Good Samaritan
HEALTH & WELLNESS CENTER

Patient's Name: _____ **Date of Birth:** _____
(Last Name) (First Name) (Middle Initial) (MN/DY/YR)

Parent/Guardian Name (If patient under 18)**:** _____

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

Home Phone:_____ **Cell Phone:** _____ **Work Phone**:_____

Gender: M ❑ F ❑ **Marital Status:** Married ❑ Single ❑ Widowed ❑ Divorced ❑ Partner ❑ Separated ❑

Social Security #: _____ **Patient (or parents) Employer**: _____

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

Physical Address if different from mailing: _____
Street Apt. Number City State Zip Code

E-mail address: _____

Race(Check all that apply)**:** Black ❑ Asian ❑ White ❑ Alaskan/ Native American ❑ Native Hawaiian ❑
Other Pacific Islander ❑ Other ❑_____

Ethnicity: Hispanic or Latin ❑ Non-Hispanic or Latin ❑ Rather Not Answer ❑

Preferred Language: English ❑ Spanish ❑ Other _____

Emergency Contact Name: _____ **Phone Number:** _____

Relationship to Patient _____

Are you a farm worker? Migrant ❑ Seasonal ❑ No❑

Have you ever served in the Armed Forces? Yes ❑ No ❑

Housing Status: Public Housing❑ Homeless❑ (If homeless, check circumstance below.)
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? _____

Insurance Information

Primary Insurance Company:_____ Policy Holder's Name:_____ DOB:_____
Policy Holder's SS#:_____Employer: _____

Secondary Insurance Company:_____ Policy Holder's Name:_____ DOB:_____
Policy Holder's SS#:_____Employer: _____

Dental Insurance Company:_____ Policy Holder's Name:_____ DOB:_____
Policy Holder's SS#:_____Employer: _____

I certify that the above information is correct. I consent to be treated by the staff and providers of GSHWC. 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.

Patient or 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.

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Discounted Fee Program

Patient Name _____

Description and Rules Account# _____

Good Samaritan Health & Wellness Center provides discounts for primary medical and dental care to qualified patients. If you choose to apply, you will be charged according to income and number of people living in household. The following services are available for discounts:

1. Office visits with Good Samaritan health & Wellness providers.
2. Certain lab services provided at Good Samaritan Health & Wellness Center.
3. Certain radiology services provided with a referral from Good Samaritan Health & Wellness Center.
4. Certain Dental services provided at Good Samaritan Health & Wellness Center by other providers are not discounted.

To determine that you are eligible for the program, and the level of discount you might qualify for, complete the necessary application (attached) and provide the required proof of income, as follows:

1. Three Current Pay Stubs, OR:
2. Most recent Federal Income Tax Return, 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. Documentation from Food Stamp Office stating the amount you receive per month and the amount of income you provided. You **must** include all pages of approval letter.

Verification of **all income** of all persons in the household is required. **You are required** to inform us if you have health insurance, including commercial insurance, Medicare, Medicaid, Peachcare, Amerigroup or WellCare. **You are required** to update this information yearly and at any time there is a change in income or persons living in the household.

Eligibility, **once granted, MAY BE LOST OR SUSPENDED**. Some reasons that will result in losing eligibility for continued participation include:

1. Not informing us that you have health insurance, including Medicare, Medicaid, Peachcare, Amerigroup or WellCare.
2. Not informing us of changes in your income or household.
3. Missing three appointments in a twelve-month period without providing notice.
4. A check returned for insufficient funds.
5. Abuse of the services of Good Samaritan Health & Wellness Center.

***Patients are responsible for payment for all services at the time the service is rendered (including discounted fee).**

I understand all of the above information and agree to all rules of the discounted fee/sliding fee program. I understand that providing inaccurate or false information will result in automatic loss of eligibility for discounts. I understand that, if I do not provide the required information by my second visit, I will be taken off the sliding fee program until such information is submitted.

Printed Name of Applicant:_____ DATE:_____

Signature of Applicant:_____

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Application for Discounted Fee Program

Patient Name_____ Account#_____

If you choose to apply for the discounted fee program, you will be charged according to income and number of people residing in your household. Read and sign the separate form called "Description and Rules":

Patients are responsible for payment for all services at the time the service is rendered (including discounted fees).

You are required to update this information **yearly** and at any time there is a **change** in income or persons living in the household. Verification of **all income** of **all persons** in the household is required.

NAME OF APPLICANT: _____
List of Names of **ALL** Persons (adults and children) in the Household:

_____ _____

_____ _____

_____ _____

Total Number of People Living in the Household: _____

Are you covered by any health insurance, Medicare, Medicaid, Amerigroup, WellCare, or PeachState? YES _____ NO _____
If yes, please complete the following:

Name of Insured Person: _____

Relationship to you: _____Self _____Spouse _____Parent _____Child

Name of Insurance Company:_____ (give copy of card to front desk)

Household Income:

Name: _____ Amount of Gross Income _____
❑ Weekly ❑ Monthly ❑ Annually

Source of Income: _____

Name: _____ Amount of Gross Income _____
❑ Weekly ❑ Monthly ❑ Annually

Source of Income: _____

TOTAL ANNUAL HOUSEHOLD INCOME: _____

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 Applicant: _____

Signature of Applicant: _____ 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 Good Samaritan Health & Wellness Center
- 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
- Know about services available through Good Samaritan Health & Wellness Center
- 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
- Ask for help with a living will or durable power of attorney for healthcare
- Refuse treatment, care and services as allowed by law
- Know the cost of your care and ways you may pay for your care
- Refuse to be included in any research program without limiting medical care or treatment

As a patient, you have the responsibility to:

- Tell your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both caregivers and other patients
- Cancel or reschedule appointments so that another person may have that time slot
- Pay your bills on time
- 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 Good Samaritan Health & Wellness Center when necessary
- Provide Good Samaritan Health & Wellness Center a copy of your living will or durable power of attorney for healthcare matters

If you have questions, please tell your medical provider or the Chief Medical Office.