TO ALL RAPHA PATIENTS,

Everyone at Rapha is here to help you heal both your body and your soul. All of our volunteers strive to be as helpful as possible to make your visit beneficial for you. Our spiritual advisors are here to pray with you, to counsel with you if needed and to help you with your walk in life, please feel free to ask them questions and for prayers.

Our physicians who freely give their time, experience, and education are primary healthcare providers. They are here to help with your ongoing health needs such as high blood pressure, high cholesterol, thyroid, acid reflux, and diabetic conditions, as well as other primary care needs.

We need your help to make your healing more positive.

- Please take all medications as directed and when directed.
- Please pick up mediations that are ordered through the Patient Assistance Program in a timely manner.
- Please keep logs and notes when requested by the physicians or nurses.
- If you are a diabetic patient, please check your blood sugar daily before meals. Please also attend the classes we provide regarding living with diabetes.

Unfortunately, the Rapha Clinic **CANNOT** provide:

- Ongoing management for pain related issues, such as but not limited to: back, shoulder, leg, hip, joint, fibromyalgia, etc.
- Mental health issues, such as but not limited to: anxiety, depression, bipolar disorder, or sleep disorders.
- Medications for seizures.
- Issues of the gastrointestinal tract and heart.
- Specialists at no cost.

Those health issues require more testing, medication, and experience than we can provide at this time. Specialized treatments will require you to make your own arrangements with providers for appointments and payment options. We will continue to provide for your primary health needs while you seek treatment from specialty providers.

Due to our limited hours, we also cannot see patients for care of cough, cold, congestion, sinus, or any condition that will need an appointment immediately.

I have read and understand the above.

Patient Signature: _____

Date: _____

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Patient ID: _____

Rapha Clinic of West Georgia

New Patient Information Form

First Name: _____ Middle Initial: ____ Last Name: _____ Suffix:_____

DOB: _____ SS#: _____ Sex: _____ Race: _____

Parent of Guardian's Name (If Minor): _____

Home Address: _____

County: _____ Mailing Address: _____

Phone Number: _____ Work Phone: _____ Email: _____

Living Arrangement: _____ Are you a veteran? _____ Yes _____ No

Marital Status: _____ # of Children: _____ # in Household: _____

How did you hear about us? _____

Emergency Contact

Name:_____ Relationship: _____ Phone:_____

Past Medical History

Last doctor/nurse seen elsewhere: _____ When: _____

May we contact them for your records? _____ Yes _____ No

Preferred Pharmacy: _____ Location: _____

Phone number: _____

Reason for Visit: _____

Allergies (please list all): _____

Past Medical History (circle all that apply):

AIDS	Diabetes—Type I	HIV	Scoliosis
Arthritis	Diabetes—Type 2	High Blood Pressure	Seasonal Allergies
Asthma & Lung	Gastrointestinal Disorder	Liver Disease/Hepatitis	Thyroid Disorder
Cancer	Glaucoma	Back or Spine Disorder	Other (please list):
Migraine	Head Injury, Seizures	Peptic Ulcer	
Colon Disorder	Heat Disease	Kidney Disease	
Depression	High Cholesterol	Vision (Retinal Disorder)	

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Past Surgical History (circle all that apply):

Appendix Removed	Gall Bladder	Knee Surgery	Vasectomy
Breast Surgery	Heart Surgery	Ovaries Removed	Other (please list):
Cataract	Hernia Repair	Thyroid Removed	
Ear Tubes	Hip Surgery	Tonsils Removed	
Fracture Repair	Hysterectomy (uterus)	Tubal Ligation	

Family History: Please list any medical problems. If deceased, please indicate age and reason.

Medical Problem	Relative	Living/Deceased	Age
Blood Clots			
Cancer (list type)			
Diabetes—Type I			
Diabetes—Type 2			
Stroke			
Heart Disease/Problems			
High Cholesterol			
High Blood Pressure			
Lung Problems			
Other (please list):			

Regular Medications: Include vitamins, over the counter medications, birth control, herbal medicines, etc. Please provide dosage/frequency. Example: Zantac, 75 mg, 2x daily (use back of sheet if needed)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Social Habits:

Did you smoke? _____ Yes _____ No Did you use tobacco? _____ Yes _____ No

Do you drink? _____ Yes _____ No Do you use street drugs? _____ Yes _____ No

Do you feel that you have a need or desire for spiritual services? _____ Yes _____ No

OFFICE USE ONLY:

_____ MEDICAL ONLY _____ DENTAL ONLY _____ MEDICAL & DENTAL ONLY

APPROVED BY: _____ DATE:_____

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Financial Information Sheet

Patient's Name: _____ SS#:_____

Do you have medical insurance? _____ Yes _____ No Are you currently homeless? _____ Yes _____ No

Name of everyone in household	Date of Birth	Employer/Source of Income	Food Stamp Amount	Income (Past 4 weeks)
			Total Income	**$**

Did you file federal income taxes last year? If yes, please provide a copy for our records. _____ Yes _____ No

Were you claimed as a dependent by someone else last year? If yes, provide a copy of the 1040. _____ Yes _____ No

Have you filed for Medicaid? If you have been denied, please provide a copy of the denial letter. _____ Yes _____ No

Do you need to be seen for? _____ Medical _____ Dental _____ Both

The above information is truthful and accurate to the best of my knowledge.

Signed: _____ Date: _____

Lab Costs

At you appointment, the doctor may order certain labs to be completed. We require that the cost of the labs be paid when they are performed. The costs will usually range between $14.75 and $22.00. We accept CASH ONLY. If you need to wait to pay for your labs, we will reschedule you for the lab work. If you have any concerns or questions, please see one of our nurses or staff. We are happy to help you in any way we can.

I have read and understand this policy.

_____ (Patient Signature)

For Staff Use Only:

Income documentation: pay stubs, W-2's, Social Security/SS Disability/Pension/Unemployment award letters, bank statements showing deposits. If there is no income documentation, note how housing and utilities are being paid. If being supported, a letter from the benefactor stating that. If taxes were not filed, please have the 4506-T form completed and signed.

% Poverty Level = _____

_____

_____

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NO SHOW POLICY AND PATIENT CONTRACT

YO**U <u>MUST</u> GIVE US AT LEAST 24 HOURS NOTICE if you need to reschedule or cancel an appointment.**

We realize that things happen that are out of your control. If, when we call our patients to confirm appointments, there is **any** uncertainty that you would be able to make your appointment, please choose to reschedule. The Rapha Clinic has many patients waiting for an appointment and an unused appointment denies someone else an opportunity to see a Healthcare Provider.

AFTER TWO "NO SHOWS" THE RAPHA CLINIC WILL BE UNABLE TO GIVE YOU AN APPOINTMENT FOR ONE YEAR.

I have read and understand the policy.

_____ (Patient Signature)

Release of Information and/or Records (HIPAA)

Patient Name: _____ Patient ID # _____

ACKNOWLEDGING RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I have received and reviewed a copy of the Rapha Clinic of West Georgia privacy policy. Initial Here _____

PERMISSION TO RELEASE INFORMATION AND/OR DISCUSS WITH OTHERS

I authorize Rapha Clinic of West Georgia to release information from my medical record(s) and/or discuss my care with the following individuals or parties as set forth below:

Name	Relationship	Phone

I understand that I may revoke this authorization at any time in writing and further understand that information disclosed to others pursuant to this release may no longer by protected by Federal Privacy Regulations. Initial here _____

Patient or Guardian's Signature: _____

Print Name: _____ Date:_____

Georgia Department of Public Health

Georgia Department of Public Health
Georgia Volunteer Health Care Program (GVHCP)
Patient Financial Eligibility Form

Georgia Volunteer Health Care Program — What You Deserve.

Clinic/Program/Provider: Rapha Clinic of West Georgia

SECTION I – PATIENT DEMOGRAPHIC INFORMATION

Patient Name:

_____

(Last Name) (First Name) (Middle Initial) (Nickname or Preferred Name)

Address:

_____

(Street) (City/State) (Zip Code) (County)

Telephone Number: _____ **Secondary Number:** _____

Date of Birth: _____ **Sex:** ☐Male ☐Female **Race/Ethnicity:** _____

SECTION II - INSURANCE INFORMATION/FINANCIAL ELIGIBILITY

Do you have insurance that covers? ☐Health ☐Vision ☐Dental ☐No Insurance

If you have insurance, what services/specialty does your insurance exclude? _____.

Do you currently have Georgia Medicaid? ☐Yes ☐No **Medicare Part B?** ☐Yes ☐No

I am: ☐**Uninsured (No Insurance)** ☐**Underinsured (Do not have coverage for services being sought)**

Your income must be at or below 200% of the Federal Poverty Level to be eligible to receive services under the GVHCP.

Please provide the number of dependents in your household (include self/spouse): _____.

Please provide gross family monthly income from all sources: $ _____.

SECTION III – LEGAL ACKNOWLEDGEMENTS

I understand that I am being referred to a volunteer health care provider who will provide care to me or to someone for whom I am legally responsible. My participation in this referral process is voluntary. The care I receive from the volunteer health care professional will be provided at no charge. I understand that the Volunteer is acting as an employee of the State of Georgia by treating me pursuant to the "Georgia Volunteer Health Care Program." I acknowledge that the exclusive remedy for any injury or damage suffered as a result of any act or omission of a health care provider acting within the scope of duties pursuant to that Program is a lawsuit under the State Tort Claims Act, O.C.G.A. § 50-21-20 *et seq*.

The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I understand that any failure to update this information to the Department upon change in my financial or health insurance status may disqualify me from receiving health or dental care under the GVHCP. I further understand that making false statements or representations on this form may be punishable under O.C.G.A. Section 16-10-20 by a fine of not more than $1,000 or by imprisonment for not less than one or more than five years, or both.

_____	_____	_____
Signature of Patient/Parent or Guardian	**Printed Name of Person Signing**	**Relationship to Minor** (If applicable)
_____	_____	_____
Signature of Eligibility Specialist	**Printed Name of Eligibility Specialist**	**Date**