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 _____

Sexual Orientation (CHECK ONE)**:**
( ) Straight (not Lesbian or Gay) ( ) Something Else
( ) Lesbian or Gay ( ) Don't Know
( ) Bisexual ( ) Choose Not to Disclose

Gender Identity (CHECK ONE)**:**
( ) Male ( ) Transgender Male/Female-to-Male
( ) Female ( ) 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.

MARCH2025REV

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

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.