FINANCIAL SCREENING

PLEASE NOTE: OUR LOBBY IS CURRENTLY CLOSED (DUE TO COVID-19)

- Once you have all the needed paperwork, please call the office for a financial screening appointment.

You will need to bring the following:

- ☐ Picture ID
- ☐ Social Security Card
- ☐ Proof of Residency
- ☐ Proof of household income, including self, spouse, and children
- ☐ Proof of food stamps if you receive them
- ☐ Medicaid Denial Letter
- ☐ Last year's tax returns if you filed them
- ☐ List of all your medications and dosages

- **This certification process will be repeated every year to be seen by our providers.**

HOW TO GET A MEDICAID DENIAL LETTER:

- If you have computer access, you can apply for Georgia Medicaid online at http://gateway.ga.gov/access or you can apply in person at your local DFCS office.

Please call the office with any questions. If we are not available, please leave a voicemail message and someone will return your call as soon as they are available.

253 East Hwy 78 Temple Ga, 30179
Phone: 770.562.4501
Fax: 770.562.6390

TO ALL RAPHA PATIENTS:

Everyone at Rapha is here to help you heal both your body and your soul. All 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 providers who freely give their time, experience, and education are primary healthcare providers. They are here to help you 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 medications that are ordered through the Patient Assistance Program in a timely manner.
- Please keep logs and notes when requested by the providers or nurses.
- Please be on time for your appointment. This is especially important. If you are late, this may result in your appointment being rescheduled.

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.
- Specialists at no cost.

These 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.

I have read and understand the above:

Patient Signature: _____ Date: _____

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Rapha Clinic of West Georgia
A PLACE OF HEALING

New Patient Information Form Pt Id:_____ Date:_____

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: _____ Are you a veteran? _____ Yes _____ No

Living Arrangement: _____

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

How did you hear about us? _____

Emergency Contacts(s):

Name:_____ Relationship: _____ Phone:_____

Name:_____ Relationship: _____ Phone:_____

Last doctor/nurse seen elsewhere: _____ When: _____

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

Pharmacy:

Preferred Pharmacy: _____ Location: _____

Phone number: _____

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

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Rapha Clinic of West Georgia
A PLACE OF HEALING

PATIENT MEDICAL HISTORY

Patient Name: _____DOB:_____ Patient ID:_____

Reason for Visit: _____

Allergies (please list all): _____

Past Medical History (circle all that apply):

AIDS	Diabetes-Type 1	HIV Disease	Scoliosis
Arthritis	Diabetes-Type2	High Blood Pressure (Hypertension	Seasonal Allergies
Asthma & Lungs	Gastrointestinal Disorder	Liver Disease/Hepatitis	Stroke
Back or Spine Disorder (Lumbago	Glaucoma	Migraines	Thyroid Disorder
Cancer	Head Injury, Seizure	Peptic Ulcer	Other (Please list):
Colon Disorder	Heart Disease	Kidney Disease (Renal Disorder)	
Depression	High Cholesterol	Vision (Retinal Disorder)	

Past Surgical History (circle all that apply):

Appendix Removed	Gallbladder	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 Blots			
Cancer (list type)			
Diabetes-Type 1			
Diabetes-Type 2			
Stroke			
Heart Disease/Problems			
High Cholesterol			
High Blood Pressure (Hypertension)			
Lung Problems			
Other: (please list)			

Regular Medications: Include vitamins, over the counter medications, birth control, herbal medicines, etc. Daily & as Needed: Example: Zantac, 75mg 2x a day. Use back of sheet if necessary.

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

Social Habits: Please tell us about your social habits. Have you ever consumed any of the following?

				Year Started:	Year Started
Alcohol:	YES	NO	Drinks per week?		
Tobacco:	YES	NO	Packs per day?		
Street Drugs:	YES	NO	Type(s)?		

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NO SHOW POLICY AND PATIENT APPOINTMENT CONTRACT

YOU MUST GIVE US AT LEAST 24 HOURS NOTICE IF YOU NEED TO RESCHEDULE OR CANCEL YOUR APPOINTMENT.

- We realize that things happen that are out of your control. When we call to confirm your appointment, if there is any uncertainty that you will be unable 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.
- Please be on time for your appointment. This is especially important. If you are late, this may result in your appointment being rescheduled.

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

☐ I have read and understand the No Show Policy and Patient Appointment Contract.

Patient Signature: _____Date: _____

LAB POLICY (LAB COSTS)

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

☐ I have read and understand the Lab Policy.

Patient Signature: _____Date: _____

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Release of Information and/or Records (HIPAA)

Patient Name: _____Patient ID: _____

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: ___

- ☐ I have received and reviewed a copy of the Rapha Clinic of West Georgia privacy policy. Initial here: ___

Patient Signature: _____Date: _____

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Rapha Clinic of West Georgia
A PLACE OF HEALING

FINANCIAL INFORMATION SHEET

Patient Name: _____ Patient ID: _____

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:		

Did you file federal income taxes last year? ____Yes ____No If yes, please provide a copy for our records.

Were you claimed as a dependent by someone last year? ____Yes ____No If yes, provide a copy of the 1040.

Have you filed for Medicaid? ____Yes ____No If you have been denied, please provide a copy of the denial letter.

Do you need to be seen for ____Medical ____Dental ____ Both?

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

Patient Signature: _____ Date: _____

FOR STAFF USE ONLY

Income documentation: pay stubs, W-2's, Social Security/SS Disability/Pension/Unemployment award letters, food stamps, bank statements showing deposits. If there is no income documentation, note how housing and utilities are being paid. If being supported, please bring a letter from the benefactor stating that.

% Poverty Level = _____

_____

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

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 (including 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:** _____

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