The Family Health Centers of Georgia, Inc.

# PATIENT REGISTRATION FORM MOBILE MEDICAL/DENTAL UNIT (PEDIATRICS)

**(To be completed by ALL PATIENTS every calendar year.)**

**Date of Service:**_____ **Service Location:**_____

**What school do you attend?**_____

**New Patients: How did you hear about us?**_____

## PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name:_____
(first) (middle initial) (last)

Parent/Guardian's Name:_____
(first) (middle initial) (last)

Patient's Social Security #:_____ Date of Birth:_____ Sex:_____

Race: [ ] Black/African-American [ ] White [ ] American Indian/Alaska Native [ ] Asian [ ] Native Hawaiian
[ ] Pacific Islander [ ] more than one race

Are you Hispanic/Latino: [ ] yes [ ] no

Primary Language: [ ] English [ ] Other_____

Patient's Address:_____
(street)

City:_____ State:_____ Zip Code:_____

Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Patient's Email:_____

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

## PATIENT DEMOGRAPHICS

### Special Populations (Check all that apply.)

[ ] Migrant Agricultural Worker/Farmer
[ ] Public Housing (live in or access to)
[ ] Seasonal Agricultural Worker/Farmer
[ ] Veteran
[ ] None of the above
[ ] Choose not to disclose

### Housing (Check all that apply.)

[ ] Doubled Up (temporarily living with others)
[ ] Homeless
[ ] Other (hotel, motel, other day to day payment, etc.)
[ ] Public Housing (live in or access to)
[ ] Shelter
[ ] Street (car, outdoors, makeshift housing)
[ ] Transitional Housing
[ ] None of the above
[ ] Choose not to disclose

## SELF REPORTED INCOME

Number of people living in household: _____ Household Income: _____ [ ] Choose not to Disclose

## INSURANCE INFORMATION (Please present current insurance card to the FHCGA representative.)

[ ] Medicaid [ ] Amerigroup [ ] Care Source [ ] PeachState [ ] WellCare [ ] Medicare [ ] Medicare supplement
[ ] Private insurance [ ] ACA Marketplace/Exchange [ ] Worker's Comp [ ] Disability [ ] Liability [ ] Other

Please indicate insurance company's name for private insurance:_____

Member's Name (as listed on insurance card):_____ Policy #:_____

[ ] Check here if you want to make KidCare/FHCGA your child's Primary Care Provider (PCP)

## PERSON RESPONSIBLE FOR PAYMENT (This section must be completed even if you are using Medicaid, Medicare, or private insurance.)

Relationship to patient (please check one): [ ] Self [ ] Parent/Guardian [ ] Spouse [ ] Other (specify)_____

**[ ] Check here if patient (self) is the responsible person and the information is the same as previously indicated. Only complete section below if any information is different.**

Responsible Party's Name:_____
(first) (middle initial) (last)

Responsible Party's Address:_____
(street)

City:_____ State:_____ Zip Code:_____

Responsible Party's Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Responsible Party's Date of Birth:_____ Responsible Party's Social Security #:_____

Responsible Party's Email:_____

Responsible Party's Insurance Company's Name:_____

Member Name (as listed on insurance card):_____ Policy #:_____

Responsible Party's Employer's Name:_____

Employer's Address:_____

City:_____ State:_____ Zip Code:_____

Telephone #:_____ Fax #:_____ Email:_____

## SIGNATURE REQUIRED (Please read and sign below.)

I, the undersigned, do hereby expressly guarantee payment in full of any and all charges in consideration for the healthcare services rendered, or to be rendered, by THE FAMILY HEALTH CENTERS OF GEORGIA, INC. I also acknowledge that I am solely responsible for payment of any services as billed by an independent provider.

**X** Signature:_____ Date:_____

The Family Health Centers of Georgia, Inc.

# AUTHORIZATION FOR TREATMENT

**(To be completed by ALL PATIENTS annually.)**

The Family Health Centers of Georgia, Inc. (FHCGA) is required by law to obtain consent to treat and disclose all material risks and alternative medical treatments. I understand that it is not possible to list every material risk for every procedure or medical treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the procedures or medical treatments; including but not limited to the following:
1. Needle sticks, such as injections (shots). The material risks associated with these types of procedures include, but are not limited to, nerve damage, infection or bruising. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective); or refusal of medical treatment.

2. Physical tests, assessments and medical treatments (e.g. vital signs, internal body examinations, wound cleaning, wound dressing, range of motion checks); and other similar procedures. There are no known major risks associated with these procedures. Medical treatment may consist of treatment for illnesses (e.g., strep throat, ear infections, pink eye, scrapes, strains, cuts, well child checks).

3. Administration of medications whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, or allergic reaction. Apart from varying the method of administration and/or refusal of medical treatment, no practical alternatives exist.

4. Drawing blood, bodily fluids or tissue samples such as that done for laboratory testing and analysis. The material risks associated with these types of procedures include, but are not limited to, infection, bleeding or nerve damage. Apart from varying long-term observation and/or refusal of medical treatment, no practical alternatives exist.

**BY SIGNING THIS FORM:**

- I **consent to FHCGA healthcare professionals performing medical treatments and procedures** as they deem reasonably necessary in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained.
- I acknowledge that I have been informed in general terms of the nature and purpose of the medical treatments and procedures, the material risks of procedures, and practical alternatives to the procedures.
- If I have any questions or concerns regarding these medical treatments or procedures, I will ask my physician to provide me with additional information.
- In order to insure medication safety and lack of drug interactions, I grant FHCGA, its staff and authorized affiliates the right to access my pharmacy and prescription information.
- I understand that it is my choice to receive voluntary confidential family planning services.
- I acknowledge that I have read and understand the above information and I give permission for myself or my child's healthcare as described.

**X Signature of Patient (or authorized representative):** _____

**Printed Name of Patient:**_____ **Date:**_____

**Relationship to patient:**_____ **Reason Patient Unable to Sign (if applicable):** _____

Acknowledgment of **receipt of Notices of Privacy Practices for Protected Health Information (HIPAA):** I acknowledge that I have received the Notice of Privacy Practices.

**X Signature of Patient (or authorized person to sign):** _____ **Date**:_____

Authorization for **medical treatment by Mid-Level Providers**: I understand that The Family Health Centers of Georgia, Inc. and its affiliates utilizes certified Mid-Level Providers (e.g., Physicians Assistants (PA), Nurse Practitioners (NP), etc.) to treat patients for the level of care for which they have been approved by the Georgia State Board of Medical Examiners. My signature on this form conveys that I am in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision of a physician.

**X Patient Signature (or authorized representative):** _____ **Date**:_____

**FHCGA is a member of and/or may participate with organizations that collect data only (not personal information) for grant funding and/or other purpose.**

**[ ] Check here if you opt out of data sharing.**



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The Family Health Centers of Georgia, Inc.

# AUTHORIZATION TO RELEASE/ DISCLOSE OF MEDICAL/DENTAL/ BEHAVIORAL HEALTH INFORMATION

**GENERAL AUTHORIZATION:**
I, the undersigned patient or legal representative, hereby authorize Family Health Centers of Georgia, Inc. to use, review, give, disclose and release the health, medical and mental health information and related records as specifies below, to the recipient named below. Method of release shall be pertinent to the need and may include photocopies, fax copies, scanned copies, postal mail, express mail, computer files, e-mail, personal review, inspection, telephone, electronic and/or verbal communication.

Patient Name:_____ Medical Record #:_____

Date of Service:_____ Date of Birth:_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____ Email:_____

*INFORMATION RELEASED TO*

Company Name:_____ Attention:_____

Purpose:_____ Expiration Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____ Email:_____

**SPECIFIC AUTHORIZATION:**
I specifically authorize the release of information regarding the following types of records, services, treatment, care and the types of medical conditions, restricted to the following dates:

[ ] problem list From (date)_____ to (date) _____
[ ] medication list
[ ] list of allergies
[ ] immunization record
[ ] most recent history and physical
[ ] most recent discharge summary
[ ] laboratory results From (date)_____ to (date) _____
[ ] x-ray and imaging reports From (date)_____ to (date) _____
[ ] consultation reports From (doctor's names)_____
[ ] entire record
other_____

**BEHAVIORAL HEALTH AUTHORIZATION:**
I authorize special permission and/or authorization to release the information below: ***(Initials required by each item)***

_____ mental/behavioral health record
_____ psychological evaluations
_____ psychological/psychiatric information (excludes psychotherapy notes which require separate release)
_____ alcohol/drug/substance abuse information
_____ HIV/AIDS/STD related information
_____ physical or sexual abuse information

I may revoke this authorization at any time, by written notice, except to the event that action has already been taken to comply with it. **This authorization will automatically expire in 5 years** or upon fulfilling the purpose or need for information as specified above, or as limited by law. This authorization shall not be affected by my death, disability or incapacitation. I understand that if a recipient is not a covered entity under privacy laws and regulations, the information disclosed or used under this authorization may be further disclosed to other parties and is no longer protected by privacy laws and regulations.

**PURPOSE OF DISCLOSURE:**
[ ] referral [ ] legal investigation [ ] insurance [ ] worker's comp. [ ] disability determination [ ] change of doctor
[ ] personal [ ] other:_____

_____ _____
Signature of Individual (Guardian or Estate Representative) Date