Good Samaritan Health Clinic
401 Arnold St. NE, Cullman, AL 35055
Phone: 256-775-1389

Office Hours: Monday, Tuesday, Wednesday, Friday 800 a.m. - 4:00 p.m.; Thursday 8:00 a.m. - 12:00 p.m.

Documentation that applies to you in this checklist are required. NO exceptions will be made.

You must live in Cullman County, be at least 19 years old and do not have Medical Insurance including: Medicare, Medicaid, VA medical benefits or private/other health insurance coverage.

Identification

- Social Security Card with correct name
- Alabama driver’s License with correct name and address
- Call Medicaid for Denial Letter at (256) 584-4127 (ask to have it mailed to the Good Samaritan Clinic)

Proof of ALL Household Income

- Federal Income Tax Return for the previous year
  W-2’s will NOT be accepted

- 4506-T If you do not file taxes the clinic will provide this form

- Paystubs 30 days prior to enrollment date for employed applicants

- Food Stamp monthly allotment verification. This letter can be picked up at the Food Stamp Office.

- Proof of unemployment benefits must have the maximum benefits listed.

- Proof of Social Security/Disability Income. No bank statements will be accepted.

- Social Security/SSI Original Award letter. (only applies if the applicant is receiving benefits)

- Alimony, child support, pension, Veteran benefits etc.

- If you are being supported by someone outside of the household, the form “Other Income Declaration Form” must be completed and notarized. This form must include the approximate dollar amount of support being provided (the clinic provides a notary public).

Proof of Residency

- Mail with the applicants name and physical address.

All documents must be dated within the last 30 days.

Applications Hours:
Monday, Tuesday, Wednesday, & Friday 8am-11am and 1pm-3pm
Thursday 8am-11am

Anyone who provides false information, fails to disclose all of their income, or has insurance will be disqualified immediately for current and future services.

We reserve the right to refuse service to anyone.  

Rev 1-2019
Good Samaritan Health Clinic Eligibility Form

NAME: ________________________________ D.O.B. / / SSN: ___-___-______

Sex: ___Male ___Female Marital Status: ___Married ___Single ___Divorced ___Widowed

Ethnicity: ___African-American ___Asian ___Caucasian ___Hispanic ___Native-American ___Other

Address: __________________________________ City: ____________________________

County: ____________ State: ______ Zip: __________ Phone: (____)___________

Cell: (____)__________ Work: (____)__________ Other: (____)__________

Emergency Contact: __________________________ Phone: (____)__________

Number of people in your household: __________ Number of people in home who work: __________

Employer: ___________________________________ If Unemployed, how long: __________

Do you currently have any private or group medical insurance?  No ____ Yes ____

Are you eligible for health insurance through your job or someone else’s?  No _____ Yes _____

Are you a Veteran?  Yes ____ No ____ Have you applied for disability?  No ____ If Yes, when? __________

Do you have a lawyer representing you?  No ____ Yes ____ Who? __________________________

Have you ever applied for Medicaid?  No ____ If Yes, when? __________ Were you denied?  No ____ Yes ____

Have you ever applied for insurance under the Affordable Care Act (Obamacare)?  No ____ Yes ____

If Yes when? __________ Were you denied? ____ Yes If No, Please explain reason you are not insured

Are you currently being supported by someone else who is not in your household?

If Yes, who? __________________________. You will need to complete the

Other Income Declaration Form and it must be notarized. The clinic can provide a notary free of charge.

How did you hear about the clinic? __________________________________

DATE _____/_______/_______
SOURCE(S) OF INCOME

<table>
<thead>
<tr>
<th>Source</th>
<th>Monthly Amount</th>
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<tbody>
<tr>
<td>Unemployment</td>
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<tr>
<td>Alimony</td>
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<td>Child Support</td>
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<td>Food Stamps</td>
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<td>Disability</td>
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<td>Social Security</td>
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<td>Retirement</td>
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<td>Other</td>
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**Total Monthly Household Income** $ 

Proof of Income: _____ Tax Return _____ Pay Stub _____ Social Security _____ Unemployment Other ______

Please list the information for EVERYONE in your household.

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<th>Relationship</th>
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We reserve the right to verify any and all information you have provided.

Patient Signature

[Signature]
Good Samaritan Health Clinic / Patient History

Name ___________________________ Date ___________________________ 

DOB __________ Age ______ New Patient ______ YES ______ NO

Name(s) of previous healthcare provider(s):
__________________________________________________________________________________________

Are you allergic to any drugs? ______ I have no known drug allergies. Yes, I am allergic to: (circle)

Penicillin   Sulfa   Erythromycin   Ciprofloxin   Aspirin   Other: ____________________________________________

Reactions:
__________________________________________________________________________________________

Preferred Pharmacy?: __________________________ 

Current Medications (list all medications you are taking. Include over the counter, herbal, or natural remedies.)

<table>
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<tr>
<th>Medication</th>
<th>Dose (mg/pill)</th>
<th>How many times per day?</th>
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Health Concerns:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

If disabled, check here: ________ Nature of disability __________________________________________________

Signature ___________________________ Date ___________________________
Good Samaritan Health Clinic
Consent and Waiver Form

I have requested medical services and/or advice from medical professionals at Good Samaritan Health Clinic. In return for such services and/or advice, I agree to the following:

1. I am here of my own free will. No one forced me or required me to be here.

2. I understand that the Clinic is here to provide free medical care to those who qualify under its guidelines.

3. I believe that I qualify under the guidelines as they have been explained to me.

4. I understand, under Alabama law, I may not sue the medical professionals who provide free medical service at the clinic unless I am harmed by their “willful and wanton misconduct.”

5. I further agree that I may not sue the Good Samaritan Health Clinic or Good Samaritan Health Clinic of Cullman, Inc., except under circumstances allowed under Alabama law.

6. I agree that same restrictions on my ability to sue under Alabama law described above also apply to any medical professionals who may provide free medical services or advice to me upon referral from Good Samaritan Health Clinic.

7. I agree that I have been given this information before seeing a medical professional, and that I have been given an opportunity to ask questions I may have before signing this form.

8. I agree to give a blood or urine sample, if asked, to test for drug use.

Patient Signature

Date
Good Samaritan Health Clinic
Outside Health Care Agencies Agreement

I understand that I am responsible for any bills, fees, or costs at any health care agency outside of Good Samaritan Health Clinic, even though these procedures and/or tests have been recommended to me by the health care professionals at Good Samaritan Health Clinic.

Patient Signature ___________________________ Date ______________

Clinic Representative _________________________ Date ______________

Power of Attorney for Medication Assistance Forms

To receive medications through the Good Samaritan Health Clinic Medication Assistance Program, it will be necessary to obtain your signature on application forms. For the sake of convenience, you may authorize an agent of the Medical Assistance Program to sign the applications for you.

I, ___________________________________________ (please print your full name), give my permission for an agent of the Good Samaritan Health Clinic Medical Assistance Program to sign the applications forms in order for me to obtain my medications through any available patient assistance program.

Patient Signature ___________________________ Date ______________

Clinic Representative _________________________ Date ______________
Good Samaritan Health Clinic
Jeremy V. Stidham MD ♦ Patricia Calvert, CRNP
401 Arnold Street, N.E., Suite A
Cullman, AL 35055-1968
(256) 775-1389 ♦ Fax: (256) 775-1396

AUTHORIZATION OF USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

To:

I hereby authorize the release/request of specified medical records pertaining to the medical and/or psychiatric treatment of the following patient to Good Samaritan Health Clinic.

PATIENTNAME:(PRINT)

DOB: _____/_____/_____
SSN: _____-____-_____

SPECIFIED RECORDS:

Expiration Date of Authorization
This authorization is effective for one (1) year unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the Good Samaritan Health Clinic, Clinic Administrator.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the Good Samaritan Health Clinic. The privacy of this information may not be protected under the federal privacy regulations.

Patient (or Representative) Signature Date  Clinic Representative Date
Dental Policy and Procedure:
Dental Evaluations:

- If you need a dental appointment, you must call our office at (256) 775-1389.
- A Dental appointment will be arranged by Good Samaritan Health Clinic at one of our local participating dentist’s office.
- Please be courteous and patient. All of our dentists are volunteering their services.
- Do not call the dental office to request an appointment or walk into their office demanding to be seen; you must go through The Good Samaritan Health Clinic.
- If you cannot keep your appointment, it is your responsibility to call our office in advance to cancel this appointment. Failure to do so will forfeit your appointment being rescheduled.
- The dentist performing dental exams or dental procedures will only extract teeth at no charge in their office. No other services will be performed at no charge.
- Please do not ask for services at no charge, other than the extraction/s the dentist determines to be done.

You will be scheduled for your dental appointment and notified by the staff at The Good Samaritan Health Clinic. You will only have 1 to 3 teeth in the same quadrant every 6 months removed.

By signing this notice, you fully understand the policy and procedures for the Dental appointments that Good Samaritan Health Clinic is providing.

Patient Signature __________________________ Date ____________

GS HC Staff __________________________ Date ____________
Good Samaritan Health Clinic
401 Arnold Street N.E., Suite A
Cullman, Alabama 35055
Phone: (256) 775-1389 • Fax: (256) 775-1396

Permission to discuss health information
with family members and/or friends

Good Samaritan Health Clinic is dedicated to protecting the privacy of each patient. It is your right to receive quality care without the concern that your personal health information will be shared or disclosed with others without your permission, authorization or as otherwise permitted by law. Your medical information is protected by law and will only be used or disclosed in accordance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA).

HIPAA allows us to discuss your medical information with family members, friends, or other persons you designate who are involved in your care or payment for care. Please list your family members, significant other, or close friend(s) with whom we may discuss your medical information including your financial information.

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Patient Signature ___________________________ Date __________

Clinic Representative ________________________ Date __________
Other Income Declaration Form
Date:__/__/____  Clinic Patient Number:_______

Applicant Name:__________________________________________
First  Ml  Last

Address: ________________________________________________
Street/Apt Number  City  Zip

Telephone: (___)____-_______

Provider of Other Income/Services to Above Applicant

Provider Name:__________________________________________
First  Ml  Last

Address: ________________________________________________
Street/Apt Number  City  Zip

Telephone: (___)____-_______

I provide the following support to the above applicant:

Housing: □ No  □ Yes  If yes, provide the monthly amount: $___________
Utilities: □ No  □ Yes  If yes, provide the monthly amount: $___________
Food: □ No  □ Yes  If yes, provide the monthly amount: $___________
Transportation: □ No  □ Yes  If yes, provide the monthly amount: $___________
Other Services: □ No  □ Yes  If yes, provide the monthly amount: $___________

Please provide a description of other services:______________________________

Total Monthly Amount: $________________

Provider Signature:______________________________  Date:

Patient Signature:______________________________  Date:

***This form must be notarized. If you need a notary public, the Clinic will provide one free of charge.

Notary Public Information: