FIRST VISIT INFORMATION SHEET (Adult)
FORMA DE INFORMACION DE PRIMERA VISITA (Adulto)

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: _____ Education: _____

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

County of Birth:

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

Telephone/Telefono:	**2nd Telephone**/Telefono:
Email Address/dirección de correo electrónico	

Marital Status/ Cual es su estado civil?		**Name of Spouse/Partner**/Nombre de esposo(a) Compañero(a)/:
◯**Single**/Soltero ◯**Widowed**/Viudo(a) ◯**Divorced**/Divoriado(a)	◯**Married**/Casado(a) ◯ **Partnered/** Compañero(a) ◯**Separated**/Separado(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 in Household? / Numero de personas que viven en su residencia?:_____

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:
Do you authorize us to release medical information to this person? ◯**Yes**/Si ◯**No**	**Do you authorize us to release medical information to this person?** ◯**Yes**/Si ◯**No**

_____ _____

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.

Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have had the opportunity to review the Good Samaritan Health Center's Notice of Privacy Practices. I acknowledge a copy will be provided to me upon my request.

_____ _____

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

Good Samaritan Health Center of Gwinnett

5949 Buford Hwy., Norcross, GA 30071
Phone: 678.280.6630 FAX: 678.280.6635

4864 Jimmy Carter Blvd. #203, Norcross, GA 30093
Phone: 770.806.0162 FAX: 770.806.0166

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____/_____/_____

Address: _____

_____

SSN: _____ **Phone**: _____

I authorize: _____
(Name of Facility / Person which **HAS INFORMATION**)

_____
(Street Address, City, State, ZIP) FAX

to release my health information to:

☐ Good Samaritan Health Center of Gwinnett
4864 Jimmy Carter Blvd. #203
Norcross, GA 30093

☐ Good Samaritan Health Center of Gwinnett
5949 Buford Hwy.
Norcross, GA 30071

☐ Patient (or Patient Representative) at my request.

☐ Other Recipient (Provide name and address)

This authorization applies to (check all that apply):

☐ All Records* (may include drug/alcohol/mental health information)

☐ Health information relating to the following treatment, condition or dates only: _____

_____

☐ Other (Please Specify): _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of this information.

For Personal Copies:

_____ (Initial) I understand I may be charged a reasonable fee for copies. (See Notice of Medical Records for Personal Use)

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This authorization expires one (1) year from the date of signature.

_____ _____
Patient / Patient Representative / Guardian Signature Date

_____ _____
Print Name Witness

Policy Regarding Uninsured, Underinsured, and Insured Consumers

The Good Samaritan Health Center of Gwinnett, Inc. (GSHCG) is a Christian non-profit health center providing discounted healthcare services to individuals without health and/or dental insurance (the uninsured). We receive charitable donations to help pay the expense of the health and dental care services we provide.

If you are uninsured, you are eligible to receive discounted health and/or dental care services at GSHCG. You will pay 100% of the published discounted fees at the time services are delivered, and charitable donations will be used to pay the remaining balance due for your treatment.

If you are insured under GA Medicaid or a health insurance plan through an employer, you are not eligible to receive healthcare services at GSHCG.

If you are enrolled in an HSA, HRA, or FSA account, you are not eligible to receive healthcare services at GSHCG.

If you are insured through the Health Insurance Exchange (the healthcare.gov plans) and your individual deductible is less than $3000, you are considered insured and not eligible to receive healthcare services at GSHCG.

If you are insured through the Health Insurance Exchange (the healthcare.gov plans) and your individual deductible is greater than $3000, you are considered underinsured and eligible to receive services at GSHCG. However, because you have insurance, donations cannot be used to help pay your fees. Therefore, your fees will be 2x (200%) the published discounted fees.

Our donors do not help pay fees for people with insurance. Therefore, if you become insured and fail to notify us of that change, we will terminate your status as an active uninsured patient.

Because we are a health center serving the uninsured, we do not provide insurance claim forms or itemized receipts. We WILL NOT provide you with information to help document your expenses at GSHCG for an insurance claim or other forms of reimbursement. Be advised insurance companies will not recognize your expenses at this clinic as payment toward your deducible.

With your signature below, you acknowledge your understanding of this policy and agreement to abide by its terms.

_____ _____

Sign Print

_____

Date

Good Samaritan Health Center
doing likewise

Patient Policies

The Good Samaritan Health Center of Gwinnett (GSHCG) is committed to providing you with high quality and affordable health and dental services. Please read the Patient Policies below and ask any questions you may have. Your signature on this policy is required in order to receive treatment; a copy will be provided to you upon request.

1. **Consent to Treatment**. I authorize GSHCG to render medical, dental, and/or other necessary treatment to me, and willingly consent to such treatment. I release GSHCG, its physicians, dentists, nurses, technicians, and any other employees or agents from any and all liabilities, claims, or causes of action that may result from treatment.

2. **Eligibility**. Good Samaritan Health Center of Gwinnett, Inc. is a Christian non- profit health center for individuals without health and/or dental insurance. Any individual without health or dental insurance is eligible to receive services at GSHCG. If you are or become insured, you may not be eligible to receive services at GSHCG. If you are or become insured and fail to notify us, we WILL NOT provide you with information to help you document your expenses at GSHCG and you may denied additional services.

3. **Required Documentation**. All patients must complete patient information forms including medical history and treatment consent forms to establish care at GSHCG. VALID PHOTO IDENTIFICATION SUCH AS A DRIVER'S LICENSE, PASSPORT, MILITARY CARD OR OTHER FORM OF GOVERNMENT ISSUED IDENTIFICATION IS REQUIRED. YOU MUST ALSO PROVIDE CURRENT PROOF OF INCOME AND NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD. Proof of income such as your most recent income tax return, last year's W-2 form, three (3) most recent bank statements, three (3) most recent pay stubs, unemployment documents from the Dept. of Labor, Social Security Income/Disability statements, or a signed letter from your employer(s) verifying your current wages and number of hours worked each week, will be accepted. IF YOU REFUSE TO PROVIDE THIS DOCUMENTATION YOU WILL BE DENIED SERVICE. THIS DOCUMENTATION MUST BE UPDATED ANNUALLY.

4**. Payment for Services.** Payment for services is required before each appointment. Partial payments are not accepted. You must maintain a $0.00 (zero) balance in order to receive additional services at GSHCG. Payment methods include cash, debit and credit cards (Visa, MasterCard, and Discover). We do not accept personal or certified checks. GSHCG offers greatly reduced prices as a community service to uninsured individuals and families. WE DO NOT ACCEPT GOVERNMENT FUNDING AND ARE NOT REQUIRED TO PROVIDE YOU WITH SERVICES YOU CANNOT AFFORD.

5**. Lab Fees.** If you require blood work or other lab services, you are responsible at the time of service for a minimum payment of $25. Some specialized lab work may be more expensive. We cannot inform you in advance what blood work you may require; that can only be determined after you have been assessed by a provider. It may take up to two weeks for your results to be

available, and WE WILL NOTIFY YOU ONLY IN THE EVENT OF ABNORMAL RESULTS. If you do not receive a call from us within two weeks, your lab results were within acceptable limits. If you would like a copy of your results you must pick them up in person. Copy fees may apply.

6**. Procedure and Extra Service Fees.** If you require a medical or dental procedure or any extra service, you may be responsible for an additional payment. We cannot tell you in advance what procedures or extra services you may require; that can only be determined after you have been assessed by a provider. Additional payment, if any, for a medical procedure or extra service is required before the procedure or extra service can be performed. If you require urgent care, the procedure or extra service may be provided immediately for your own health safety. In this case, fees must be paid at the end of your visit. FAILURE TO PAY PROCEDURE AND EXTRA SERVICE FEES WILL RESULT IN TERMINATING YOUR STATUS AS A PATIENT AT GSHCG.

7. **Acknowledgment of Medical Providers' Status.** The GSHCG is staffed with volunteer medical and dental providers including physicians, dentists, physician assistants, nurse practitioners, registered nurses, dental hygienists, and medical and dental students. Patients are assigned to providers on a random basis; however a licensed physician supervises all providers. WE CANNOT PROVIDE HEALTHCARE SERVICES TO YOU IF YOU REFUSE TO BE TREATED BY ANYONE OTHER THAN A LICENSED PHYSICIAN.

8**. NO EMERGENCY MEDICAL CARE:** GSHCG is not an urgent medical care or emergency medical care facility. We only provide routine primary medical care. We do not provide after-hours services or physician on-call response. Do not leave voicemail messages about your emergency needs. If you experience what you believe to be a medical emergency you must seek help at a hospital. If our daily dental schedule allows, we will provide emergency dental appointments to relive pain and infection.

9**. No Legal Assistance:** GSHCG does not provide healthcare for the purpose of supporting workers compensation, personal injury, Social Security disability or other loss claims. We will not provide care for the purpose of offering a medical opinion to your lawyer. WE DO NOT COMPLETE PAPERWORK OF ANY KIND FOR OTHER BUSINESSES OR PURPOSES.

10. **Duration of Appointments.** GSHCG reserves the right to end your medical appointment after FIFTEEN (15) MINUTES. You may be asked to return to the Center for additional appointments if all of your healthcare problems cannot be addressed within fifteen (15) minutes. Your first visit and annual physical appointments may last longer. GSHCG reserves the right to end your dental appointment after SIXTY (60) MINUTES. You may be asked to return for additional appointments if all your dental problems cannot be addressed in one appointment.

11**. Late Arrival.** You must arrive on time or early for your appointment. In order for GSHCG to honor the time of its volunteer staff, you must honor the time we have scheduled for your appointment. Patients arriving more than fifteen (15) minutes late may lose their appointment. GSHCG reserves the right to cancel the appointment of anyone not signed in within fifteen (15)

minutes of their scheduled appointment time. If you arrive late and your appointment has not been cancelled you may be seen that day at a time convenient to the volunteer medical staff.

12**. Missed Appointment Fee.** A $20.00 fee is due for missed medical appointments not canceled within 24 hours of the appointment. A $50.00 fee is due for missed routine dental appointments and $75.00 for specialty dental appointments not canceled within 48 hours of the appointment. These charges are due in addition to the fees for your next visit. MISSED APPOINTMENT FEES WILL NOT BE WAIVED AND MUST BE PAID BEFORE YOU CAN BE SEEN FOR A NEW MEDICAL APPOINTMENT. Missed appointment fees may be charged if you arrive more than fifteen (15) minutes late and we are unable to provide you with an appointment because of other appointments that have arrived on time. Repeated failure to cancel medical and/or dental appointments with advanced notice may result in your dismissal as a patient of GSHCG.

13. **Active or Inactive Status.** You are considered an Active Patient if you have been seen in the Center within the last twelve (12) months. If you have not been seen for a period greater than twelve (12) months, you are considered an Inactive Patient. We reserve the right to deny requests for medication refills if you are an Inactive Patient. We also reserve the right to charge you a Re-Assessment Fee if you have not been seen for a period greater than twelve (12) months.

14. **Referrals to Other Providers.** You may be referred to other healthcare providers for additional medical services, including mammography, ultrasound and other imaging, surgery, and consultation. You are responsible for payment of those services and disputes about amounts due must be handled by you directly with that provider. You should ask the provider for specific payment information prior to receiving medical treatment. GSHCG WILL NOT ASSIST YOU WITH RESOLVING BALANCES DUE FOR SERVICES YOU RECEIVED ELSEWHERE.

15. **Medication Refills Policy.** YOU MUST NOTIFY GSHCG OF YOUR NEED FOR A PRESCRIPTION REFILL AT LEAST TEN (10) DAYS BEFORE YOU RUN OUT OF MEDICATIONS. To obtain a prescription refill, you must either bring your medication bottles to the clinic or fax a complete Refill Request Form to 678-280-6635. This form is available at the checkout counter and on our website, www.goodsamgwinnett.org. DO NOT CALL TO REQUEST OR LEAVE A VOICEMAIL REQUESTING MEDICATION REFILLS. WE DO NOT PROCESS PHONE OR VOICEMAIL REQUESTS FOR MEDICATION REFILLS. Refill requests may be phoned in by your pharmacist.

16. **Controlled Substances Policy.** GSHCG WILL NOT PRESCRIBE NARCOTICS, OPIOIDS OR OTHER MEDICATION KNOWN TO HAVE ADDICTIVE PROPERTIES, INCLUDING BUT NOT LIMITED TO MEDICATIONS FOR PAIN, ATTENTION DEFICIT DISORDER, AND PSYCHIATRIC DISORDERS.

17. **Interpretation Services.** GSHCG IS NOT OBLIGATED TO PROVIDE YOU WITH AN INTERPRETER. Our fee for providing an interpreter is $10. Although we have interpreters, we cannot guarantee an interpreter will be available for you at each visit. For this reason, if you require an interpreter and do not bring one who is a fluent English speaker, and we do not have a volunteer interpreter available, your appointment may be delayed or cancelled. In the

case of cancellation due to lack of an interpreter, you will be charged the applicable cancellation fee. If you are not a fluent English speaker you will be charged the interpretation fee even if your provider speaks your primary language because every staff member you may come in contact with during your visit may not speak your primary language.

18. **Medical Records and Confidentiality.** We will provide you with a copy of your medical and/or dental records for a minimum fee of $10, not to exceed a maximum fee of $25, the charge determined by how many pages must be copied. You must pay the minimum $10 before we will copy the record. You must pick up the copied medical records in person. We will not give your records to another person unless you have authorized in writing that we may release the records to someone other than you. That person must present identification before we will release the records to him/her. We will not mail, email, or fax a copy of your records to another business who has not first provided us with a Medical Records Release form signed by you within thirty (30) days of the request for records.

19. **Photo Release.** GSHCG is a nonprofit charity and from time to time conducts marketing activates to promote its services to donors. Marketing activities may include photographs, videos, and voice recordings. Unless you specifically refuse to appear in the marketing activities, it will be assumed you have given consent for your image to be included in marketing activities. Your identifiable personal and confidential information will never be included in our marketing activities without your written consent.

20. **Research.** GSHCG is a nonprofit charity and from time to time conducts research activities to fulfill its obligations under scientific grants. Your anonymous health information may be included in research results and reports provided to grant funders. Your identifiable personal and confidential information will never be included in research reports.

21. **Dismissal Policy**. Failure to adhere to Patient Policies may result in dismissal from GSHCG for you and your immediate family. Unruly, disruptive, and threatening behavior will result in dismissal from GSHCG. We also expect you to participate and cooperate with your treatment. Repeatedly failing to participate and cooperate with medical and/or dental care and instructions, especially if that failure results in your medical instability, may result in dismissal. If dismissal were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical and/or care. During that 30-day period, our physician or dentist will only be able to treat you on a medically necessary basis.

22. **Right to change policies.** We reserve the right to change these and all other office policies and prices without prior notice.

I have read and understand GSHCG's Patient Policies and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

Good Samaritan Health Center of Gwinnett	Today's Date:					
Name (Nombre)	**Age (Edad)**	**Date of Birth (Fecha de nacimiento)**				
Have you ever had the following (¿Alguna vez ha tenido lo siguiente)?	**Yes**	**No**	**Habits/Lifestyle (Habitos Personales)**			
AIDS/HIV(SIDA)			Have you ever smoked/used tobacco?(Fuma?)		**Yes**	**No**
Blood pressure (low or high)			Cigarretes/pack per day? (Cigarros/paquete?)			
Cancer			Do You Drink Alcohol? (Toma alcohol?)		**Yes**	**No**
Diabetes (Diabetes)			Do you use drugs? (Usa drogas ilegales?)		**Yes**	**No**
Heart Attack(ataque cardiaco)			Number of Sex partners in the last 6 months			
Other serious disease not listed (alguna otra enfermedad seria no mencionda)			Numero de parejas en los ultimos 6 meses			
			Circle sexual history with: Men/ Women/ Both			
			Circule sus parejas sexuales: Hombre/ Mujer/ Ambos			
			Age of first menstrual period? (edad del primer período)			
			Last menstrual cycle (último ciclo menstrual)			
Allergies to medications/ food?Alergias a medicamentos/comida?	**Yes**	**No**	Birth Control? (toma anticonceptivos?)		**Yes**	**No**
			How many living children now? (Cuantos hijos viven?)			
			Family Medical History Historia médica familiar	**Father/Mother padre/madre**	**child/ hijos**	**siblings/ hermanos**
			Blood Pressure (high or low) (presion alta)	Yes / No	Yes / No	Yes / No
Have you had surgery?						
Alguna vez ha sido hopitalizado o ha sido operado?			Heart Attack (problemas del corazón)	Yes / No	Yes / No	Yes / No
When (fecha)	**Reason (problema)**					
1			Diabetes (diabetes)	Yes / No	Yes / No	Yes / No
2			Cancer	Yes / No	Yes / No	Yes / No
3			**Any other family medical problem? Algun otro probelma medico familiar?**			
PHARMACY/ FARMACIA						
Name/ Nombre:						
Number/ Numero:						
Street/City/ Calle/Ciudad:						

If we need to call to give results, do you authorize **GSG** to leave medical information on your voicemail? / Si necesitamos llamar para dar resultados, usted authoriza **GSG** dejar un correo de voz con su informacion medica? **Circle (Yes/No)**

Initials

If yes, please provide: Phone number: _____

Si autoriza, por favor proveer numero de telefono _____

Do you authorize **GSG** to release general medical information to the following personl? Usted autoriza a **GSG** dar informacion general medica a la siguiente persona? **Circle (Yes/No)**

Initials

If yes, please provide: **Si autoriza,** por favor proveer :

Name/ Nombre _____

Phone number/numero de telefono _____

_____ _____

Patient signature (Firma del paciente) Date (fecha)