

First Visit Information Sheet (Adult)

Forma De Información De Primera Visita (Adulto)

Print your name as it appears on your ID/ Imprima su nombre tal y como aparece en su ID

Last Name/Apellido: _____ First Name/Nombre: _____

Preferred Name/Nombre preferido: _____ Date of Birth/Fecha de Nacimiento: __/__/__

Country of Birth/país de Nacimiento: _____ Sex/Sexo: Male/Hombre Female/Mujer

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

Education/educación: _____

Ethnicity/Grupo Étnico	Race/Raza	Primary Language/Idioma primario
<input type="radio"/> Hispanic or Latino	<input type="radio"/> Asian <input type="radio"/> Biracial	English <input type="radio"/> Español <input type="radio"/>
<input type="radio"/> Not Hispanic or Latino	<input type="radio"/> Black <input type="radio"/> Other	Other <input type="radio"/>
	<input type="radio"/> White	

Address/Dirección:			Apt #/ Apartamento #:
City/Ciudad			State/Estado
County/Condado		Zip Code/Código Postal	
Telephone/teléfono:		2 nd Telephone/teléfono secundario:	
Email Address/dirección de correo electrónico:			
Marital Status/ Estado Civil		Name of Spouse or Partner/Nombre de Esposo(a) Compañero(a):	
<input type="radio"/> Single/Soltero(a)	<input type="radio"/> Married/Casado(a)	Phone Number/Número de teléfono:	
<input type="radio"/> Widowed/ Viudo(a)	<input type="radio"/> Partnered/Compañero(a)		
<input type="radio"/> Divorced/Divorciado(a)	<input type="radio"/> Separated/Separado(a)		

Female Head of Household?/Mujer Cabeza de Familia Yes/Si No

Monthly Household Income (all sources)/Ingreso mensual familiar: \$ _____

Number of People in Household / Número de personas que viven en su residencia _____

Employer/Empleador: _____ Occupation/Ocupación: _____

Do you have any health insurance? ¿Tiene Seguro médico? Yes/Si No

Emergency Contact Information/Contacto de emergencia	
Name/Nombre:	Telephone/teléfono:
Do you authorize us to release medical information to this person? Yes/Si <input type="radio"/> No <input type="radio"/>	¿Usted nos autoriza a dar su información médica a esta persona? Yes/Si <input type="radio"/> No <input type="radio"/>

Signature/Firma _____

Date/Fecha _____

Good Samaritan Health 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 es un Centro de salud basado en la Fe. Existimos para honrar a Dios por medio de nuestro ministerio atendiendo las necesidades de salud de la comunidad. No somos una clínica gratuita pero nuestros precios son a bajo costo.

Patient Medical History
Historia Médica del Paciente

1. Are you allergic to any medications? Yes _____ No _____
If yes, which medications?

¿Es alérgico a algún medicamento? Si _____ No _____
En caso afirmativo, ¿qué medicamentos?

2. Which Pharmacy do you use?

Name: _____

Telephone Number/Address: _____

¿Qué farmacia utilizas?

Teléfono Nombre: _____

Numero/Ciudad: _____

3. If we need to give results, do you authorize GSG to leave medical information on your voicemail or text?

Yes _____ No _____

Si necesitamos dar resultados, ¿autoriza a GSG a dejar información médica en su correo de voz o mensaje de texto? Si _____ No _____

Do you authorize GSG to release general medical information to any other person?

Yes _____ No _____

If yes, please provide the person's name and phone number

¿Autoriza a GSG a divulgar información médica general a cualquier otra persona?

Si _____ No _____

En caso afirmativo, proporcione el nombre y el número de teléfono de la persona.

Patient Signature (Firma del paciente)

Date (Fecha)

Acct # _____

Please answer the following questions by circling a number

(Por favor responda las siguientes preguntas marque el numero con un circulo)

Over the last <u>2 weeks</u> how often have you been bothered by any of the following? -(Durante las últimas <u>2 semanas</u> , ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?)	Not at all (Ningún día)	Several days (Varios días)	More than half the days (Más de la mitad de los días)	Nearly every day (Casi todos los días)
Little interest or pleasure in doing things -(Poco interés o placer en hacer cosas)	0	1	2	3
Feeling down depressed, or hopeless -(Se ha sentido decaído(a), deprimido(a) o sin esperanzas)	0	1	2	3
PHQ- 2 Total:				

Total: _____

Over the last <u>2 weeks</u> how often have you been bothered by any of the following? -(Durante las últimas <u>2 semanas</u> , ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?)	Not at all (Ningún día)	Several days (Varios días)	More than half the days (Más de la mitad de los días)	Nearly every day (Casi todos los días)
Feeling nervous, anxious, or on edge -(Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta)	0	1	2	3
Not being able to stop or control worrying -(No ha sido capaz de parar o controlar su preocupación)	0	1	2	3
GAD-2 Total:				

Total: _____





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, advanced practice providers, dentists, nurses, technicians, and 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 be 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 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 signed 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. Payments 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 SERVICES.
- 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 of the bloodwork 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

will be 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 may be provided immediately for your own health and safety. In this case, fees must be paid at the end of your visit. **THE FAILURE TO PAY FOR PROCEDURES AND EXTRA SERVICE FEES WILL RESULT IN TERMINATING YOUR STATUS AS A PATIENT AT GSHCG.**
- 7. Acknowledgement 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.** If your scheduled provider is unavailable due to unforeseen circumstances, you may be scheduled with an alternate provider without prior notice.
- 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 relieve pain and infection.
- 9. No Legal Assistance.** GSHCG does not provide healthcare for the purpose of supporting worker's 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 appointment after the allotted appointment time. You may be asked to return to the Center for additional appointments if all your healthcare problems cannot be addressed within the allotted appointment time. Your first visit and annual physical may take longer than follow-up visits. GSHCG reserves the right to end your dental appointment after the allotted appointment time. 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 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 medical or dental staff.
- 12. Missed Appointment Fee.** A \$20.00 fee is due for missed medical appointments not cancelled within 24 hours of the appointment. A \$50 fee is due for missed appointments with a medical specialist. A \$50 dollar fee is due for missed routine dental appointments and \$75.00 for dental specialty appointments not cancelled 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 OR DENTAL 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 the 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 at 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 charge you a Re-Assessment Fee if you have not been seen for a period greater than (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 directly with that provider. You should ask the provider for specific information prior to receiving medical treatment. GSHCG WILL NOT ASSIST YOU WITH RESOLVING BALANCES DUE FOR SERVICES YOU RECEIVED ELSEWHERE.
- 15. Medication Refill 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

 - a. Bring your medication bottles to the clinic at your next appointment.
 - b. Call 678-280-6635 to request a refill. Leave your name, date of birth, and the name of the medication needed.
 - c. Refill Request from an outside pharmacy
- 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. Although we have interpreters, we cannot guarantee an interpreter will be available for you 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 an interpreter available, your appointment may be delayed or cancelled. In the case of cancellation due to lack of interpreter, you will be charged the applicable cancellation fee.
- 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 records. 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 their identification before we release the records to him/her. We will not mail, email, or fax a copy of your records to another business that has not 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 non-profit charity and from time to time conducts marketing activities to promote its services to donors. Marketing activities may include photographs, videos, and voice recordings. Unless you specifically refuse to appear in marketing activities, your identifiable personal and confidential information will never be included in our marketing activities without your written consent.

- 20. Consent to Text.** GSHCG utilizes texting platforms to confirm appointments and occasionally send HIPAA compliant messages. You can opt out of the system at any time.
- 21. Research.** GSHCG is a non-profit 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 used in research reports.
- 22. Use of recording devices during medical or dental procedures.** GSHCG prohibits the use of recording devices during medical and dental procedures. Failure to comply with this policy will result in the appointment being suspended and you may be asked to reschedule. Multiple violations of this policy will result in dismissal from GSHCG.
- 23. Dismissal Policy.** Failure to adhere to Patient Policies may result in dismissal from GSHCG for you and 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 dental care. During the 30 -day period, our providers will only be able to treat you on a medically necessary basis.
- 24. Right to change policies.** We reserve the right to change these and all other 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

**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 Highway, Norcross, GA 30071
Phone: 678.280.6630 FAX: 678.280.6635

1175 Commercial Court, 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 that **HAS YOUR HEALTH INFORMATION**)

(Street Address, City, State, ZIP)

FAX

to release my health information to:

Good Samaritan
Health Center of Gwinnett, Inc.

(Name of Facility / Person **TO RECEIVE INFORMATION**)

5949 Buford Hwy.
Norcross, GA 30071
678-280-6630 (Phone)
678-280-6635 (FAX)

(Street Address, City, State, ZIP)

Phone

Fax

Self (Patient or Patient Representative) at my request

This authorization applies to (check one):

All Records (may include drug/alcohol/sexual, and mental health information)

Other (Please Specify): _____

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 does not expire.

Patient / Patient Representative / Guardian Signature

Date

Print Name

Witness