Good Samaritan
HEALTH & WELLNESS CENTER

Pediatric Patient Information
(Under Age 18)

Patient's Name: ____
(Last Name) (First Name) (Middle Initial)

Patient DOB: ________________________ **Patient Social Security #:** ____

GSHWC is a Federally Qualified Health Center that receives government funding. The funding for your health center is based on information you provide and is necessary for us to better serve you, our patient. Please answer each of the following questions for reporting purposes.

Birth Sex: M ❑ F ❑ **Sexual Orientation:** Straight ❑ Lesbian/Gay❑ Bisexual❑ Other ❑_______

Gender Identity: Male ❑ Female ❑ Transgender Male (Female to Male)❑ Transgender Female (Male to Female)❑ Other ❑___

Race: White❑ Asian❑ Black❑ Alaskan/ Native American❑ Native Hawaiian❑ Other Pacific Islander ❑ Other❑_______

Ethnicity: Are you Hispanic or Latino Yes ❑ No ❑ **Preferred Language**: English ❑ Spanish ❑ Other ________

Does the minor have an Advance Directive? ❑ Yes ❑ No Would you like information on Advance Directives? ❑ Yes ❑ No

Does the minor have medical insurance? Yes ❑ No ❑ Does the minor have dental insurance? Yes ❑ No ❑

Guarantor/Responsible Party Information

If other than Mother or Father, please provide a copy of custody paperwork.
We consider the person completing this form to be financially responsible for patient.

Person Completing This Form: Mother❑ Father❑ Legal Guardian❑ Other (specify):___________

Name: ______________________________________ **DOB:**_____________ **SSN#:**_______________________________

Mailing Address: ____
Street Apt. Number City State Zip Code

Home Phone: _______________________ **Cell Phone:** _______________________ **Work Phone**: _______________________

Employer: ____

Employment Status: Employed Full-time❑ Employed Part-time❑ Self-employed❑ On Active Military Duty❑
Retired❑ Not Employed❑ Student Full-time❑ Student Part-time❑

E-mail address: _______________________________________

Marital Status: Married ❑ Single ❑ Widowed ❑ Divorced ❑ Partner ❑ Separated ❑

Are you a farm worker? Migrant ❑ Seasonal ❑ No❑ **Have you ever served in the Armed Forces?** Yes ❑ No ❑

Housing Status (if applicable): Public Housing: Yes ❑
Homeless: Doubling up ❑ Street ❑ Transitional ❑ Homeless Shelter ❑ Other________

Annual Wage: ≤$12,060❑ $12,061-15,075❑ $15,076-18,090❑ $18,091-21,105❑ $21,106-24,120❑ ≥$24,121❑

How many people live in your household? _____

I certify that the above information is correct. I authorize payment of medical benefits to GSHWC and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

I hereby authorize employees and agents, including physicians, dentists, physician assistants, nurse practitioners, and other healthcare practitioners of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the providers; including consultants, associates and assistants of the provider's choice. I consent to voluntary and confidential family planning services. I authorize Good Samaritan Health & Wellness Center to secure my prescription history from external sources. *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian unless here for confidential family planning services.

Parent/Responsible Party's Signature*____ **Date:** ____________________

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Patient Name **Patient DOB**

Emergency Contact Information

Name: ____ **Relationship to Patient:** _____________________________________

Cell Phone: _______________________________________ **Alternate Phone:** ____

Permission to Verbally Discuss Protected Health Information

I, ____, hereby authorize Good Samaritan Health and Wellness Center to discuss my protected health information with the following individuals:

Name: ________________________________ Relationship: ________________ Phone: __________________

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to GSHWC. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released in response to authorization or to information that GSHWC has used based on this authorization. If I have questions about the use and disclosure of information, I can contact GSHWC.

Parent/ Responsible Party's Signature*____ Date: ___________________
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian unless here for confidential family planning services.

Notice of Privacy Practices and Patient Rights

Your signature below is acknowledgement of being offered a copy of Good Samaritan Health & Wellness Center's Notice of Privacy Practices. The Notice of Privacy Practices and Patient Rights is available to you at any time from staff or accessible on our website. The HIPAA Privacy Act allows disclosure of your information for treatment, payment and health care operations without authorization from you. However, you can request restrictions to this disclosure, subject to agreement by Good Samaritan. These restrictions will be effective until revoked by you in writing unless disclosure has been made.

Patient Signature____ Date: _____________________
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian unless here for confidential family planning services.

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Application for Discounted Fee Program

Patient Name ____ Patient DOB ________________

Good Samaritan Health & Wellness Center provides discounts for medical, dental and behavioral health services to qualified patients. The discount is based on the number of persons in the household and the combined **GROSS** income of all persons in the household. Income verification must be provided before the sliding fee discount will be applied.

The following can be provided for **GROSS** income verification:

1. Three current pay stubs, OR
2. Most recent Federal Income Tax Return/W-2's, OR
3. Documentation from Social Security, OR
4. Letter from your employer stating the average hours worked in a week and the hourly rate of pay. This must be on the employer's letterhead, OR
5. Income Verification Form.

Please list ALL persons (adults and children) in the Household:

Name: ____ Amount of **Gross** Income ____________ ❑ Weekly ❑ Monthly ❑ Annually

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Total Number of People Living in the Household: _________ Total Household Income: _________________

You are required to update this information annually and at any time there is a change in income or persons living in the household, or if you become eligible for insurance.

We are not a free clinic and payment of services is required at the time of your visit. Payments include insurance co-payments, sliding scale fee or full payment. Cash, debit cards and major credit cards are accepted.

I understand and agree to all rules of the discounted fee/sliding fee program. I confirm that all information provided above is correct and accurate. I understand that providing inaccurate or false information will result in automatic loss of eligibility for discounts.

I understand that it is my responsibility to supply all required information to Good Samaritan Health & Wellness Center. I understand that, if I do not have the required information by my second visit, I will be taken off the sliding fee program and will be required to pay 100% of the fees due. I agree to inform Good Samaritan Health & Wellness Center if there is any change in my household income, persons living in the household, or any change in health insurance coverage.

Printed Name of Parent/Responsible Party:____

Signature of Parent/Responsible Party: _____________________________________ Date: ____________

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Patient Rights and Responsibilities

As a patient, you have the right to:

- Take part in your health care and treatment
- Know the names of the people caring for you
- Be treated with respect and dignity in a safe and private setting
- Be informed about your illness and treatment, including options for your care
- Change medical providers at GSHWC
- Get another opinion about your illness or treatment
- Privacy of your health records
- Talk with the Chief Medical Officer about questions or problems with your care
- Respect for your cultural, social, spiritual and personal values and beliefs
- Know about legal reporting requirements
- Ask for special arrangements if you have a disability
- Refuse treatment, care and services as allowed by law
- Know the cost of your care and ways you may pay for your care
- Ask for help with Advanced Directives or Durable Power of Attorney for Healthcare

As a patient, you have the responsibility to:

- Notify the clinic of changes in residence or phone number
- Bring all medication bottles from all doctors to your appointment at GSHWC
- Tell your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both caregivers and other patients
- Use medications or medical devices for yourself only
- Inform the medical provider if you become worse or you have an unexpected reaction to a medication
- Give written permission to release your other health records to GSHWC when necessary
- Provide GSHWC a copy of your Advanced Directive and Durable Power of Attorney for Healthcare
- Call and make appointments at least 2 weeks prior to running out of medications
- Call the pharmacy (where you currently get your prescriptions filled) 1 week prior to needing refills
- **Cancel or reschedule appointments so that another person may have that time slot**
- **Make payment when services are rendered or prescriptions are picked up**
- Inform us when your household income or occupancy number changes
- Notify the center of changes in insurance coverage or eligibility, including private insurance, Medicaid, Medicare, PeachCare for Kids, Amerigroup, WellCare or Veteran's Choice

Loss of Services:

Should you fail to comply with the above stated responsibilities, the center reserves the right to reschedule your appointment, suspend your services, refer you to another practice, or dismiss you from our practice.

Prescriptions:

The clinic has a strict policy on the prescribing of class 2 medications, such as Opioids (pain pills) and Benzodiazepines (sedatives). The medications are only given in accordance with guidelines and at the providers' discretion.

Prior to any ADD or ADHD medication for pediatric or adults being prescribed, documentation of a formal diagnosis from a psychologist or psychiatrist is required. The patient may schedule an appointment with our psychologist for testing.

Signature of Parent/Responsible Party:____ Date: __________