FIRST VISIT INFORMATION SHEET (Adult)
FORMA DE INFORMACION DE PRIMERA VISITA (Adulto)
SOCIAL HISTORY/DATOS PERSONALES

Print your name as it appears on your ID/ Nombre como aparece en su Identificacion.

Last Name/Apellido: _____ **First Name**/Primer Nombre: _____
Preferred Name / Nombre Preferido:_____

Date of Birth/Fecha de Nacimiento: __/__/__ **Sex**/Sexo: ◯ **Male**/Hombre ◯**Female**/Mujer _____

Social Security #/ Tax ID/ # de Seguro Social: _____

Ethnicity/ Grupo Etnico	**Race/**Raza	**Primary Language**/ Idioma primario:
◯Hispanic or Latino ◯Not Hispanic or Latino	◯Asian ◯Black ◯ White ◯ Other: _____	◯English ◯Spanish ◯ Other: _____

Address/Direccion:	**Apt #**/# De Apartamento:
City/Cuidad, **State**/Estado	**Zip Code**/Codigo Postal:

Telephone/Telefono:	**Email Address**/dirección de correo electrónico
Cell Phone/Celular:	

Marital Status/ Cual es su estado civil?	
◯**Single**/Soltero ◯**Widowed**/Viudo(a) ◯**Divorced**/Divoriado(a)	◯**Married**/Casado(a) ◯ **Patnered/** Compañero(a) ◯**Separate**d/Separado(a)

Name of Spouse/Partner/Nombre de esposo(a) Compañero(a)/:
_____

Phone Number/Numero de telefono:
_____

Female Head of Household? ◯**Yes**/Si ◯**No**
Monthly household income (all sources)?/Ingreso mensual (de todos): $_____
Number of people living with you? / Numero de personas viviendo con usted?:_____
Employer/Empleador: _____ Occupation/Ocupacion: _____
Do you have any health insurance? / Tiene seguro medico? ◯**Yes**/Si ◯**No**

Emergency Contact Information / Informacion en caso de emergencia	
Name/Nombre:	**Telephone**/Telefono:
Name/Nombre:	**Telephone**/Telefono:

_____ _____
Signature/Firma **Date**/Fecha

Good Samaritan Gwinnett is a faith-based health center. We exist to honor God by ministering to the healthcare needs of the community. We are not a free clinic but charge discounted fees.

El Buen Samaritano de Gwinnett is un Centro Medico de fe. salud basado en Fe. Existimo para honrar a Dios por medio de dar ministerio de salud a las necesidades de la comunidad. No somos una clinica gratis pero nuestros precios son de bajo costo.

Receipt of Privacy Practices

Written Acknowledgement Form

I, _____, have had the opportunity to review a copy of the Good Samaritan Health Center's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Recibo del Formulario Para La Confirmación Por Escrito
De Haber Recibido Aviso De Las Prácticas De Privacidad

Yo, _____, he tenido una oportunidad de Revisar el Aviso de las Practicas del Centro de Salud de Buen Samaritano (Good Samaritan Health Center)

_____ _____
Firma del Paciente Fecha

_____ _____
Firma del Interprete Fecha

PATIENT TREATMENT CONSENT FORM

CONSENTIMIENTO PARA TRATAMIIENTO DEL PACIENTE

DATE (FECHA) :_____
PATIENT (PACIENTE) :_____

DATE OF BIRTH (FECHIA DE NACIMIENTO):_____

CHART NUMBER
(NUMERO DE HISTORIA) :_____

Autorizo a *Good Samaritan Health Center*, *los* médicos, *enfermeras, técnicos y* personal *paramédico a* brindarme tratamiento medico *y/o* quirúrgico. Además *estoy* de *acuerdo con que* se efectúe el procedimiento y se le envíen o informen los resultados a mi supervisor de trabajo o si este no existe, a mi. Igualmente relevo a Good Samaritan Health Center, sus médicos, enfermeras, técnicos y personal paramédico o empleado de la oficina, de todos o cualquier acto que conlleve riesgos, reclamos o acción legal como resultado del tratamiento recibido en esta oficina.

I authorize The Good Samaritan Health Center to render medical, dental, and/or other treatment, willingly consent to such procedure, and authorize the release of the results to (1) the employer, if any is shown, or (2) solely to the undersigned if no employer is named,

Service(s) Requested(Servicios deseados)**:** _____
_____

I release The Good Samaritan Health Center, its physicians, dentists, nurses, technicians, and any other employees or agents from any and all liabilities, claims, or causes of action resulting from treatment.

Patient Signature/Firma **DateI**Fecha

_____ _____

_____ _____

Witness/Testigo **Date/**Fecha

Good Samaritan Health Center
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) directs healthcare providers, payers, and other health care entities to develop policies and procedures to ensure the security, integrity, privacy and authenticity of health information, and to safeguard access to and disclosure of health information. The federal government has privacy rules which require that we provide you with information on how we might use or disclose your identifiable health information. The Good Samaritan Health Center is required by the federal government to give you our **Notice of Privacy Practices.**

OUR COMMITMENT TO YOUR PRIVACY

As a healthcare provider, GSHC uses your confidential health information and creates records regarding the health information in order to provide you quality care and to comply with certain legal requirements. We understand that this health information is personal and we are dedicated to maintaining your privacy rights under Federal and State law. This notice applies to records of your care created or maintained by GSHC, whether made by GSHC personnel or your personal physician while at the GSHC.

We are required by law to: (1) make sure that your health information is kept private; (2) give you this Notice of our legal duties and privacy practices with respect to your health information; and (3) follow the terms of the Notice that are currently in effect.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

The following information describes different ways that we may use or disclose your health information without your authorization. For each category of use or disclosure we will explain what we mean and give examples to help you better understand each category. Although we cannot list every use or disclosure within a category, we are only permitted to use or disclose your health information without your authorization if it falls within one of these categories.

If your health information contains information regarding your mental health or substance abuse treatment or certain infectious diseases (including HIV/AIDS tests or results), we are required by state and federal confidentiality laws to obtain your consent prior to certain disclosures of such information. Once we have obtained your consent on the GSHC Admission/Registration Agreement, we will treat the disclosure of such information in accordance with our privacy practices outlined in this Notice.

CATEGORIES FOR USES AND DISCLOSURES:

Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, residents, student nurses, dentist, dental assistants, dental hygienist, optometrist or other healthcare personnel who are involved in taking care of you at the GSHC or at another healthcare provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments within the GSHC also may share health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

Health Care Operations. We may use and disclose health information about you for the GSHC operations. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients to decide what additional services should be offered, what services are not needed, and whether certain new treatments are effective. We may disclose your health information to doctors, nurses, technicians, medical students, residents, nursing staff, dentist, dental assistants, dental hygienist, optometrist and other personnel for review and learning purposes. We may combine the health information we have with health information from other healthcare providers to compare how we are doing and see where we can make improvements in the care and services we offer.

Appointment Reminders, Follow-up Calls and Treatment Alternatives. We may use or disclose health information to remind you that you have an appointment or to check on you after you have received treatment. If you have an answering machine we may leave a message. We also may send you a post card appointment reminder. We may contact you about possible treatment options or alternatives or other health related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information to a friend or family member who is involved in your medical care or who assists in taking care of you. We may also give information to someone who helps pay for your care.

As Required By Law. We will use or disclose health information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use or disclose health information when necessary to prevent a serious threat to your health and safety, another person or the public. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

We may also use or disclose your health information without your authorization in the following situations:

Military and Veterans. To military command authorities as required, if you are a member of the armed forces. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. To workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Activities. To public health agencies or other governmental authorities to report public health activities or risks. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition as authorized by law; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence(we will only make this disclosure if you agree or when required or authorized by law).

Health Oversight Activities. To a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. In response to a court or administrative order, if you are involved in a lawsuit or a dispute. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the health information requested.

Law Enforcement. In response to a court order, subpoena, warrant, summons or similar process; or upon request by a law enforcement official to identify or locate a suspect, fugitive, material witness, or missing person or to obtain information about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization. We may report a death we believe may be the result of criminal conduct or report suspected criminal conduct occurring on the premises. We may also report information related to a suspected crime discovered in the course of providing emergency medical services.

National Security and Intelligence Activities. To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. To the correctional institution or law enforcement official, if you are an inmate of a correctional institution or under the custody of a law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES WHICH REQUIRE YOUR AUTHORIZATION

Other types of uses and disclosures of your health information not described in this Notice will be made only with your written authorization. You may revoke your authorization by giving written notice to the medical records department where you received your care. Please see the list of addresses at the end of this Notice. If you revoke your authorization we will no longer use or disclose your health information as permitted by your initial authorization. Please understand that we will not be able to take back any disclosures we have already made and that we are still required to retain our records containing your health information that documents the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
THESE RIGHTS ARE EFFECTIVE APRIL 14, 2003

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical record (except psychotherapy notes) or billing record.

To inspect and copy your medical or billing record, you must submit your request in writing to the Medical Records Department where you received your care. You need to include in your request your name or if acting as a personal representative include the name of the patient, social security number, date of birth and dates of service if known. If you request a copy, you will be will charged a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy records in certain limited circumstances; however, you may request that the denial be reviewed. A licensed health care professional chosen by the GSHC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment. If you feel that health information we have about you is incorrect, you may ask us to amend it. You have the right to request an amendment for as long as the health information is kept by or for The Good Samaritan Health Center

To request an amendment, your request must be made in writing and submitted to the GSHC Medical Record Department. Your request may not include dates before April 14, 2003. In addition, you must provide a reason that supports your request. You need to include in your request your name or if acting as a personal representative include the name of the patient, social security number, date of birth and dates of service if known.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend health information that:

Was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;

Is not part of the health information kept by or for the Good Samaritan Health Center
Is not part of the health information which you would be permitted to inspect and copy; or
Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we made of your health information except for disclosures:

for treatment, payment or healthcare operations,
pursuant to an authorization,
incident to a permitted use or disclosure, or
certain other limited disclosures defined by law.

To request this list of disclosures, you must submit your request in writing to the Good Samaritan Health Center. Your request must specify a time period for which you are seeking an accounting of disclosures and include your name or if acting as a personal representative include the name of the patient, social security number, date of birth and dates of service if known.

You may not request disclosures that are more than six years from the date of your request or that were before April 14, 2003. Your request should indicate in what form you want the list, for example, on paper or electronically. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. We have the right to revoke our agreement at any time, and once we notify you of this revocation, we may use or disclose your health information without regard to any restriction or limitation you may have requested.
To request restrictions, you must make your request in writing to the GSHC In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to The Good Samaritan Health Center, 3700 Club Drive, Lawrenceville, GA 30044. You will need to include your name or if acting as a personal representative include the name of the patient, social security number, date of birth and dates of service if known.

We will not ask you the reason for your request. We will work to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right To Receive a Paper Copy of This Notice. Even if you have agreed to receive this Notice electronically, you have the right to receive a paper copy of this Notice, which you may ask for at any time.

You may obtain a copy of this Notice at our website, www.goodsamatlanta.org

To obtain a paper copy of this Notice, write to The Good Samaritan Health Center, Attn: Privacy Officer, 3700 Club Drive, Lawrenceville, GA 30044.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at The Good Samaritan Health Center facilities and you may request a copy of the current notice. In addition, the current notice will be posted at www.goodsamatlanta.org.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint by writing to:, The Good Samaritan Health Center, Attn: Privacy Officer, 3700 Club Drive, Lawrenceville, GA 30044, You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**