The Family Health Centers of Georgia, Inc.

PATIENT REGISTRATION FORM

(Please complete if your last visit was before 4/20/15)

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:_____

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 #:_____

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 #:_____

PLEASE COMPLETE BACK PAGE
SIGNATURE REQUIRED

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

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: _____

The Family Health Centers of Georgia, Inc.

AUTHORIZATION TO TREAT
IN ABSENCE OF PARENT/LEGAL GUARDIAN

I, _____, hereby authorize _____,
(parent/legal guardian) (specify authorized representative's name)

_____ to bring my child, _____,
(specify authorized representative's relationship to child) (specify child's name)

to The Family Health Centers of Georgia, Inc. or its affiliates to be receive medical care.

I further give permission for the above mentioned individual to access _____'s
(specify child's name)
confidential health information for care and treatment.

I further verify that I have received a copy of the Notice of Privacy Practices for Protected Health Information that explains my rights regarding protecting my child's confidential health information and that this notice will be valid for a period of one year from the date it was issued.

X Signature of Parent/Legal Guardian: _____

Date Signed: _____

Witnessed by: _____ Date: _____
(FHCGA authorized representative)

OR

Witnessed by: _____ Date: _____
(Notary Public)

my commission expiration date: ____/____/____

Please return completed form to the location indicated below.

For internal use only

Location name: _____

Fax #: _____

Email address: _____

Attn: _____

_____

Notary Seal

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