



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.)

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.



Name _____

Date _____

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before? _____

In the past **2 weeks**, have you been bothered by:

Little interest or pleasure in doing things?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Feeling down, depressed or hopeless?	<input type="checkbox"/> No <input type="checkbox"/> Yes

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General

- Unexplained weight loss/ gain
- Unexplained fatigue/ weakness
- Fall asleep during day when sitting
- Fever, chills
- No problems**

Skin

- New or change in mole
- Rash / itching
- No problems**

Breast

- Breast lump / pain / nipple discharge
- No problems**

Ears/Nose/Throat

- Nosebleeds, trouble swallowing
- Frequent sore throat, hoarseness
- Hearing loss / ringing in ears
- No problems**

Eyes

- Change in vision / eye pain / redness
- No problems**

Cardiovascular

- Chest pain / discomfort
- Palpitations (fast or irregular heartbeat)
- No problems**

Respiratory

- Cough / wheeze
- Loud snoring/ altered breathing during sleep
- Short of breath with exertion
- No problems**

Gastrointestinal

- Heartburn/ reflux/ indigestion
- Blood or change in bowel movement
- Constipation
- No problems**

Genitourinary

- Leaking urine
- Blood in urine
- Nighttime urination or increased frequency
- Discharge: penis or vagina
- Concern with sexual function
- No problems**

Musculoskeletal

- Neck pain
- Back pain
- Muscle/ joint pain _____
- No problems**

Endocrine

- Heat or cold sensitivity
- No problems**

Hematologic/Lymphatic

- Swollen glands
- Easy bruising
- No problems**

Neurological

- Headache
- Memory loss
- Fainting
- Dizziness
- Numbness/ tingling
- Unsteady gait
- Frequent falls
- No problems**

Allergic/Immune

- Hay fever/ allergies
- Frequent infections
- No problems**

Psychiatric

- Anxiety/ stress/ irritability
- Sleep problem
- Lack of concentration
- No problems**

Women only

- Pre-menstrual symptoms (bloating cramps, irritability)
- Problem with menstrual periods
- Hot flashes/ night sweats
- No problems**

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information.

Tetanus (Td)____ With Pertussis (Tdap)____ Varicella (Chicken Pox) shot *or* illness____ Pneumovax (pneumonia)____

Influenza (flu shot)____ Hepatitis A____ Hepatitis B____ MMR____ Meningitis____ Zostavax (shingles)____ HPV____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

TAKE NO MEDICATIONS

Medication _____ Dose (e.g. mg/pill) _____ How many times per day? _____

Allergies or intolerance to medications (include type of reaction): _____

NONE

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Abnormal? No Yes
 Sigmoidoscopy or Colonoscopy (circle one) Date _____ Polyp? No Yes

Women only:

Mammogram Date _____ Abnormal? No Yes
 Pap Smear Date _____ Abnormal? No Yes
 Bone Density Test Date _____ Abnormal? No Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? NONE

Condition	Code	Current	Past	Comments
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder/ Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			

PERSONAL MEDICAL HISTORY Continued: Condition	Code	Current	Past	Comments
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis - Type A	070.1			
Hepatitis - Type B	070.30			
Hepatitis - Type C	070.51			
Hepatitis - Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease/ Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive)/ Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

SURGICAL HISTORY - Please check off any procedure or surgeries. List any abnormal findings or complications. **NONE**

Surgical Procedure	Code	Yes	Year	Comments
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued: Surgical Procedure	Code	Yes	Year	Comments
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidoscopy				
Sinus Surgery				
Other (list)				

Adopted- Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY - Indicate which relative has had the following diseases parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No Significant history known										
Alcoholism / Drug Abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (child onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use

Smoke cigarettes: Never No Yes
(If you never smoked please go to alcohol use question now)
Quit date: _____ How many years did you smoke? _____
Approximately how many packs a day did you smoke? _____
Current smoker: Packs/day: _____ # of years: _____
Other tobacco: Pipe Cigar Snuff Chew

Alcohol Use

Do you drink alcohol? No Yes
of drinks per week: _____ Beer Wine Liquor

Drug Use

Do you use marijuana or recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

Sexual Activity

Sexually involved currently? No Yes
Sexual partner(s) is/are/have been: Male Female
Birth control method (circle below all that apply): None needed
Condom, pill, diaphragm, vasectomy, other _____

Exercise: Do you exercise regularly? No Yes

What kind of exercise? _____

How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? Good Fair Poor

Would you like advice on your diet? No Yes

Safety: Do you use a bike helmet? No Yes

Do you use seatbelts consistently? No Yes

Does your home have a working smoke detector? No Yes

If you have guns in your home, are they locked up?
 Not Applicable No Yes

Is violence at home a concern for you? No Yes

Have you completed a Living Will,
Advance Directive for Health Care (ADHC),
or POLST (Physician Orders for Life Sustaining Therapy)?
(Circle above all that apply) No Yes

SOCIAL HISTORY:

Occupation (or prior occupation): _____ retired/unemployed/leave of absence/disabled (circle one)

Employer: _____ Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____ Number of children: _____ Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menopause): _____ Age at end of periods (menopause): _____

Thank you for taking the time to fill this out.



Patient Label	
Name	
DOB	(Month/Day/Year)
PT #	(Filled Out By Staff)

Pediatric Health History Form

Your relationship to child: _____

Child's previous doctor/
primary care provider: _____

Present health concerns: _____

Medicines/Vitamins: _____

Herbs/Home Remedies: _____

Allergies/Reactions to
medicines or vaccinations: _____

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: Birth Adoption Stepchild
 Other: _____

Please indicate any medical problems during pregnancy
 None Specify: _____

Delivery by Vaginal birth Caesarean (C-Section)
If Caesarean, why? _____

Birth weight: _____ Birth length: _____

APGAR score 1 min _____ 5 min _____

Please indicate any medical problems during the baby's
newborn period None Premature
If premature, how early? _____

Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? No Yes
If so, how long? _____

Has your child had any unusual feeding/dietary
problems? No Yes
If yes, specify: _____

Milk intake now:
 Cow's milk (Nonfat 1% fat 2% fat Whole)
 Soy milk Rice milk
Average ounces per day (Note: 8 ounces = 1 cup)

SLEEP

Hours per night _____

Naps (number & length) _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit alone _____

Walk alone _____ Say words _____

Toilet train (daytime) _____

Girls only: Age at first menstrual period _____

DENTAL HISTORY

Has child been seen by a dentist? No Yes

If so, how often? _____

Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your
appointment.

Has your child had any of the following diseases:

Chickenpox Measles Mumps
 Rubella Meningitis Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?
(old home/plumbing/peeling paint) No Yes
Do any household members smoke? No Yes

TV – hours per day _____

Computers – hours per day _____

Video games – hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their
dates?

Hospitalization/operations (with dates): _____

Broken bones or severe sprains: _____

FAMILY HISTORY

Please indicate any deaths of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____

High cholesterol _____

Cancer, specify type _____

High blood pressure _____

Heart disease _____

Stroke _____

Depression/suicide _____

Bleeding or clotting disorder _____

Genetic disorders _____

Asthma/COPD _____

Diabetes _____

Other: _____

SOCIAL HISTORY

Who lives at home?

Name | Age | Relationship | Highest Education Level

Are your child's parents Married Unmarried
 Separated Divorced

If divorced or separated, when? _____

Mother's Occupation _____

Mother's Employer _____

Father's Occupation _____

Father's Employer _____

Child care situation Parents Others (specify who and how often) _____

Concerns about your child: Alcohol use Tobacco

Sexual activity Aggressive behavior

Is violence at home a concern? No Yes

Are there guns in the home? No Yes

SCHOOL HISTORY

Does your child attend school/preschool? No Yes

Current grade _____

Name of school _____

Any concerns about school performance? _____

Any concerns about relationship with:

Teachers No Yes

Peers No Yes

If more than 4 years old: does your child have a best friend? No Yes

Sports/exercise: Type _____

How often? _____

How long (minutes)? _____

REVIEW OF SYMPTOMS:

Please check any current problems your child has on the list below:

General

Fevers/chills/excessive

Sweating

Unexplained weight loss/gain

Eyes

Squinting/"crossed" eyes/asymmetric gaze

Ears/Nose/Throat

Unusually loud voice/hard of hearing

Mouth breathing/snoring

Bad breath

Frequent runny nose

Problems with teeth/gums

Cardiovascular

Tires easily with exertion

Shortness of breath

Fainting

Respiratory

Cough/wheeze

Chest pain

Gastrointestinal

Nausea/vomiting/diarrhea

Constipation

Blood in bowel movement

Genitourinary

Bedwetting

Pain with urination

Discharge:penis or vagina

Musculoskeletal

Muscle/joint pain

Skin

Rashes

Unusual moles

Allergy

Hay fever/itchy eyes

Neurological

Headaches

Weakness

Clumsiness

Psychiatric/Emotional

Speech problems

Anxiety/stress

Sleep issues

Depression

Nail biting/thumb sucking

Bad temper/breath holding/jealousy

Blood/Lymph

Unexplained lumps

Easy bruising/bleeding

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 warranties 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

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 patient 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 hereby 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



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: _____

<u>PAY DATE</u> (Prefer 4 dates if available)	<u>GROSS PAY</u>	<u>FREQUENCY</u> (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:



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.

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

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.

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

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.

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.
-

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.

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.

Marketing and Sale of PHI

We will not:

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

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.

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.

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

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.

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.

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.

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.

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.
