MedLink GEORGIA

PATIENT INFORMATION

PATIENT INFORMATION – Please Print

Last Name ______________________________

First Name ______________________________

Preferred Name ______________________________

Middle ______________________ Suffix ________

Former Last name(s) ______________________

Gender Reported at Birth [ ] Male [ ] Female

Birth Date ______________________________

SS Number ______________________________

Address ______________________________

____

Zip Code ________ County of Residence __________

City __________________ State __________

Home Phone ______________________________

Cell Phone ______________________________

Work Phone______________________________

e-mail______________________________

I prefer to be contacted by: [ ] e-mail [ ] Text Message

[ ] Home Phone [ ] Work Phone [ ] Cell Phone

[ ] OK to leave message [ ] Do NOT leave a message

[ ] Don't call Home Number [ ] Don't call Work

[ ] Other ______________________________

Provider ______________________________

Pharmacy ______________________________

Imaging Center ______________________________

Language:

[ ] English [ ] Spanish

[ ] Other ______________________________

Race [ ] American Indian/Alaskan Native [ ] Asian

[ ] Black/African American [ ] Native Hawaiian

[ ] Other Pacific Islander [ ] White

[ ] Other ______________________________

Ethnicity [ ] Hispanic/Latino [ ] Not Hispanic

[ ] Other ______________________________

Marital Status [ ] Married [ ] Single

[ ] Widowed [ ] Divorced

[ ] Separated [ ] Other __________

Are you Homebound? [ ] Yes [ ] No

Migrant Worker Status [ ] Migrant [ ] Seasonal

[ ] Not a migrant or seasonal farmworker

Living Situation [ ] Doubling Up [ ] Shelter

[ ] Street [ ] Transitional

[ ] Not Homeless [ ] Other ________

Do you Live in Public Housing? [ ] Yes [ ] No

Are You a Veteran? [ ] Yes [ ] No

Guardian's Last Name ______________________________

First Name ______________ Middle __________ Suffix___

Next of Kin's Last Name ______________________________

First Name ______________ Middle __________ Suffix___

EMERGENCY CONTACT INFORMATION

Name ______________________________

Relationship ______________________________

Home Phone ______________________________

Cell Phone ______________________________

EMPLOYMENT INFORMATION

Employer's Name ______________________________

Employer's Phone ______________________________

Usual Occupation ______________________________

Usual Industry ______________________________

GUARANTOR INFORMATION (to whom statements are sent)

Relationship to Patient ______________________________

Last Name ______________________________

First Name ______________________________

Middle ______________________ Suffix ________

Birth Date ______________________________

Address ______________________________

Zip Code ____________

City ______________________ State __________

SS Number ______________________________

Work Phone Number______________________________

Cell Phone ______________________________

How did you find us? [ ] Already a patient [ ] Friend

[ ] Yellow Pages [ ] Radio

[ ] Newspaper Ad [ ] Hospital

[ ] TV [ ] Web Site

[ ] Other ______________

SEXUAL ORIENTATION AND GENDER IDENTITY

NOTE: This data is required for federal statistical reports and is not associated with individual patients

Sexual Orientation

[ ] Lesbian, gay, or homosexual

[ ] Straight or heterosexual

[ ] Bisexual [ ] Something else

[ ] Choose not to disclose

Gender Identity

[ ] Male [ ] Female

[ ] Transgender male/female-to-male

[ ] Transgender female/male-to-female

[ ] Choose not to disclose

[ ] Other

INSURANCE and PAYMENT INFORMATION

Insurance Status Private Insurance [ ] Medicare [ ]
Medicaid [ ] Uninsured [ ]

Do you want to apply for fee discounts based on your household income and size? [ ] Yes [ ] No

HOUSEHOLD SIZE AND COMBINED YEARLY INCOME
Please circle family size then look at income range. Find where your gross household income falls and circle the amount to the right.

Family Size	101% or Below	102%	103%	104%	Title X (NA)
1	$15,060.00	$18,825.00	$22,590.00	$30,120.00	$37,650.00
2	$20,440.00	$22,550.00	$30,660.00	$40,880.00	$51,100.00
3	$25,820.00	$32,275.00	$38,730.00	$51,640.00	$64,550.00
4	$31,200.00	$39,000.00	$46,800.00	$62,400.00	$78,000.00
5	$36,580.00	$45,725.00	$54,870.00	$73,160.00	$91,450.00
6	$41,960.00	$52,450.00	$62,940.00	$83,920.00	$104,900.00
7	$47,340.00	$59,175.00	$71,010.00	$94,680.00	$118,350.00
8	$52,720.00	$65,900.00	$79,080.00	$105,440.00	$131,800.00

Insurance Plan Name:

Policy Holder if other than the patient

Last Name ____________________
First Name ____________________
Middle ____________________
Address ____________________
City __________ State ______ Zip Code __________
Birth Date __________ Gender [ ] Male [ ] Female

Policy Information

Patient's Relationship to Policy Holder: __________
ID/Certification No.: __________
Policy/Group Number: __________
Employer Name __________

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: ____________________

Policy Holder if other than the patient

Last Name ____________________
First Name ____________________
Middle ____________________
Address ____________________
City __________ State ______ Zip Code __________
Birth Date __________ Gender [ ] Male [ ] Female

Policy Information

Patient's Relationship to Policy Holder: __________
ID/Certification No.: __________
Policy/Group Number: __________
Employer Name __________

ASSIGNMENT, RELEASE, and CONSENT

- I hereby authorize the MedLink Georgia, Inc., to furnish information to insurance carriers concerning my illness and treatment, and direct the insurer to pay, without equivocation, directly to the MedLink Georgia, Inc., all benefits due as a result of treatment.
- I acknowledge MedLink Georgia participates with health record sharing networks for care coordination, and I give my consent.
- I understand that I am financially responsible for all non-covered services, copays, deductibles, co-insurance and or any patient responsibility under the sliding fee discount program and payment is expected at time of service. I authorize and consent for MedLink Georgia to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- If you would like information on available resources that may assist in determining eligibility for third party coverage in inquire.
- I authorize the physician to release any medical information required to process claims.
- A copy of this authorization will be as valid as the original.
- I consent to routine medical care rendered to me or my dependents by the attending provider/physician(s).
- I consent to treatment by a Physician's Assistant or Advanced Practice Nurse acting under the supervision of a MedLink Georgia Physician.
- I acknowledge that I have the right to explanations about my care and treatment in a language and manner that assures I understand my treatment options.
- I understand that I have the right to refuse treatment after risks and benefits have been explained.
- I consent to voluntary Title X Family Planning services if I request them. I understand that all Title X services are voluntary and confidential. I understand that obtaining Title X services is NOT required and is NOT a requirement to obtain other services at MedLink Georgia, Inc. I understand that I cannot be turned away for Title X services for inability to pay.
- I understand that an HIV test is included as part of standard preventative screening tests, and that I may decline having the test performed at any time.
- I understand that some professional medical services such as laboratory and pathology services may be independent contractors and will bill me separately for their services.
- I acknowledge treatment may be rendered in an emergency without further consent.
- I understand that MedLink Georgia is not liable for any act or omission in the following of provider/physician(s) instructions.

I certify that all information given by me is true.

Signature ____________________ Date __________

[ ] Patient [ ] Parent [ ] Guardian