G.A. CARMICHAEL
FAMILY HEALTH CENTER

Put Your Family's Health In Our Hands

PATIENT DEMOGRAPHIC FORM

Today's Date: _______________

PATIENT INFORMATION:

Patient's Name: ____
(First Name) (MI) (Last Name)

Preferred Name______________________________**E-mail Address**____________________________

SS #: _________________________**DOB**:_________________

___

Sex at Birth ☐ Male ☐ Female

Mailing Address: ____
(Street Address) (City/State) (Zip Code)

Home Phone: (_____) ____________________ **Cell Phone:** (_____) __________________

Referring Physician: ___________________________ **Primary Care Physician**: ____________________________

PATIENT'S EMPLOYER INFORMATION

Employer's Name: ____

Employer's Address: ____
(Street Address) (City/State) (Zip Code)

Employer's Phone **(_______)** ___________________ FT PT Retired Unemployed FT student

PT student Disabled

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? ____

Relationship to Patient: ___________________________ Phone: (____) ______________________

INSURANCE COVERAGE: *(we will need to make a copy of your cards – please provide your cards)*

Is the Patient covered by insurance? Yes No

If No, please ask about our *Sliding Fee Program Discount*. If yes, please complete the following:

Primary Insurance Company: ______________________________Name of Insured: ______________________

DEMOGRAPHICS:

1) **Race:** American Indian or Alaska Native   Asian   Black or African American   White
   Native Hawaiian   Other Pacific Islander   More than One Race   Declined to Answer

2) **Ethnicity:** Hispanic or Latino   Not Hispanic   Unknown

3) **Preferred Language:** English   Spanish ☐ other: ____________________

4) **Preferred Notification Method:** Postal Mail   Phone   E-mail   Text

5) **Marital Status**: M   S   D   W

6) **Household Size:** 1 2 3 4 5 6 7 8 9 10 Other______

7) **Estimated Household Income** $ _______________

8) **Primary Language:** English   Spanish   Other____________

9) **Are you a Veteran of the U. S. Armed Forces?** Yes   No

10) **Housing Status: Current Resident of Public Housing**   Homeless   Doubling up   Shelter   Transitional   Unknown
   Not Homeless and Not current resident of public housing

Policy Number: _____________________________________ Group Number: _____________________________________
Secondary Insurance Company: ________________________Name of Insured: ___________________________________
Policy Number:_____________________________________ Group Number: _____________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH INSURANCE PROVIDER(S) PAYMENT

I, the patient, hereby authorize any holder of medical information about me to release to the State Medicaid fiscal agent, Medicare fiscal intermediary or other insurance carrier any information needed for this or a related claim. I request that payment of authorized health insurance benefits be made on my behalf to *G.A. Carmichael Family Health Center.*

_____________________________________ ______________________

Patient or Guardian Signature   Date

GUARANTOR INFORMATION

Is the patient a minor? (Under 18) **Yes / No** *(If Yes, please fill out the Guarantor information)*

Is Guarantor information same as above? **Yes / No** (If No, please fill out the Guarantor information)

Guarantor Name: ____
(First Name)   (MI)   (Last Name)

Address ____
(Street Address)   (City/State)   (Zip Code)

Social Security Number: _____________________________ Relationship to patient: ______________________________

Home Phone: (_____) ___________Work Phone: (_____) ______________Cell: (____) _______________

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:
I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.

These are the additional persons I give my permission to disclose information about my medical treatment:

Name: ____ Relationship: ____________________________

Phone #: (___) ________________ Entire Medical Record Exclude Specific:____________________

ALL PATIENTS, PLEASE READ

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I hereby acknowledge that I have been provided with an opportunity to review the privacy notice of health information practices of *G.A. Carmichael Family Health Center*. __________ **(initials)**

CONSENT FOR TREATMENT/DIAGNOSIS, RECEIPT OF PATIENT BILL OF RIGHTS, AND FINANCIAL POLICIES

I, the undersigned Patient or responsible person, having registered at *G. A. Carmichael Family Health Center* for the purpose of obtaining health services, does hereby voluntarily consent to such diagnostic and treatment services as might be provided by or at the direction of a physician, dentist or other qualified health care staff of the Health Center.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Health Center. I also recognized that I will be asked to sign a specific consent, as needed, for surgical and other special procedures, including general and/or extensive local anesthesia.

I am aware that health services are not based on exact science but are provided according to the judgment of the physician, dentist or other qualified health care staff of *G. A. Carmichael Family Health Center*. I further acknowledge that no guarantees have been made to me as to the results of any diagnostic or treatment services.

I hereby authorize *G. A. Carmichael Family Health Center* to retain, preserve and use for scientific or teaching purposes or dispose of, at their convenience, any specimen or tissue taken from my body during my treatment.

I have been given a copy of the Health Center's "Patient Bill of Rights." After reading this document, I have had a chance to ask questions. I believe I understand what the Patient Bill of Rights means. I understand what I might expect from *G. A. Carmichael Family Health Center* and what is expected of me and my family member(s) as registered patients.

I further understand that this is consent for Medical, Dental, Behavioral services.
I certify that this form has been fully explained to me and that I understand its contents.

Patient/Legal Guardian Signature: ____________________________________ Date: ____________

G.A Carmichael Staff: ____ Date: ____________

Patient Acknowledgement and Consent Form

We understand that medical costs can often be barriers to receiving much-needed comprehensive medical care. Medication adherence is crucial to ensuring our patients have the best care possible.

Effective ***January 1, 2022***, we are introducing additional patient benefits and enhanced pharmacy services. These services include:

- **iSaved Copay Program**: The iSaved program is designed to remove the barrier of copays and out-of-pocket costs for vital medications. Many branded medications can have copays that become barriers to quality care. (please see flyer attached for details)
- **Medication Auto-Fill**: All iSaved eligible medications will be automatically filled when the pharmacy receives the medication
- **Medication Auto-Refill**: All iSaved eligible medications will be automatically refilled at the refill date
- **Medication Delivery**: If a medication is not picked up by **14** number of days, we will deliver it to you.

Each of these services will be provided at no additional cost to you!

PATIENT CONSENT

Please sign this form below to consent to our enhanced service offer that we deem necessary in order to provide you with proper care.

I consent to:

1. Using GAC Community pharmacy as my primary pharmacy
2. Have all qualifying medications automatically filled and refilled monthly
3. Have any medication delivered that is not picked up by __14__ days after medication fill date
4. Have my medications delivered

____

Patient/Guardian Signature   Print Patient Name   Date

____

Print Patient and Guardian Name