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	$15,960.00	$19,950.00	$23,940.00	$31,920.00	$39,900.00
2	$21,640.00	$27,050.00	$32,460.00	$43,280.00	$54,100.00
3	$27,320.00	$34,150.00	$40,980.00	$54,640.00	$68,300.00
4	$33,000.00	$41,250.00	$49,500.00	$66,000.00	$82,500.00
5	$38,680.00	$48,350.00	$58,020.00	$77,360.00	$96,700.00
6	$44,360.00	$55,450.00	$66,540.00	$88,720.00	$110,900.00
7	$50,040.00	$62,550.00	$75,060.00	$100,080.00	$125,100.00
8	$55,720.00	$69,650.00	$83,580.00	$111,440.00	$139,300.00

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 accept financial responsibility for all non-covered service, including copays, deductibles, and any charges under the sliding fee scale. Payment is expected at the time of service.
- I authorize MedLink Georgia to bill me for services not covered by my health plan.
- Assistance is available for determining eligibility for third-party coverage upon request.
- I authorize and release MedLink Georgia to share information with insurance carriers for claim processing and direct payment of benefits.
- I understand MedLink Georgia participates in health record-sharing networks for care coordination, and I consent.
- I consent to routine care for MedLink Georgia's physicians or supervised Physician Assistants and or Nurs Practitioners.
- I have the right to receive careful explanations in the language and manner I understand, and to refuse treatment after receiving information about risks and benefits.
- Providers may use AI ambient listening to enhance clinical documentation. This ensures precise medical details and allows providers to focus on your care. All information is securely managed and adhered to HIPPA regulations. Your signature signifies consent, which you may revoke at any time by informing your provider.
- I consent to voluntary and confidential Title X Family Planning services, which are not required to receive other care. I cannot be denied these services based on inability to pay.
- I understand HIV testing is included in standard preventative screening and may be declined.
- I acknowledge that some services such as labs and pathology may be billed separately by independent contractors.
- Emergency treatment may be provided without further consent.
- MedLink Georgia is not responsible for following provider instructions outside of its care.
- A copy of this authorization is valid as the original.

I certify that all information given by me is true.

Signature _____ Date _____

[ ] Patient [ ] Parent [ ] Guardian