Patient Registration Form Patient Number _____

Have you had a medical visit at Goshen within the last year? ( )Yes ( )No

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

Ethnicity (CHECK ONE)**: ( )** Hispanic/Latino **( )** Non-Hispanic/Latino **Primary Language:** _____

Race (CHECK ONE)**: ( )** American Indian/Alaska Native **( )** Asian **( )** Black/African American
( ) Native Hawaiian **( )** Pacific Islander **( )** White **( )** More than 1 race

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: (** _____ **)** _____

Please Continue on Next Page

Patient Registration Form (Page 2) Patient Number _____

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***)**

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.)

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 _____

Sexual Orientation (CHECK ONE)**:**

(**)** Lesbian or Gay
(**)** Straight (not Lesbian or Gay)
(**)** Bisexual
(**)** Something Else
(**)** Don't Know
(**)** Choose Not to Disclose

Gender Identity (CHECK ONE)**:**

(**)** Male
(**)** Female
(**)** Transgender Male/Female-to-Male
(**)** Transgender Female/Male-to-Female
(**)** Other
(**)** Choose Not to Disclose

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.

APR2016REV

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

GOSHEN MEDICAL CENTER, INC.

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? □ **No** □ **Yes**
Feeling down, depressed or hopeless? □ **No** □ **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 <u>not</u> 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 Bike □ 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.

Pediatric Health History Form

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

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 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

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: GOSHEN MEDICAL CENTER, INC.

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:**

Effective: 9/24/15

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.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for account collection.

For example: When a date of service balance reaches an overdue status, we may forward the account to a collection agency. Account information sent to a collection agency can include identifying information about you or the account guarantor, amount of balance and date of service, physician and location name, and type of service.

We will use your health information for regular health operations.

For example: Your health information may be used or disclosed in the course of operating our medical center, such as evaluating the quality of services provided, auditing purposes, federal or state agencies. This information will be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: Some services are provided to Goshen Medical Center through contracts with business associates, which may require the use or disclosure of your health information. Examples include services provided by a laboratory or radiology clinic. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by the administration of Goshen Medical Center and protocols have been established to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

***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**

NOTICE OF PRIVACY PRACTICES & FTCA COVERAGE

For

Goshen Medical Center, Inc.
444 SW Center Street
Faison, NC 28341

Corporate Office
412 SW Center Street Faison, NC

Satellite Sites Located in:
Beulaville, NC
Bolton, NC
Chadbourn, NC
Clinton, NC
Fayetteville, NC
Fremont, NC
Garland, NC
Goldsboro, NC
Jacksonville, NC
Kenansville, NC
Mount Olive, NC
New Bern, NC
Rose Hill, NC
Rosewood, NC
Tabor City, NC
Trenton, NC
Wallace, NC
Warsaw, NC
Whiteville, NC

April 2003
Revised Dates:
August 2003, March 2004,
December 2004, January 2006
January 2006, April 2008
July 2008, August 2014, November 2015
(Revisions Made to Include New Sites)

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

You should read this Notice before signing the Consent that authorizes the use and disclosure of health information for treatment, payment and health care operations.

Introduction

At Goshen Medical Center, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal health information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Goshen Medical Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. The information is considered your personal health information. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Goshen Medical Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and request a copy of your health record however a charge for copying may be imposed, depending upon the circumstances,
- Request, in writing, an amendment to your health record,
- Obtain an accounting of disclosures of your health information,
- Request communications of your health information by alternative means or at alternative locations, Request a restriction on certain uses and disclosures of your information and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Goshen Medical Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Lynn Hardy at 910-267-1942 ext 1141.

If you believe your privacy rights have been violated, you can file a complaint with the Goshen Medical Center's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

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

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Health information obtained during the course of treatment will be recorded in your medical record and used to determine the course of treatment. Your physician, nurse and other members of the healthcare team will document your health treatment, observations and actions taken in your medical record.