GWINNETT ROCKDALE NEWTON
COUNTY HEALTH DEPARTMENTS

PATIENT REGISTRATION AND INCOME INFORMATION

Please print and fill out completely:

Last Name _____ First Name _____ Preferred Name _____ Middle Initial___
Maiden/Former Name _____ Date of Birth ___/___/_____ Age _____
Sex Assigned at Birth ☐ Female ☐ Male ☐Intersex Gender Identity: ☐ Female ☐ Male ☐ Other_____
Georgia Resident: ☐Yes ☐ No County _____
Street, House or Apt. #_____ City _____ Zip code _____
Mailing Address (if different) _____
Email address: _____ Day Phone _____ Mobile _____
I can be contacted by (check all that apply): ☐Mail ☐Email ☐Mobile (☐voice message and/or ☐text message)
Emergency Contact: If less than 18 years old, name of Parent/ Guardian and Phone #
Name _____Relationship _____ Phone # _____

Racial Group- You can select more than one.
☐African American/Black ☐Native American/ Native Alaskan
☐Asian ☐Native Hawaiian/ Pacific Islander
☐Caucasian/White ☐Other

Ethnic Group
☐Hispanic
☐Non-Hispanic

Marital Status
☐Married ☐Widowed
☐Divorced ☐Single
☐Separated

Do you have health insurance, Medicaid, or Medicare? No ☐ Yes ☐
Health Insurance/Medicaid/Medicare Provider: _____ **ID#** _____
Primary Policyholder Name: _____ **Primary Policyholder DOB:** _____
Were you referred by TANF? No ☐ Yes ☐ Do you participate in WIC? No ☐ Yes ☐

Service fees for Family Planning, Women's Health, and STD are set on a sliding scale based on gross income and family size. Patients over the age of 19 will be asked to prove income and residency, in order to qualify for a reduced price. Eligibility for BCCP is based on gross income and family size.
List all members in household who support you or who are supported by you, including yourself. List all income, including child support, alimony, unemployment, SSI, etc.

NAME	AGE	DOB	RELATIONSHIP	GENDER	INCOME BEFORE TAXES
SELF					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr

I certify that the above information is true and correct. _____ _____
Patient Signature Date
I did not provide proof of income and/or residency and agree to pay 100% of my costs. _____ _____
Patient Signature Date

INTAKE USE ONLY
Total # people in household_____ Total Household Income $ _____mo/yr FP/WH/STD % pay _____ BCCP eligible_____
_____ _____
Intake Signature Date

092019

GWINNETT ROCKDALE NEWTON COUNTY HEALTH DEPARTMENTS

Audrey Arona, MD – District Health Director

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:		
Patient Address:		
City:	**State:**	**Zip Code:**
Patient #:	**Date of Birth:**	
Identifier (SSN, License or Other):		

I hereby authorize this practice to make uses and disclosure of my Protected Health Information (PHI) (information about me in my medical records and/or financial records) as indicated below.

To obtain from:

The information may be disclosed to: **(Name/ Address of Person or Agency Requesting Information)**

Name:	**FAX #:**
Address:	**Phone #:**
City: State: Zip:	**Contact:**

Description of information to be disclosed:

For the purpose of: Continued Health Care.

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
- The practice will not condition treatment or payment based on my signing this authorization
- I am signing this authorization freely
- The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use and have received a copy of the authorization

All information I authorize to be released from this agency will be held strictly confidential. I understand that this authorization will remain in effect for:

☐Ninety (90) days, unless I specify an earlier expiration date here:

☐One (1) year from the date of signature.

☐The period necessary to complete all transactions on accounts related to services provided to me.

Patient Signature:	**Date:**
Signature of Patient's Representative:	**Date:**
Signature of Witness:	**Date:**
Title or Relationship to Patient:	**Expiration Date:**

Consent to and Treatment Plan for Latent Tuberculosis Infection

Form 3609.LTBI (revised 10/2016)

I, _____, have been advised and counseled by _____
(patient's name) (Public Health Representative/Title)

that based on available information, I may have/have latent tuberculosis infection (LTBI). The following has been explained to me:

- ❑ LTBI means I have been infected by the TB germ *M. tuberculosis.* My immune system has walled off the germs to keep them dormant (sleeping). I have no symptoms and can not spread the germ to others.
- ❑ I know that without treatment, I can get sick with active TB disease and have symptoms such as cough, fever, night sweats, weight loss or extreme tiredness. If any of these symptoms appear, I agree to call the health department at _____ immediately.
- ❑ I understand the link between TB and HIV and therefore, I agree to be tested for HIV.
- ❑ I agree to follow this treatment plan. I agree to come to the health department for medical evaluations and medication refills as prescribed. I agree to cooperate during my treatment. If I am unable to keep a scheduled appointment, I will call the health department at once and reschedule another appointment within 7 days.
- ❑ I agree to take my TB medication as ordered for the entire length of treatment. I will notify the health department if I am unable to take my medication for any reason.
- ❑ The side effects of the medication I am taking have been explained to me. I agree to call the health department at _____ immediately if I develop any of these side effects.
- ❑ I agree to tell the health department if I move or change my phone number. I agree to tell the health department how to reach me in person and by telephone.
- ❑ My treatment plan has been explained to me and all my questions have been answered. I have a copy of this plan.

Patient signature _____ Date _____

Public Health Representative Signature _____ Date _____
Public Health Representative Title _____

Witness/Interpreter Signature _____ Date _____

Affix Patient label or complete:

Patient Name _____
Patient Address _____
City, State, Zip _____
Patient Telephone _____
Patient ID# _____

GWINNETT ROCKDALE NEWTON
COUNTY HEALTH DEPARTMENTS

Preventive Health Clinic
455 Grayson Highway Suite 400
Lawrenceville, GA 30046
Phone: (678) 442-6880
Fax: (770) 237-5317
www.gnrhealth.com

Missed Appointment and Interruption in Treatment Agreement

x_____I understand that it is the policy of the Preventive Health Clinic that I will be charged **$15.00** for each appointment I miss without informing the clinic within at least twelve (12) hours before my scheduled appointment time. If it is after hours, I will leave a voicemail message.

Interruption in Treatment

x _____I understand that if two (2) months of treatment are missed, I will need to restart treatment for Latent TB Infection and assume all responsibility for associated fees.

_____ _____
SIGNATURE OF CLIENT DATE

_____ _____
SIGNATURE OF NURSE DATE