Yes ○ No
- **Repaired CHD with residual defects** ○ Yes ○ No

## Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

- **Cardiovascular disease** ○ Yes ○ No
- **Angina** ○ Yes ○ No
- **Arteriosclerosis** ○ Yes ○ No
- **Congestive heart failure** ○ Yes ○ No
- **Damaged heart valves** ○ Yes ○ No
- **Heart attack** ○ Yes ○ No
- **Heart murmur** ○ Yes ○ No
- **Low blood pressure** ○ Yes ○ No
- **High blood pressure** ○ Yes ○ No
- **Other congenital heart defects** ○ Yes ○ No
- **Mitral valve prolapse** ○ Yes ○ No
- **Pacemaker** ○ Yes ○ No
- **Rheumatic fever** ○ Yes ○ No
- **Rheumatic heart disease** ○ Yes ○ No
- **Abnormal bleeding** ○ Yes ○ No
- **Anemia** ○ Yes ○ No
- **Blood transfusion** ○ Yes ○ No
  - **If yes, date** ____________
- **Hemophilia** ○ Yes ○ No
- **AIDS or HIV** ○ Yes ○ No
- **Arthritis** ○ Yes ○ No
- **Autoimmune disease** ○ Yes ○ No
- **Rheumatoid arthritis** ○ Yes ○ No
- **Systemic lupus erythematosus** ○ Yes ○ No
- **Asthma** ○ Yes ○ No
- **Bronchitis** ○ Yes ○ No
- **Emphysema** ○ Yes ○ No
- **Sinus trouble** ○ Yes ○ No
- **Tuberculosis** ○ Yes ○ No
- **Cancer/Chemotherapy/Radiation Treatment** ○ Yes ○ No
- **Chest pain upon exertion** ○ Yes ○ No
- **Chronic pain** ○ Yes ○ No
- **Diabetes Type I or II** ○ Yes ○ No
- **Eating disorder** ○ Yes ○ No
- **Malnutrition** ○ Yes ○ No
- **Gastrointestinal disease** ○ Yes ○ No
- **G.E. Reflux/persistent heartburn** ○ Yes ○ No
- **Thyroid problems** ○ Yes ○ No
- **Stroke** ○ Yes ○ No
- **Glaucoma** ○ Yes ○ No
- **Hepatitis, jaundice or liver disease** ○ Yes ○ No
- **Epilepsy** ○ Yes ○ No
- **Fainting spells or seizures** ○ Yes ○ No
- **Neurological disorders** ○ Yes ○ No
  - **If yes, please specify** ____________
- **Sleep disorder** ○ Yes ○ No
- **Mental health disorders** ○ Yes ○ No
  - **Specify** ____________
- **Recurrent infections** ○ Yes ○ No
  - **Type of infection** ____________
- **Kidney problems** ○ Yes ○ No
- **Night sweats** ○ Yes ○ No
- **Osteoporosis** ○ Yes ○ No
- **Persistent swollen glands in neck** ○ Yes ○ No
- **Severe headaches/migraines** ○ Yes ○ No
- **Severe or rapid weight loss** ○ Yes ○ No
- **Sexually transmitted disease** ○ Yes ○ No
- **Excessive urination** ○ Yes ○ No

## Premedication

**Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?** ○ Yes ○ No

**Name of physician or dentist making recommendation (include phone number)** ____________

**Do you have any disease, condition, or problem not listed above that you think I should know about?** ○ Yes ○ No

**Please explain** ____________

____________

Signature of Patient/Legal Guardian

**Patient #:**

**Patient DOB:**

# DESIGNATION OF PERSONAL REPRESENTATIVE

***This form must be completed, signed and dated in order to be considered a valid designation.***

**IMPORTANT NOTICE:** **ONE COMPLETED FORM IS REQUIRED FOR EACH DESIGNATED PERSONAL REPRESENTATIVE**

**PATIENT DESIGNATION OF A PERSONAL REPRESENTATIVE**

Name of Patient:________________________________________________________________

I hereby designate the person listed below to be my personal representative and request that Goshen Medical Center, Inc. treat the named individual as it would otherwise treat me with regard to my Protected Health Information. I understand that this designation is voluntary. I understand that my disclosure of my protected health information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

**PERSONAL REPRESENTATIVE INFORMATION**

Name of Personal Representative:_____________________________________________________

Address of Personal Representative:___________________________________________________

___________________________________________________

Phone # of Personal Representative:___________________________________________________

Personal Representatives Relationship to Patient:_______________________________________

**ACCESS TO PATIENT'S PROTECTED HEALTH INFORMATION**

By signing this designation form, I am authorizing my personal representative access to:

_____ All Protected Health Information (e.g. Demographic, medical and billing information)

______Health Information Only _____ Billing Information Only

_____ Sensitive Health Information (e.g. HIV/AIDS status) _____ Mental Health

_____ **Appointment Information Only**

**EXPIRATION AND REVOCATION**

_____ This designation will expire on ___________________________

I understand that I may revoke this designation of a personal representative at any time by submitting a written revocation to Goshen Medical Center Inc. Privacy Officer. I understand that I may revoke this designation at any time, except to the extent that action has already been taken to comply with this designation.

Signature of Patient:_________________________________Date:_______________________

## REVOCATION

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Goshen Medical Center Inc. must receive the revocation in writing. The revocation must include:

- The patient's name and address
- The effective date of this authorization and the recipients of the protected health information according to this authorization
- The patient's desire to revoke this authorization and
- The date of the revocation and the patient's signature

Goshen Medical Center Inc. will accept written revocations of this authorization via:

- In person
- Certified U.S. mail or
- Facsimile at ________________________

**ALL revocations must be sent to Goshen Medical Center Inc. to the attention of the Privacy Officer. The revocations are not effective until received by the Privacy Officer.**

**This authorization shall expire on the date noted, not to exceed one year.**

---

## FOR OFFICE USE ONLY

## IDENTIFICATION OF RECIPIENT, IF IN PERSON:

Type of Identification:

( ) Valid State Driver's License or Identification Card
( ) Agency photo identification or other photo identification must be presented with agency letter.
( ) Government agency identification
( ) Other photo identification______________________________________________

Identification Information:

Number:____________________________________ Expiration Date:_______________________

Identification Verification:

ID verified by:______________________________________ Date:_______________________

Authorization added to the patient's medical record on____________________________________________
(Date and Initial)

---

**Patient Consent for Treatment**
**And**
**Consent for and Acknowledgment of Receipt of the Notice of Privacy Practices**

**Patient Name: __________________________________ Chart: ____________**

I understand that as part of my health care, Goshen Medical Center, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Goshen Medical Center, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Goshen Medical Center, Inc. has already taken action. I also understand that by refusing to sign this consent or revoking this consent, Goshen Medical Center, Inc. may refuse treatment. Upon refusal to sign this consent, I agree to assume the risk of any injury or damage from the lack of any medical care or treatment arising out of or in connection with Goshen Medical Center's denial to provide any medical care or treatment.

I further understand that Goshen Medical Center, Inc. reserves the right to change their notice and practices in accordance with federal regulations. Should Goshen Medical Center, Inc. change their notice, the revised Notice will be made available.

I understand that as part of Goshen Medical Center's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

☐ I fully understand and **accept** the terms of this consent.

☐ I fully understand and **decline** the terms of this consent.

______________________________________________ ______________________

**Patient's Signature / Guardian** **Date**

**I hereby voluntarily consent to medical and/or dental examinations, treatments and procedures which are deemed necessary in the opinion of my physician, and health care providers, including HIV tests, laboratory tests and x-rays. I understand that my medical information is strictly confidential and is protected by NC General Statute 130A-143 and no guarantees or warrantees have been made to me concerning the results of the examinations, treatments or procedures. My signature acknowledges that I have been given the opportunity to ask questions about this consent form.**

______________________________________________ ______________________

**Patient's Signature / Guardian** **Date**

***The Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 (Pub. L. 102-501) and 1995 (Pub. L. 104-73) extend Federal Tort Claims Act (FTCA) protections under 28 U.S.C. 1346(b), 2401(b), and 2679-81 to eligible health centers funded under the Health Center Program, section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended. Goshen Medical Center, Inc. is protected under this legislation.***

SLF _____________

# SLIDING FEE DISCOUNT PROGRAM ELIGIBILITY FORM

| Name | Guarantor Relationship | Date of Birth | Income (Gross) | Frequency (Weekly, Bi-Weekly, Hourly, Monthly or Yearly) | Date all Documentation Received | Document Received |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |

| Household/Family is all persons physically residing in the same home who are the legal responsibility of the guarantor | Income | Household |
|---|---|---|
| | | |

**Documentation must be provided by the patent or guarantor to determine eligibility for Sliding Fee Scale**

1. I understand that the information I provide on this form is subject to verification by Goshen Medical Center.
2. I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.
3. I do herby attest that this information is true, accurate, and complete to the best of my knowledge and that I understand that any falsification, omission, or concealment of material fact may subject me to disqualification from the Sliding Scale Discount Program.
4. I understand that it is my responsibly to notify Goshen Medical Center of any changes in income or insurance.

**ACCEPTABLE INCOME DOCUMENTATION**

PAYCHECK STUBS
1099'S
W2 OR TAX FORMS
COMPANY LETTER STATING ANNUAL EARNINGS (LETTER MUST CONTAIN A CONTACT PERSON AND PHONE NUMBER)
OFFICIAL LETTERS/DOCUMENTS FROM SOCIAL SECURITY, COURTS, CHILD SUPPORTS ESC, ETC…
VERIFICATION OF INCOME FORM COMPLETED AND SIGNED BY THE EMPLOYER

☐ I do not wish to enroll myself in the Sliding Fee Program currently.

_________________________________ _______________________________________

PATIENT/GUARDIAN SIGNATURE PRINTED NAME DATE

_________________________________ _______________________________________

GOSHEN STAFF SIGNATURE PRINTED NAME DATE

_________________________________ _______________________________________

GOSHEN STAFF SIGNATURE PRINTED NAME DATE

SLF__________________

# "Self-Declaration"

# Sliding Fee Discount Program

We appreciate the opportunity to provide you with health services. All patient records are strictly confidential and cannot be released without your permission. Services rendered are expected to be paid on the date of service. The Sliding Fee Discount Program is based on total household size and income. In order to qualify, you must provide one of the following sources of information:

• Copy of most recent paycheck or paycheck stubs.
• Letter on agency letterhead verifying financial status, i.e., Social Security, Housing Authority
• Temporary Assistance for Needy Families documentation.
• Alimony and/or Child Support amount reported on sliding fee document.
• Dated letter from employer stating amount of gross payment (does not need to be notarized)
• Copy of Federal tax return or W-2's.
• Student Grant Information/SARs (Student Aid Reports) (self-declare on sliding fee
• If self-employed, tax forms from most current year (W-2's or 1099)
• Dated letter from head of household/family where patient resides stating financial responsibility.

## Self-Declaration of required information:

**This document is only used during your initial visit under the Sliding Fee Discount Program**

My current total household income is $_________________________

Total number of household members that you are financially responsible for_______________

| Name | DOB | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

I have read the above information and understand the qualifications and documentation necessary to apply for the Sliding Fee Discount Program.

I further understand to bring income verification, if possible, upon the next visit, or within 6 months of the initial visit of the sliding fee calendar year. If I do not provide the necessary information, I will be required to pay 100% of charges for services received at Goshen Medical Center.

Patient Signature: ___________________________________________Date______________________

Staff Signature: ___________________________________________Date______________________

# EMPLOYEE INCOME VERIFICATION

From:


To: Patient/Guarantor

Request your employer to complete the information requested below. It is important that this information be provided by ______ /_______ /_______, for use as income documentation. If you have questions please feel free to call __________________________ at (_____) _______ -________. Thank you for your assistance.

Employer Section:

Company Name: ________________________________________

Doing Business As: ______________________________________

Mailing Address: _______________________________________

_______________________________________

Phone Number: ________________________________________

FAX Number: __________________________________________

EMPLOYEE NAME: _____________________________ POSITION: ___________________________________

| PAY DATE (Prefer 4 dates if available) | GROSS PAY | FREQUENCY (Please Circle) |
|---|---|---|
| | | Weekly Bi-Weekly Monthly |
| | | Weekly Bi-Weekly Monthly |
| | | Weekly Bi-Weekly Monthly |
| | | Weekly Bi-Weekly Monthly |
| | | Weekly Bi-Weekly Monthly |

| **SIGNATURE OF COMPANY REPRESENTATIVE:** | **DATE:** |
|---|---|
| **PRINTED NAME OF COMPANY REPRESENTATIVE:** | **DATE:** |

www.goshenmedical.org

# Sliding Fee Discount Program Fact Sheet

## Our Mission

*"Our mission is to provide access to health care for all people in our service area."*

Goshen Medical Center has the ability to reduce your cost of healthcare through our Sliding Fee Discount Program. This program is designed to offset a portion of your out-of-pocket expenses for selected medical and dental services. To see if you qualify for our Sliding Fee Discount Program, please ask the receptionist.

**The following documents may support proof of income:**

1. Copy of most recent paycheck or paycheck stubs.
2. Copy of Federal tax return or W-2's.
3. Dated letter from employer stating amount of gross wages (does not need to be notarized).
4. Alimony and/or Child Support amount reported on sliding fee document.
5. Temporary Assistance for Needy Families documentation.
6. Letter on agency letterhead verifying financial status (i.e., Social Security, Housing Authority).
7. Student Grant Information / Student Aid Report (self-declare on sliding fee).
8. If self-employed, tax forms from most current year (W-2's or 1099).
9. Dated letter from head of household/family where patient resides stating financial responsibility.
10. Self-Declaration.

## Frequently Asked Questions

### *What is the Sliding Fee Discount Program (SFDP)?*

The Sliding Fee Discount Program is a federal grant that allows our healthcare facility to reduce or "slide" the fees of medical services for patients that reside at or below 200% of Federal Poverty Guideline.

### *Who is eligible for the SFDP?*

Any GMC patient is eligible that is at or below 200% of Federal Poverty Guidelines.

### *How is eligibility determined?*

1. **Income**
   "Income" is defined as all payments received by total family or household members over a period. Assets are not included.
2. **Household/Family Size**
   "Household"/ "Family" is defined as all persons physically residing in the same home who are the legal responsibility of the guarantor. The "guarantor" is the financially responsible person within the household/family. An individual can be claimed on the sliding fee by the guarantor if they provide more than 50% of that family member support.

### *How does a patient apply?*

Provide one of the documents as proof of income. This income documentation will need to be reviewed and updated annually.

### *Who pays for the services that are discounted?*

Our federal grant pays for the remainder of the balance for patients that qualify for Sliding Fee Discount Program.

### *Does the patient have to be a citizen to apply for the program?*

No.

### *What if the patient has no income at all?*

They can still apply. We need a brief note from the person or facility covering the patient's cost of living.

### *If the patient has insurance with deductible, co-insurance and/or copayment, can they still apply for the program?*

Yes. If the patient qualifies for the program, the patient's insurance will be filed, and if the insurance contract allows for a reduced co-payment, then GMC will apply the discount.

Please see receptionist if you have further questions.

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## NOTICE OF PRIVACY PRACTICES

## & FTCA COVERAGE

Effective: February 16, 2026

### Goshen Medical Center, Inc.

444 SW Center Street
Faison, NC 28341

Satellite Sites Located In:
Albemarle • Beulaville • Bolton • Bridgeton • Cape Fear • Chadbourn • Clinton (2) • Dunn • Duplin •Elizabethtown • Faison • Fayetteville • Fremont • Garland • Goldsboro • Jacksonville • Kenansville • Morehead • Mount Olive • New Bern • New River • Raeford • Rockingham • Rose Hill • Rosewood • Sanford • Southport • Star • Tabor City • Wallace • Warsaw • Whiteville

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Our Commitment to Your Privacy

Goshen Medical Center, Inc. (“Goshen”) is committed to protecting your Protected Health Information (PHI) in accordance with:

- The Health Insurance Portability and Accountability Act (HIPAA)
- The HIPAA Final Rules and Security Rule updates enforced as of February 16, 2026
- The HITECH Act
- 42 CFR Part 2 (Substance Use Disorder Records)
- Applicable North Carolina confidentiality laws

This Notice applies to all PHI we create or receive, including paper, electronic, telehealth, and patient portal communications.

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**Understanding Your Medical Record**

Each visit — including telehealth encounters — results in a record that may include:

- Symptoms and examination findings
- Test results and diagnoses
- Treatment plans
- Billing and insurance information
- Care coordination notes
- Patient portal communications

Your record serves as:

- A basis for treatment planning
- A communication tool among providers
- A legal document of care received
- A billing verification tool
- A quality improvement and public health resource

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**How We May Use and Disclose Your Information**

We limit uses and disclosures of PHI to the **minimum necessary** to accomplish the intended purpose, except where HIPAA permits broader use (such as for treatment).

**Treatment**

We use PHI to provide, coordinate, and manage your healthcare, including telehealth services and electronic consultations.

**Payment**

We use PHI to obtain payment for services provided.

**Collections**

We may disclose limited information necessary to third-party collection agencies working on our behalf under a Business Associate Agreement that requires them to protect your PHI.

**Health Care Operations**

We use PHI for quality assessment, compliance, auditing, accreditation, training, and operational management.

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**Business Associates**

We may share PHI with contracted vendors (laboratories, billing companies, IT providers, telehealth platforms).

Under 2026 HIPAA enforcement:

- Business Associates are directly liable for HIPAA compliance.
- Written agreements require mandatory security safeguards.
- Required safeguards include risk analysis, encryption where applicable, multi-factor authentication, access controls, monitoring, and breach response protocols.

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**Telehealth & Patient Portal**

If you use telehealth or our patient portal:

- Communications are encrypted and secure.
- You may request electronic copies of your PHI in the form and format requested, if readily producible.
- You may direct us to transmit electronic PHI to a third-party app of your choice.
- You are responsible for safeguarding your login credentials.
- While we use secure technologies, transmission of information through the internet or mobile applications carries inherent risks. Patients should take precautions to protect their personal devices.

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**Reproductive Health Information Protections**

Federal law prohibits the use or disclosure of PHI for criminal, civil, administrative, or investigative proceedings related to lawful reproductive health care.

Goshen Medical Center:

- Will not disclose PHI for prohibited reproductive health investigations.
- Will require a signed attestation when certain requests involve potentially protected reproductive health information.
- Will deny requests that do not meet federal requirements.

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**Marketing and Sale of PHI**

We will not:

- Use or disclose your PHI for marketing purposes without your written authorization.
- Sell your PHI.

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**Fundraising Communications**

We may contact you for fundraising purposes permitted by law.

You have the right to opt out at any time by:

- Calling our Privacy Officer, or
- Following the opt-out instructions included in any fundraising communication.

We will not use Substance Use Disorder treatment information for fundraising.

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**Substance Use Disorder (SUD) Records – 42 CFR Part 2**

If you receive SUD treatment services:

- Your records are protected under 42 CFR Part 2.
- These records may not be disclosed without your written consent except as permitted by law.
- They may not be used in civil, criminal, administrative, or legislative proceedings without your specific consent or a specialized court order.
- You may revoke consent in writing at any time.

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**Public Health & Legal Disclosures**

We may disclose PHI as required by law for:

- Public health reporting
- FDA safety monitoring
- Workers' compensation
- Health oversight activities
- We may disclose PHI for law enforcement purposes when required by law or in response to a court order, subpoena, warrant, or other lawful process.
- Organ procurement
- Correctional institutions
- Funeral Directors
- Research
- Communication with family

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**Breach Notification**

If your unsecured PHI is breached, you will be notified without unreasonable delay and no later than 60 days following discovery, as required by federal law.

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**Your Rights**

You have the right to:

- Obtain a paper or electronic copy of this Notice.
- Inspect and obtain a copy of your PHI within 15 days of request (one 15-day extension permitted with written explanation).
- Receive copies in electronic form if available.
- Direct electronic transmission to a third party.
- Request amendments to your record.
- Obtain an accounting of disclosures.
- Request restrictions on certain disclosures.
- Request confidential communications by alternative means.
- Revoke authorizations in writing.
- Be notified of breaches.

Reasonable, cost-based fees may apply.

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**Our Responsibilities**

Goshen Medical Center is required to:

- Maintain the privacy and security of PHI.
- Implement administrative, physical, and technical safeguards designed to protect the confidentiality, integrity, and availability of electronic protected health information (ePHI).
- Conduct regular risk analyses and security evaluations.
- Apply minimum necessary standards.
- Provide breach notification as required.
- Abide by this Notice.
- Notify you of material changes.

We reserve the right to revise this Notice and make changes effective for all PHI we maintain.

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**Non-Discrimination Statement**

Goshen Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Goshen Medical Center provides free language assistance services to individuals whose primary language is not English.

**Complaints**

If you believe your privacy rights have been violated, contact:

Privacy Compliance Officer, Tori Gautier
Goshen Medical Center, Inc.
Phone: 910-267-2045

Or file a complaint with:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

There will be no retaliation for filing a complaint.

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**Federal Tort Claims Act (FTCA) Coverage**

The Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 and 1995 extend Federal Tort Claims Act protections under 28 U.S.C. §§ 1346(b), 2401(b), and 2679–2680 to eligible health centers funded under Section 330 of the Public Health Service Act (42 U.S.C. § 254b).

Goshen Medical Center, Inc. is covered under this legislation.

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