PATIENT REGISTRATION FORM
(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 (Please check appropriate [ ] IN EACH CATEGORY.)

Special Populations (Check all that apply.)

[ ] Doubled Up (temporarily living with others)
[ ] Homeless
[ ] Migrant Agricultural Worker
[ ] Other (hotel, motel, other day to day payment, etc.)
[ ] 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

Gender Identification

[ ] Male
[ ] Female
[ ] Transgender Male/Female-to-Male
[ ] Transgender Female/Male-to-Female
[ ] Other (Genderqueer or Non-Binary)
[ ] Choose not to disclose

Sexual Orientation

[ ] Lesbian/Gay
[ ] Straight
[ ] Bi-sexual
[ ] Something else (Queer, Asexual or Pansexual)
[ ] Don't know (unsure of sexual orientation)
[ ] Choose not to disclose

PLEASE COMPLETE BACK PAGE
SIGNATURE REQUIRED

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FHCGA-GenericNewPatientReg-02282018

SELF REPORTED INCOME

Number of people living in household: __________ Household Income: ______________________ [ ] Refused 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 #:______________________

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.

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:______________________

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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

Effective 3/1/12
ADHIREL-09222014
Patient Authorization to **RELEASE** information