GOSHEN

PATIENT REGISTRATION FORM / FARMULARIO DE REGISTRACION DEL PACIENTE

PAGE # A01 | DATE

PATIENT #	DOCUMENT #	LOCATION	VEHICLE INFO / INOFORMACION DEL VEHICULO
		NEW RIVER	

Patient First Name / Nombre del paciente	Patient Middle Name / Segundo nombre del paciente	Patient Last Name / Apellido de paciente

Patient Suffix / Sufijo de paciente	Patient Previous Name / Nombre anterior del paciente	Patient Date of Birth / Fecha de nacimiento del paciente

Social Security # / Seguro Social	Birth Sex / Sexo de nacimiento	Birth Order / Orden de nacimiento
- -		

Address Line 1 / Direccion Linea 1

Address Line 2 / Direccion Linea 2 | PO Box / Caja de correo

Zipcode / Codigo Postal	City / Ciudad	County / Condado	State / Estado

Home Phone / Teléfono de casa	Work Phone / Telefono de trabajo	Cell Phone / Telefono celular
( ) -	( ) -	

Foreign Address / Dirección en el extranjero | Foreign Phone # / Telefono extranjero #

Email Address / Correo electrónico | Student Status / Estatus de estudiante: ◯ Full Time / Tiempo completo ◯ Part Time / Tiempo parcial

Marital Status / Estado civil: ◯ Single / soltero ◯ Married / casado ◯ Separated / Separado ◯ Divorced / Divorciado ◯ Widower / Viudo

Spouse Name / Nombre del cónyuge	Spouse Date of Birth / Fecha de nacimiento del cónyuge	Spouse's Employer / Empleador del cónyuge
	- -	

Spouse Address / Dirección del cónyuge

Patient's Employer / Empleador del paciente | Employer Address / Dirección del empleador

Emergency Contact Person Name / Nombre de la persona de emergencia | Emergency contact Telephone #/ Telefono del contacto del emergencia #: ( ) -

DL # / Licencia de canducir # | Primary Care Provider / Medico de cabecera

RESPONSIBLE PARTY INFORMATION : (WHO PAYS THE BILLS?) / INFORMACIAN DE LA PERSONA RESPONSABLE (QUIEN PAGA LA CUENTA)

☐ Self / Yo | First Name / Primer Nombre | Last Name / Apellido

Telephone / Telefono	Work Phone / Telefono del trabajo	Relationship to Patient / Relación con el paciente
( ) -	( ) -	

Date of Birth / Fecha de nacimiento	Social Security # / Seguro social	Employer / Empleador
- -	- -	

Address / Direccion | PO Box / Caja de correo

Zipcode / Codigo Postal	City / Ciudad	County / Condado	State / Estado

GOSHEN MEDICAL CENTER

PATIENT REGISTRATION FORM / FARMULARIO DE REGISTRACION DEL PACIENTE

PAGE # A02 | DATE

PATIENT #	DOCUMENT #	LOCATION
		NEW RIVER

GUARDIAN / NEXT OF KIN INFO / INFORMACIÓN DEL TUTOR / PARIENTE PRÓXIMO

☐ Same as Responsible Party / Igual que la parte responsable

Relationship to Patient / Relación con el paciente

First Name / Primer Nombre	Middle Name / Segundo nombre	Last Name / Apellido

Date of Birth / Fecha de nacimiento	Telephone / Telefono	Work Phone / Telefono de trabajo
- -	( ) -	( ) -

Address / Direccion

Zipcode / Codigo Postal	City / Ciudad	County / Condado	State / Estado

DEMOGRAPHIC CHARACTERISTICS

Characteristics – Special Populations (Data used by Goshen Medical Center due to being a Federally Qualified Health Center which offers the Sliding Fee Discount based on family size and income.)

Ethnicity / Etnicidad

- ◯ Hispanic / Latino / Hispano / Latino
- ◯ Non-Hispanic / Latino / No Hispano / Latino
- ◯ Unreported/Refused to Report / Sin reportar / negar a informar

Race / Raza

- ◯ American Indian/Alaska Native / Indio Americano / Nativo de Alaska
- ◯ Asian / Asiatico
- ◯ Black/African American / Negro/Afro americano
- ◯ White / Blanco
- ◯ Pacific Islander / Isleno del pacifico
- ◯ Native Hawaiian / Nativo hawaiano
- ◯ More than 1 race / Mas de una raza
- ◯ Unreported/Refused to Report / No denunaar/se nego a informa

Language / idioma

- ◯ English / Ingles
- ◯ Spanish / Espanol
- Other / Otro .....

How long have you lived in the United States / Cuánto tiempo has vivido en los estados unidos	Are you a US Veteran? / Eres un veterano de EE. UU ?
---------- Years /Anos, ---------- Months / Meses	◯ Yes / Si ◯ No

Persons in Household / Personas en el hogar

1

Household Income Range / Rango de ingrsos del hogar

- ◯ <$13590
- ◯ $13591-$20385
- ◯ $20386-$27180
- ◯ >$27181

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? / En los últimos tres meses, ¿ usted o sus padres han trabajado en la agricultura, ya sea en el campo o en una industria basada o en una industria basada er la agricultu?

- ◯ Yes / Si
- ◯ No

If yes, which applies / Si es así, cual aplica

- ◯ Year Round Employment / Emoleo todo el ano (permanent residence in area)
- ◯ Migrant / Inmigrante (establishes temporary residence in area)
- ◯ Seasonal / Estacional (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor / Tipo de vivienda para el paciente o el padre / gaurdian leaal del paciente si es menor de edad

- ◯ Rent or own home / Alquila o propia
- ◯ No

If No, Housing Type / Si no, Tipo de vivienda

- ◯ Public Housing / Vivienda pública
- ◯ Homeless Shelter / Refugio para vagabundo
- ◯ Street / calle
- ◯ Transitional (live place to place) / Transicional (vivir de un lugar a otro)
- ◯ Doubled Up (live with another person or family unit) / Doble unidad familiar (vivir can otra persona o familia)
- Other / otro .....

Gender Identity / identidad de genero

- ◯ Male / Masculino
- ◯ Female / Femenina
- ◯ Transgender Male/Female-to-Male / Hombre Transgénero/ Feminino-a-masu
- ◯ Transgender Female/Male-to-Female / Mujer Transgénero / masculino-a-femenina
- ◯ Other / otro
- ◯ Choose Not to Disclose / Elegar no divulgar

Sexual Orientation / Identidad de genero

- ◯ Lesbian or Gay / Lesbianas o gay
- ◯ Straight (not Lesbian or Gay) / Derecno (no lesbiana o gay)
- ◯ Bisexual
- ◯ Something Else / Algo más
- ◯ Don't Know / No lo sé
- ◯ Choose Not to Disclose / Elegir no divulgar

Is this visit due to an Accident/Injury / Esta visita se deba a un accidente / heridaz	If yes, Date of Injury / Si es así, fecha del accidente o heridaz
◯ Yes / Si ◯ No	- -

MR #	PATIENT NAME:	PATIENT DOB	LOCATION
			New River

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 the 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

☐ Patient Declined DPR

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 do not wish to set an expiration date

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: _____

MR #	PATIENT NAME:	PATIENT DOB	LOCATION
			NEW RIVER

Patient Consent for Treatment
And
Consent for and Acknowledgment of Receipt of the Notice of Privacy Practices

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.