Goshen Medical Center Rosewood

104 Adair Drive
Goldsboro NC 27530
(919) 648-4435

WELCOME TO GOSHEN MEDICAL CENTER

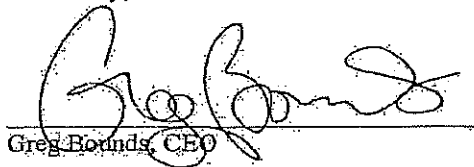
Attached is your scheduled appointment. When you come for your appointment, please make sure the enclosed packet is completed and everything is signed. If you are applying for Goshen Medical Center's Sliding Fee Discount Payment Scale please bring proof of income information (for example: current check stubs, food stamp letter, social security benefits, and/or any additional information as discussed in the attached Sliding Fee Payment Scale Patient Informational Handout). Also, please bring a picture ID.

If you have no insurance, or are eligible for the Sliding Fee Payment Scale based on income level and family size, the cost of your first visit's copay can be as low as $35.00. Your income information, along with the size of your household, will determine how much you will be charged. Flu vaccines are available and are separate from the office visit charge.

If you are uninsured and have not applied for health insurance we have a certified application counselor on site for your convenience. The counselor can aid with your determination of insurance eligibility and coverage options.

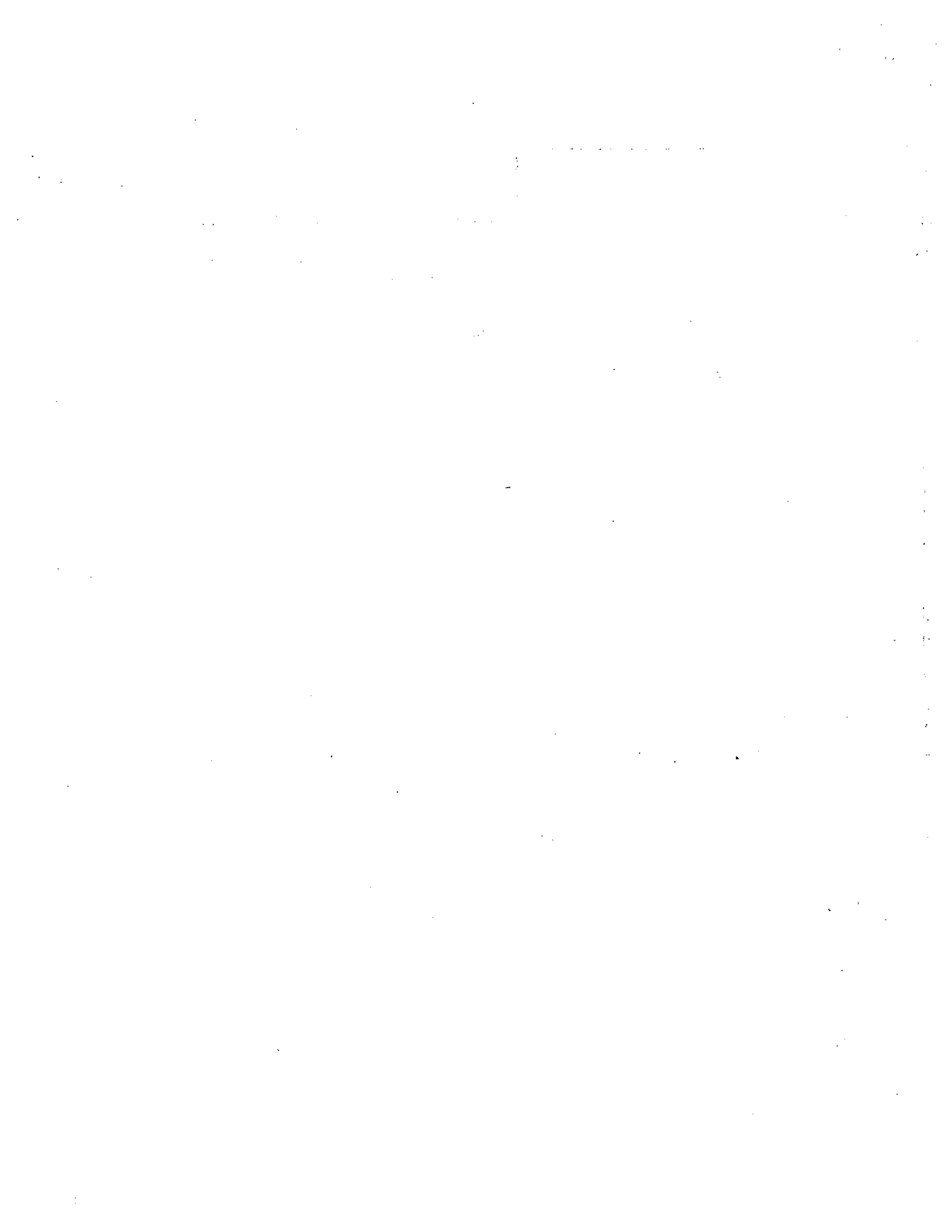
If you have any questions or need directions to the facility, please feel free to call us at (919) 648-4435.

Sincerely,



Greg Bounds, CEO

Goshen Medical Center, Inc.



Patient Registration Form Patient Number ______________________

Name: ______________________ ______ ______________________
FIRST MI LAST

Date of Birth: ______ / ______ / ______ **Sex at Birth:** ( ) Male ( ) Female
PLEASE CHECK ONE

Social Security Number: ______ - ______ - ______

Street Address: ______________________ **PO Box:** __________

City: ______________ **State:** ________ **Zip Code:** __________

Home Telephone: (_____) ______________ **Work Phone:** (_____) ______________

Cell Phone: (_____) ______________ **Email Address:** ______________________

Marital Status: ______________________ **Student Status:** ( ) Full Time ( ) Part Time
PLEASE CHECK ONE IF APPLICABLE

Ethnicity (CHECK ONE): ( ) Hispanic/Latino ( ) Non-Hispanic/Latino **Primary Language:** __________
Race (CHECK ONE): ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African American
( ) Native Hawaiian ( ) Pacific Islander ( ) White ( ) More than 1 race

Spouse's Name: ______________________ **Date of Birth:** ______ / ______ / ______

Patient's Employer: ______________________ **Spouse's Employer:** ______________________

Emergency Contact: ______________________ **Telephone:** (_____) ______________

Responsible Party Information: (Who Pays the Bills?) **Guarantor Name:** ______________________

Telephone: (_____) ______________ **Work Phone:** (_____) ______________

Relationship to Patient: ______________________ **Date of Birth:** ______ / ______ / ______

Street Address: ______________________ **PO Box:** __________

City: ______________ **State:** ________ **Zip Code:** __________

Social Security Number: ______ - ______ - ______ **Employer:** ______________________

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Name: ______________________ ______ ______________________
FIRST MI LAST

Relationship to Patient: ______________________ **Date of Birth:** ______ / ______ / ______

Telephone: (_____) ______________ **Work Phone:** (_____) ______________

Please Continue on Next Page

Patient Registration Form (Page 2) Patient Number ________________

Parent/Legal Guardian of Minor (2) *[If Applicable]*

Name: ______________________ ________ ______________________
FIRST MI LAST

Relationship to Patient: ______________________ **Date of Birth:** ______ / ______ / ______

Telephone: (______) ______________ **Work Phone:** (______) ______________

(*IMPORTANT NOTICE: The Parent/Legal Guardian Information Listed is Not Authorization and/or Designation of a Personal Representative***)**

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.)

How long have you lived in the United States? ______ years, ______ months

Are you a US Veteran? ( ) Yes ( ) No

Persons In Household (PLEASE CIRCLE) 1 2 3 4 5 6 7 8 9 10 Other ________

Household Income Range (PLEASE CIRCLE):

<$11,500 *$11,501-15,000* *$15,001-20,000* *$20,001-30,000* *$30,001-40,000*
$40,001-50,000 *$50,001-60,000* *$60,001-70,000* *$70,001-80,000* *$80,001-90,000* *>$90,000*

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? ( ) Yes ( ) No **If yes, which applies?** (PLEASE SEE BELOW)

( ) Year Round Employment (permanent residence in area)
( ) Migrant (establishes temporary residence in area)
( ) Seasonal (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor (CHECK ONE):

( ) Public Housing ( ) Homeless Shelter ( ) Doubled Up (live with another person or family unit)
( ) Rent or own Home ( ) Street ( ) Transitional (live place to place) ( ) Other ______________

Sexual Orientation (CHECK ONE):

( ) Lesbian or Gay
( ) Straight (not Lesbian or Gay)
( ) Bisexual
( ) Something Else
( ) Don't Know
( ) Choose Not to Disclose

Gender Identity (CHECK ONE):

( ) Male
( ) Female
( ) Transgender Male/Female-to-Male
( ) Transgender Female/Male-to-Female
( ) Other
( ) Choose Not to Disclose

Is this visit due to an Accident/Injury: Yes_____ No_____ If yes, Date of Injury: _____ / _____ / _____

I certify that the information given above is true and correct ______________________
(Patient Signature)

____
(Parent/Guardian signature if patient a minor)

____
(Print Name)

_____ / _____ / _____
(Date)

NOTE: Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.

APR2016REV

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

Patient Name: ______________________________ **Chart:** __________

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.

Consentimiento del paciente para el tratamiento
Y
Consentimiento de recibir el Aviso de Prácticas de Privacidad

Nombre del Paciente:____ **Chart:**____________________

Entiendo que como parte de mi cuidado de salud, Goshen Medical Center, Inc. se origina y mantiene papel y / o registros electrónicos que describen mi historial médico, síntomas, exámines y resultadoes de pruebas, diagnóstico, tratamiento y cualquier plan para futuro cuidado o tratamiento.

Entiendo y hen recibido un Aviso de prácticas de privacidad que proporciona una descripción más completa de los usos y divulgaciones de información. Entiendo que tengo los siguientes derechos y privilegios:

- El derecho de revisar el Aviso de Prácticas de Privacidad antes de firmar este consentimiento.
- El derecho de solicitar restricciones en cuanto a cómo mi información de salud puede ser utilizada o revelada pare llevar a cabo el tratamiento, pago u operaciones de atención médica.

Entiendo que Goshen Medical Center, Inc. no está obligado a aceptar las restricciones solicitadas. Entiendo que puedo revocar este consentimiento por escrito, excepto en la medida en que Goshen Medical Center, Inc. ha tomado ya medidas. Entiendo también que al negarse a firmar este consentimiento a la revocación de este consentimiento, Goshen Medical Center, Inc. puede rechazer el tratamiento. Ante la negativa de firmar este consentimiento, estoy de acuerdo en asumir el riesgo de cualquier lesión o daño causado por la falta de atención médica o tratamiento que surja de o en relatción con la negación Goshen Medical Center para proporcionar cualquier cuidado o tratamiento médico.

Además, entiendo que Goshen Medical Center, Inc. se reserva el derecho de cambiar su aviso y prácticas de acuerdo con las regulaciones federales. En caso de Goshen Medical Center, Inc. cambia su notificación, el Aviso modificado estará disponible.

Entiendo que como parte del tratamiento de Goshen Medical Center, pago u operaciones de atención de salud, puede ser necesario revelar mi información de salud protegida a otra entidad, y doy mi consentimiento a la divulgación de estos usos permitidos, incluyendo las revelaciones a través de fax.

☐ Entiendo completamente y **acepto** los términos de este consentimiento.

☐ Entiendo perfectamente y el **declive** de los términos de este consentimiento.

____ ____________________
Firma del Paciente / Guardián **Fecha**

Por la presente consiento voluntariamente a los exámenes médicos y / o dentales, tratamientos y procedimientos que se consideren necesarias, a juicio de mi médico, y proveedores de cuidado de la salud, incluyendo pruebas de VIH, exámenes de laboratorio y radiografías. Entiendo que mi información médica es confidencial y está protegida por los Estatutos Generales de Carolina del Norte 130A-143 y no garantiza ni garantías se han hecho para mi en relación con los resultados de los exámenes, tratamientos o procedimientos. Mi firma reconoce que se me ha dado la oportunidad de hacer preguntas acerca de este formulario de consentimiento.

____ ____________________
Firma del Paciente / Guardián **Fecha**

Los Centros de Salud con apoyo federal de asistencia (Hechos FSHCAA) de 1992 (Pub. L. 102-501) y 1995 (Pub. L. 104-73) se extienden Federal Tort Claims Act (FTCA) protecciones bajo 28 USC 1346 (b), 2401 (b), y 2679-81 para los centros de salud elegibles financiados por el Programa del Centro de Salud, el articulo 330 del Servicio de Salud Pública (PHS) (42 USC 254b), en su versión modificada. Goshen Medical Center, Inc. está protegido por la legislación.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for account collection.

For example: When a date of service balance reaches an over-due status, we may forward the account to a collection agency. Account information sent to a collection agency can include identifying information about you or the account guarantor, amount of balance and date of service, physician and location name, and type of service.

We will use your health information for regular health operations.

For example: Your health information may be used or disclosed in the course of operating our medical center, such as evaluating the quality of services provided, auditing purposes, federal or state agencies. This information will be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: Some services are provided to Goshen Medical Center through contracts with business associates, which may require the use or disclosure of your health information. Examples include services provided by a laboratory or radiology clinic. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by the administration of Goshen Medical Center and protocols have been established to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health Information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

***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**

NOTICE OF PRIVACY PRACTICES & FTCA COVERAGE

For

Goshen Medical Center, Inc.
444 SW Center Street
Faison, NC 28341

Corporate Office
412 SW Center Street Faison, NC

Satellite Sites Located in:
Beulaville, NC
Bolton, NC
Chadbourn, NC
Clinton, NC
Fayetteville, NC
Fremont, NC
Garland, NC
Goldsboro, NC
Jacksonville, NC
Kenansville, NC
Mount Olive, NC
New Bern, NC
Rose Hill, NC
Rosewood, NC
Tabor City, NC
Trenton, NC
Wallace, NC
Warsaw, NC
Whiteville, NC

April 2003
Revised Dates:
August 2003, March 2004,
December 2004, January 2006
January 2006, April 2008
July 2008, August 2014, November 2015
(Revisions Made to Include New Sites)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You should read this Notice before signing the Consent that authorizes the use and disclosure of health information for treatment, payment and health care operations.

Introduction

At Goshen Medical Center, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal health information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Goshen Medical Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. The information is considered your personal health information. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Goshen Medical Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and request a copy of your health record however a charge for copying may be imposed, depending upon the circumstances,
- Request, in writing, an amendment to your health record,
- Obtain an accounting of disclosures of your health information,
- Request communications of your health information by alternative means or at alternative locations, Request a restriction on certain uses and disclosures of your information and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Goshen Medical Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Sprunt Hall at 910-267-1942.

If you believe your privacy rights have been violated, you can file a complaint with the Goshen Medical Center's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Health information obtained during the course of treatment will be recorded in your medical record and used to determine the course of treatment. Your physician, nurse and other members of the healthcare team will document your health treatment, observations and actions taken in your medical record.

Patient #: | **Patient DOB:**

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 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

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:__________________________

REVOCATION

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Goshen Medical Center Inc. must receive the revocation in writing. The revocation must include:

- The patient's name and address
- The effective date of this authorization and the recipients of the protected health information according to this authorization
- The patient's desire to revoke this authorization and
- The date of the revocation and the patient's signature

Goshen Medical Center Inc. will accept written revocations of this authorization via:

- In person
- Certified U.S. mail or
- Facsimile at ______________________

ALL revocations must be sent to Goshen Medical Center Inc. to the attention of the Privacy Officer. The revocations are not effective until received by the Privacy Officer.

This authorization shall expire on the date noted, not to exceed one year.

FOR OFFICE USE ONLY

IDENTIFICATION OF RECIPIENT, IF IN PERSON:

Type of Identification:

( ) Valid State Driver's License or Identification Card
( ) Agency photo identification or other photo identification must be presented with agency letter.
( ) Government agency identification
( ) Other photo identification____

Identification Information:

Number:________________________________ Expiration Date:____________________

Identification Verification:

ID verified by:__________________________________ Date:__________________

Authorization added to the patient's medical record on______________________________________
(Date and Initial)

FollowMyHealth® Universal Health Record

GOSHEN MEDICAL CENTER, INC.

Create an Account from an **Invitation**

Your Email Address: ______________________________ ☐ Entered

The front desk staff will enter your email address into our system and we will send your invitation the next business day.

Portal Registration Instructions

Welcome to the all-in-one personal health record and patient portal that lets you access your medical information in a secure online environment **24 hours a day, 7 days a week** from any computer, tablet or smartphone!

Just follow these simple steps to request your connection today!

1

Check your Email. You will receive an email from noreply@followmyhealth.com. Click the registration link and follow the onscreen prompts.

2

Click Create an Account. If you already have a portal account and want to add an additional provider, click **Add This Connection.**

3

Choose a Login Method. Create a username and password for your portal account by clicking the FMH Secure Login icon. **OR** Use an existing username and password from Facebook, Gmail, Yahoo, Windows Live or CernerHealth by clicking the respective icon. **Skip to Get Connected on back if you select this option.**

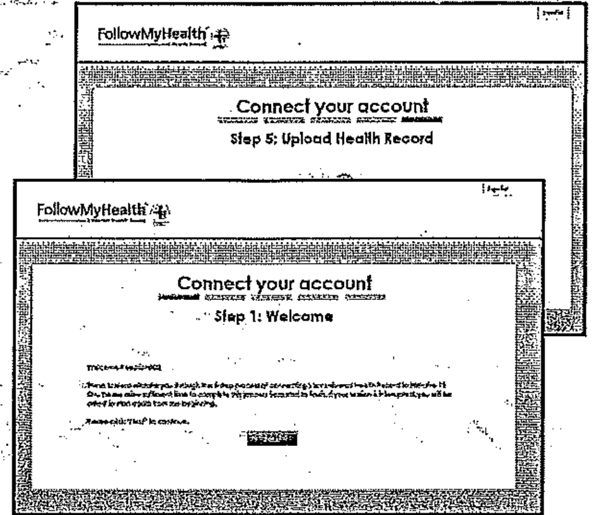
If You Are Creating a FMH Secure Login Account, Follow These Easy Steps:

Provide a unique username and password, along with your email and hit *Continue*.

Enter your FMH Secure Login username and password.

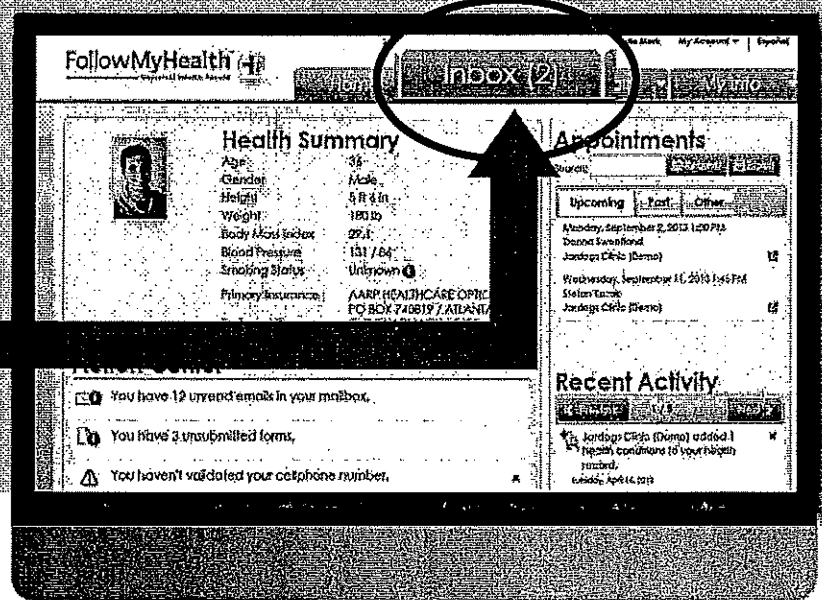
Print and **save** the email containing your username. You will need it if you lose your username or password.

Get Connected



Get Connected. Follow the on-screen prompts on the next four screens to complete your connection. These screens include accepting our **Terms of Service**, entering your **Invite Code** and accepting the **Release of Information.** Your health record will then begin to upload. Once populated, you'll be able to view your account.

Have Questions for Your Physician?



Avoid phone tag – communicate with your doctor by using the secure messaging feature within the portal. It's quick and easy – just like email!

Click on the **Inbox** tab and **Compose** to start a message.

Circle the method you used to log in, and write your username and password hint below.

Username ______________________ *Password Hint* ______________________

FollowMy**Health**® Universal Health Record

www.goshenmedical.org

Sliding Fee Discount Program Fact Sheet

Our Mission

"Our mission is to provide access to health care for all people in our service area."

Goshen Medical Center has the ability to reduce your cost of healthcare through our Sliding Fee Discount Program. This program is designed to offset a portion of your out-of-pocket expenses for selected medical and dental services. To see if you qualify for our Sliding Fee Discount Program, please bring in **one** of the follow documents:

- Copies of one month of employment check stubs
- Copy of payment from a third party
- Copy of Federal tax return (W-2 only is not acceptable)
- Dated letter from employer stating amount of cash payment (does not need to be notarized)
- Pay check stubs for one month (preferably with year to date income)
- Alimony and/or Child Support Agreement
- Office of Public Assistance Benefit
- Temporary Assistance for Needy Families documentation
- Letter on agency letterhead verifying financial status, i.e., Social Security, Housing Authority
- Student Grant Information/SARs (Student Aid Reports)
- If self-employed, tax forms from most current year
- Dated letter from head of household where patient resides stating financial responsibility

Frequently Asked Questions

What is the Sliding Fee Discount Program (SFDP)?

The Sliding Fee Discount Program is a Federal grant that allows our healthcare facility to reduce or "slide" the fees of medical services for patients that reside at or below 200% of Federal Poverty Guideline.

Who is eligible for the SFDP?

Patients who have no insurance or insurance that does not cover all healthcare expenses and who reside at or below 200% of the Federal Poverty Guideline.

How is eligibility determined?

1. The income of the patient or patient's family
2. How many people are in the patient's household

How does a patient apply?

Provide one of the documents below as proof of income. This income documentation will need to be reviewed and updated annually.

Who pays for the services that are discounted?

Our Federal grant pays for the remainder of the balance for patients that qualify for Sliding Fee Discount Program.

Does the patient have to be a citizen to apply for the program?

No.

What if the patient has no income at all?

They can still apply. We need a brief note from the person or facility covering the patient's cost of living.

If the patient has insurance with deductible, co-insurance and/or copayment, can they still apply for the program?

Yes. If the patient qualifies for the program, the grant will cover a portion or all of their out-of-pocket expense.

GOSHEN MEDICAL CENTER, INC.

Patient History Form

Patient's Name / Nombre del Paciente______________________________

Name of Pharmacy / Nombre de la farmacia ______________________________

Date of Birth /Fecha de nacimiento _____/_____/_____ Sex /Sexo ______ Race /Raza______________

Drug Allergies / Alergias a medicinas ______________________________

Surgeries / Cirugías ______________________________

Medical History / Historia Medical

(please ✓ all that apply)

(por favor marque ✓ todo lo que le aplique)

_ Asthma / Asma

_Anemia/Blood disorders / Anemia/Desorden de Sangre

_Cancer / Cancer ______________________

_Heart Disease / Enfermedad del Corazón

_Diabetes / Diabetis

_Emotional Problems / Problemas Emocionales

_Chronic Respiratory Illness/Enfermedades respiratorias crónicas

_Intestinal Disease / Enfermedad del intestino

Liver Disease / Enfermedad del Igado

_Chronic joint/muscular disease/enfermedad crónica muscular

_Elevated cholesterol/ Colesterol Elevado

_Pain/Painful disease / Dolor/Enfermedad Dolorosa

_Disorders of stomach/Desorden del Estomago/Esófago

_High Blood Pressure / Alta Presión de Sangre

_Sexually Transmitted Diseases ______________________

_ Enfermedades transmitidas sexualmente______________

_Tuberculosis(or previous (+) TB skin test)

(o prueba (+) anterior)

Family Medical History/Historia Medica Familiar

(please indicate any health problems of family members)

(por favor indique problemas de salud familiar)

Father / Padre ______________________

____

Mother / Madre ______________________

____

Siblings / Hermanos ______________________

____

Grandparents / Abuelos______________________

____

Children / Hijos ______________________

____

Others / Otros______________________

____

Females: / Mujeres:

Last menstrual period/Última menstruación ______________

Number of pregnancies/Número de embarazos______________

Number of live births/Número de niños vivos______________

Last mammogram/ Último mamograma______________

Date:last Pap Smear/Fecha: Último papaniculau______________

Date: last bone density test ______________

Fecha: última prueba de densidad de masa ósea ______________

Have you had a hysterectomy? /Le han hecho Histerectomía?

No _____ Yes / Si _____ (year/año)________

Health Care Maintenance

Date of last: Fecha del último:

Tetanus booster/Vacuna para Tétano______________

Flu shot /Vacuna para Gripa______________

Pneumonia shot/Vacuna para Pulmonía ______________

HepatitisB shots/Vacunas para Hepatitis B______________

TB Skin Test / Prueba del Tuberculosis______________

Colonoscopy/Colonoscopia ______________

➢Names/locations of other physicians managing your care:

➢Nombres/lugares de médicos manejando su cuidado:

____

____

____

____

Habits / Habitos

_____ Smoke/Fuma ________/day /dia

_____ Alcohol ____________/day / dia

_____ Drugs/Drogas ______________

____

_____ Caffeine/Cafeina _____/day / dia

➢Occupation / Ocupación______________________

➢Education Level /Nivel de Educación______________________

Patient Signature/Firma del Paciente

Date/Fecha