



PATIENT REGISTRATION FORM

SCHOOL-BASED HEALTH CENTERS

(To be completed by ALL PATIENTS annually.)

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

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 choose not to disclose

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.)

- Doubled Up (temporarily living with others)
- Homeless
- Migrant Agricultural Worker
- Other (hotel, motel, other day to day payment)
- Public Housing (Live in or Access to)
- School-Based Health Center Patient
- Seasonal Agricultural Worker
- Shelter
- Street (car, outdoors, makeshift housing)
- Transitional Housing
- Veteran
- None of the above

PLEASE COMPLETE BACK PAGE
SIGNATURE REQUIRED

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 #: _____

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: _____



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.

Medical treatments and/or procedures may include, but are 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.

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.

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.

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



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

- THE FAMILY HEALTH CENTERS OF GEORGIA, INC.
868 York Avenue, SW | Atlanta, GA 30310
P: 404.752.1400 | F: 404.752.1404

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate.)

- Consultation Reports from (doctor's names) _____
- Entire Record
- Immunization Record
- Laboratory Results from (date) _____ to (date) _____
- List of Allergies
- Medication List
- Most Recent Discharge Summary
- Most Recent History and Physical
- Problem List from (date) _____ to (date) _____
- X-ray and Imaging Reports from (date) _____ to (date) _____
- Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to restrict what information can be released. I further understand that I must indicate those restrictions before signing this Authorization to Disclose Health Information form.

5. This information may be disclosed to and used by the following individual or organization:

Address: _____

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

Parental/Legal Guardian

Relationship to patient

Date

Witness

Date