GOSHEN MEDICAL CENTER, INC.

Patient Registration Chart Number _____

Name: _____ _____ _____
Last First Middle

Date of Birth: ____/____/____ **Social Security Number:** _____ **Sex:** _____

Street Address: _____

PO Box _____ **City** _____ **State** _____ **Zipcode** _____

Marital Status: _____ **Student:** ( )Full Time ( )Part Time **Primary Language:** _____

Ethnicity (check one) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ More than 1 race

Characteristics– Special Populations (Data used by Goshen Medical Center due to being a Federal Qualified Health Care Center which offers the Sliding Fee based on income along with number of family members.)

How long have you lived in the United States? _____years, _____months Are you a US Veteran? ☐Yes ☐No

Household Income Range (circle one) <$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

Persons In Household (circle one) 1 2 3 4 5 6 7 8 9 10 other _____

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? ☐ Migrant (establishes temporary residence in area) ☐ Year Round Employment (permanent 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 ☐ Rent or own home ☐ Homeless Shelter ☐ Street ☐ Doubled Up (live with another person or family unit) ☐ Transitional (live place to place) ☐ Other _____

Home Telephone: (____)_____ **Work Phone:** (____)_____ **Cell Phone:** (____)_____

Patient's Employer: _____ **Address:** _____

Spouse's Name: _____ **Date of Birth:** ____/____/____

Spouse's Employer: _____ **Address:** _____

In case of Emergency, Center may Contact: Name: _____ Telephone: (____)_____

Responsible Party Information: (Who Pays the Bills?) Name: _____

Telephone: (____)_____ Work Phone: (____)_____ Relationship_____

Address:_____ City_____ State_____ Zipcode_____

Employer: _____ Social Security Number: _____ Date of Birth: ____/____/____

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Full Name: _____ **Telephone:** (____)_____

Relationship to Patient: _____ **Work Phone:** (____)_____

Parent/Legal Guardian of Minor (2) [If Applicable]

Full Name: _____ **Telephone:** (____)_____

Relationship to Patient: _____ **Work Phone:** (____)_____

(IMPORTANT NOTICE: The Information Listed Above Is Not Authorization and/or Designation of a Personal Representative)

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) (Date)

_____ _____ ____/____/____
(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.

(Rev SEPT2014)

GOSHEN MEDICAL CENTER, INC.

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.

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:_____