GLENDALE AREA
MEDICAL ASSOCIATION

Glendale Dental Center
850 Main St, P.O. Box 375
Coalport, PA 16627
Phone: 814-672-5480

Glendale Area Medical Association, Inc. (GAMA) is a Federally Qualified Health Center (FQHC) established in 1979 in Coalport, PA. GAMA specializes in family medicine. We also have a dental center (Glendale Dental Center) that was established in 1986. We are dedicated to providing quality health and dental care to our patients regardless of the ability to pay. Our facility offers on-site laboratory, basic x-rays and woman's healthcare along with many other services. Our dental facility offers general dentistry which includes radiographs, oral exams, cleanings, restorative care, dentures, partials, oral surgery, root canals, crowns and many other services. Please complete the attached documents. Thank you.

Our Dental Providers

Anthony M. Kibelbek, D.M.D.
Deborah Jo Savino, R.D.H.

Our Medical Providers

Jay A. Robinson, MD
Sohail Shariff, MD
Staci Kephart, PA-C
Lindsey Link, PA-C

Our administration, providers and staff look forward to assisting you with your healthcare needs.

Welcome to GAMA!

Welcome to the Glendale Dental Center

Helpful Tips For Your Dental Visit:

1. Bring your dental insurance card, if you don't have a card please have the following information: Name of Insurance, address to send the claim, your ID number, and your group #, phone # of the insurance company.

2. Medication list of all prescribed and over-the-counter medications including any herbal supplements that you take.

3. If under of the age of 18 years, PA law requires you to be accompanied by a parent or legal guardian.

4. Be prepared to pay your co-pay, self-pay, or any outstanding balance. If you are a sliding fee patient, you must pay the day of the visit to receive your discount. We accept cash, checks, Visa/Mastercard & Care Credit.

5. Patients that arrive late will be asked to reschedule.

6. If you've had recent x-rays of your teeth, you may want to contact your prior dentist and request that they send your dental x-rays to us.

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Broken/Cancelled Appointment Policy

We have a busy practice, with appointment schedules often filled months in advance. The time we set aside for your appointment is important to you and to our staff. In addition to providing appointment cards with your appointment date and time, we also attempt to remind you by telephone or by postcard of an upcoming appointment.

If you cannot keep your appointment, we ask you provide us with at least 24 hour advanced notice for a single patient appointment and at least a 48 hour notice for a same day multiple family appointment. Broken appointments are appointments that a patient fails to keep or cancel in less than 24/48 hours in advance. Unless there are unusual circumstances, patients with two broken appointments within one year will lose scheduling privileges.

Patients who have lost their scheduling privileges may still be seen for emergency care or open access appointments.

Emergency appointments are available. Our office personnel are instructed not to provide promises to patients above any specific treatment during an emergency appointment. Without knowing the nature of the emergency, the type of treatment and time required, as well as the amount of time available in the schedule to provide treatment, it is unreasonable to make such promises.

Open Access Policy

Patients who have a recent exam and treatment plan may call for same day appointment for treatment if there is time available in our schedule. The amount of time available is unpredictable and varies from day to day. This means patients limited to open access scheduling may have to make multiple calls to obtain appointments. Patients who demonstrate reliability keeping open access appointments may be readmitted to making appointments in the regular schedule on an individual basis as determined by the Dental Director.

_____ (Patient Signature)

_____ (Date)

Patient Profile

Glendale Area Medical Center
850 Main Street PO Box 375
Coalport, PA 16627

[ ] HIPAA
[ ] Rx
[ ] Photo ID
[ ] Insurance Card

OFFICE USE ONLY - Doctor: _____ Patient ID# _____ Chart # _____

PATIENT INFORMATION

Name: _____

Preferred Name: _____ □ NA

Address: _____

_____

City, ST, Zip: _____

Primary Phone: _____[ ] Home [ ] Work [ ] Other

Additional Phone:_____[ ] Home [ ] Work [ ] Other

Primary Language: _____

Veteran: [ ] Yes [ ] No

Date of Birth: _____

Social Security #: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other

Living Situation: [ ] Own/Rent/Lease [ ] Temporary Family/ Friends [ ] Transitional (recovery/sober living) [ ] Temporary Shelter [ ] Released from institution with no stable living [ ] Foster care [ ] Doubling up [ ] Other

Today's Date: _____

Preferred Pronoun: □ He/Him □ She/Her □ They/Them

Gender at Birth: [ ] Male [ ] Female

Gender Identity: [ ] Male [ ] Female [ ] Transgender Male [ ] Transgender Female [ ] Refuse to disclose [ ] Non-binary [ ] Other (specify)_____

Sexual Orientation: [ ] Straight [ ] Gay/Lesbian [ ] Bisexual [ ] Something Else _____ [ ] Don't know [ ] Refuse to disclose

Race: (Circle One) White / Black-African American / Asian American Indian-Alaska Native / Native Hawaiian More than one race / Other Pacific Islander

Hispanic Origin: (Circle One) Hispanic/Latino Not Hispanic/Latino

Tobacco Use: [ ] Yes [ ] No

PATIENT EMPLOYMENT:

[ ] Employed [ ] Unemployed [ ] Student[ ] Retired [ ] Other

Employer: _____ **Occupation:**_____

PATIENT'S INSURANCE INFO: PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

***PRIMARY INSURANCE*: [ ] Same as Patient [ ] Same as Guarantor [ ] Other _____**

Insurance Company: _____ Insured ID: _____

Insured Party: _____ Policy Group #: _____

Relationship to the patient: _____ Group Name: _____

Insured Sex: [ ] Male [ ] Female Insured SS #: _____

Effective Date of Insurance: _____ Insured Date of Birth: _____

***SECONDARY INSURANCE*: [ ] Same as Patient [ ] Same as Guarantor [ ] Other _____**

Insurance Company: _____ Insured ID: _____

Insured Party: _____ Policy Group #: _____

Relationship to the patient: _____ Group Name: _____

Insured Sex: [ ] Male [ ] Female Insured SS #: _____

Effective Date of Insurance: _____ Insured Date of Birth: _____

***GUARANTOR*: *MUST be completed for patients less than 18 years of age.**

[ ] Same as Patient *(See Above)* [ ] Same as Guarantor *(See Above)* [ ] Other *(List Below)*

Name: _____ Guarantor's Date of Birth: _____

Address: _____ Guarantor's SS #: _____

_____ Relationship to the Patient: _____

City, ST, Zip: _____

HOUSEHOLD INFORMATION: (Must be completed for reporting purposes)

Family Members (Name/Relationship to Patient): # in Household: _____ Head of Household: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

For statistical reporting purposes, please circle your annual household income:

$0-$15,000 $15,001-$30,000 $30,001-$45,000 $45,001-$60,000 $60,001-$75,000 $75,001 &up Refuse to provide

OFFICE USE ONLY - Sliding Fee Form [ ] Sliding Fee Discount % _____ Effective Date: _____

Dental And Medical History

Patient Name: _____ Date: _____

Primary reason for this dental appointment: □ Examination □ Emergency □ Consultation

Dental History

Do you have a specific dental problem? Describe_____ Yes No
Do you have dental examinations on a routine basis? Last visit_____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Ph:_____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? (See attached sheet to complete)_____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber □ Milk □ Other _____ Yes No
Women (Please check): □ Pregnant/trying to get pregnant □ Nursing □ Taking oral contraceptives Discuss_____Yes No

Do you now have or have you ever had any of the following? Do you take any of these medications? Please check appropriate boxes. *If yes to any of the starred conditions, please call prior to your appointment, premedication or changes in medication may be required.

Heart Disease/Surgery*	Y □ N □	Excessive Bleeding	Y □ N □	Chemotherapy	Y □ N □	Night Sweats	Y □ N □	Cold Sores	Y □ N □
Heart Murmur or Defect*	Y □ N □	Sickle Cell Disease	Y □ N □	Osteoporosis	Y □ N □	Yellow Jaundice	Y □ N □	Fever Blisters	Y □ N □
Irregular Heartbeat	Y □ N □	Hemophilia	Y □ N □	Bisphospho-nates	Y □ N □	Kidney Problems	Y □ N □	Herpes	Y □ N □
Angina/Chest Pain	Y □ N □	Methemoglob-inemia	Y □ N □	Osteonecrosis of Jaw	Y □ N □	Renal Dialysis	Y □ N □	Stroke	Y □ N □
Heart Attack/Failure	Y □ N □	Leukemia	Y □ N □	Aredia I.V. Reclast I.V.	Y □ N □	Thyroid Disease	Y □ N □	Convulsions	Y □ N □
Congenital Heart Disorder*	Y □ N □	Recent blood transfusion	Y □ N □	Zometa I.V.	Y □ N □	Parathyroid Disease	Y □ N □	Epilepsy/ Seizures	Y □ N □
Mitral Valve Prolapse*	Y □ N □	Swelling of limbs	Y □ N □	Fosamax, Actonel, Boniva	Y □ N □	Arthritis or Gout	Y □ N □	Fainting or Dizziness	Y □ N □
Scarlet Fever	Y □ N □	Lung Disease	Y □ N □	Stomach or Intestinal Disease	Y □ N □	Rheumatism	Y □ N □	Glaucoma	Y □ N □
Rheumatic Fever*	Y □ N □	Breathing Problem	Y □ N □	Ulcers	Y □ N □	Pain in Jaw Joints*	Y □ N □	Tumors or Growths	Y □ N □
Artificial Heart Valve*	Y □ N □	Shortness of Breath	Y □ N □	Recent Weight Loss	Y □ N □	Cortisone Medicine	Y □ N □	Nervousness	Y □ N □
Heart Pacemaker*	Y □ N □	Frequent Cough	Y □ N □	Frequent Diarrhea	Y □ N □	Artificial Joint*	Y □ N □	Psychiatric Care	Y □ N □
Pulmonary Shunt*	Y □ N □	Hay Fever	Y □ N □	Diabetes	Y □ N □	Sexually Trans. Disease	Y □ N □	Alzheimers Disease	Y □ N □
High Blood Pressure	Y □ N □	Sinus Trouble	Y □ N □	Excessive Thirst	Y □ N □	AIDS	Y □ N □	Allergies (Medicine)	Y □ N □
Low Blood Pressure	Y □ N □	Asthma	Y □ N □	Hypoglycemia	Y □ N □	HIV Positive	Y □ N □	Allergies (Pollen/Dust)	Y □ N □

Bacterial Endocarditis*	Y □ N □	Bloody Sputum	Y □ N □	Liver Disease	Y □ N □	Genital Herpes	Y □ N □	Hives or Rash	Y □ N □
Unexplained Fever	Y □ N □	Emphysema	Y □ N □	Hepatitis A (Infectious)	Y □ N □	Drug Addiction/ Alcholism	Y □ N □	Need Premedication?	Y □ N □
Bruise Easily/ Blood Disease	Y □ N □	Tuberculosis	Y □ N □	Hepatitis B or C	Y □ N □	Tattoos/Body Piercing	Y □ N □	Ever taken fen-phen?*	Y □ N □
Anemia	Y □ N □	Cancer	Y □ N □	Protease Inhibitor	Y □ N □	Sleep Apnea	Y □ N □	Cochlear Implants	Y □ N □
Coronary Stent*	Y □ N □	Radiation (Xray) Therapy	Y □ N □			Smoking	Y □ N □		

Have you ever had any other serious illness not checked above? Discuss_____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Patient Signature (Parent/Guardian) _____ Date_____

Reviewed by Doctor _____ Date_____ BP _____ Pulse_____

History Review and Significant Findings:

_____

_____

_____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	None	Patient Signature	BP	Pulse	Reviewed by Dr.
_____	_____	□	_____	_____	_____	_____
_____	_____	□	_____	_____	_____	_____
_____	_____	□	_____	_____	_____	_____
_____	_____	□	_____	_____	_____	_____
_____	_____	□	_____	_____	_____	_____
_____	_____	□	_____	_____	_____	_____

Glendale Area Medical Center-Patient Current Medication List

Patient Name: _____ DOB: _____

Allergies: _____

Pharmacy: _____

Medication Name	Dose	Directions
Have you ever or are you currently receiving any treatment using Methadone or Suboxone? Yes / No Where are/were you receiving treatment?		

I understand that if more medical information, other than that disclosed is discussed, GAMA has the right to terminate my medical care.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

GLENDALE AREA MEDICAL ASSOCIATION, INC.
850 Main Street
PO Box 375
Coalport, PA 16627
814-672-5141

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR MEDICAL INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the practices of **GLENDALE AREA MEDICAL ASSOCIATION, INC.** in connection with the use and disclosure of your medical information and your rights and certain obligations we have regarding the use and disclosure your medical information. It applies to the physicians and other health care professionals within our center who are involved in your care and/or are authorized to enter information into your medical records, and all of our employees, staff, and other personnel working in our offices. We are required by law to maintain the privacy of your medical information and to provide you with this Notice describing our privacy practices. We are required to abide by the terms of this Notice, as it is modified from time to time.

WE MAY MAKE CHANGES TO THIS NOTICE IN THE FUTURE, AND ANY OF THE TERMS OF THIS NOTICE THAT ARE CHANGED WILL APPLY TO ALL OF YOUR MEDICAL INFORMATION. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A COPY OF THE REVISED NOTICE BY REQUESTING IT IN PERSON AT OUR SITE OR BY SENDING A WRITTEN REQUEST FOR A COPY TO OUR PRIVACY OFFICER AT THE ABOVE ADDRESS.

HOW WE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION

We are permitted or required to use your medical information for various purposes. We cannot describe every possible use or disclosure of your medical information in this Notice. However, uses or disclosures that we are permitted or required to make will generally fall within one of the following categories:

For Treatment. We may use and disclose medical information about you in order to ensure that you receive proper medical treatment. For example, we may disclose your health information to another health care provider involved in your care.

For Payment. We may use and disclose medical information about you so that we obtain payment for the treatment and services we provide to you from you, an insurance company or another third party. For example, we may need to give your health insurance plan information about your diagnosis and a description of the care that we provided to you in order to receive payment for your care.

For Health Care Operations. We may use and disclose medical information about you for our healthcare operations. Healthcare operations are activities that are necessary to run our offices, maintain licensure, and to make sure that our patients receive quality care. For example, we may use your medical information to review our treatment of you and the services we provided and to evaluate the performance of our staff in caring for you.

Appointment Reminders. We may contact you or your personal representative with a reminder that you have an appointment with us.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may tell you about health-related benefits or services that we provide that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may discuss your medical care with family members or close personal friends who are involved in your medical care or payment for that care. You have the right to restrict or refuse any of these uses or disclosures.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threatened harm.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness as required or permitted by law if you are injured at work.

Health Oversight Activities. We may disclose your medical information to a health oversight agency such as licensing boards for activities authorized by law.

Lawsuits and Disputes. We may disclose medical information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. Under certain circumstances, we may release information about you if asked to do so by a law enforcement official

Coroners, Medical Examiners and Funeral Directors. Under certain circumstances, we may release medical information to a coroner, medical examiner or funeral director.

Government Purposes. We may release your medical information under limited circumstances if you are a member of the armed forces or foreign military personnel, or for intelligence, counterintelligence and other national security activities authorized by law.

Incidental Uses and Disclosures. We may use or disclose your medical information if it is a by-product of any of the uses or disclosures described above and it could not be reasonably prevented.

Limited Data Sets. We may use or disclose certain information that does not directly identify you for research, public health or health care operations if the recipient of that information agrees to protect the information.

Certain types of health information are subject to more stringent protections under state law than those described above. For example, mental health records, HIV related information and drug and/or alcohol abuse or dependence information is subject to special protections.

DISCLOSURES WITH YOUR AUTHORIZATION

We must obtain your authorization before we release psychotherapy notes prior to engaging in certain marketing activities. We are also required to obtain your authorization to use or disclose health information in those situations not otherwise described in this Notice. If you do authorize us to use or disclose your medical information, you have the right to revoke that authorization at any time.

YOUR RIGHTS IN CONNECTION WITH YOUR MEDICAL INFORMATION.

You have the following rights in connection with the medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your medical information that is in our possession. You may not, however, have access to psychotherapy notes or information that is put together for use in a civil, criminal or administrative proceeding.

To inspect or copy your medical information, you must submit your request in writing to our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect or copy your health information in certain very limited circumstances. If you are denied access to your medical information, you may be able to request that the denial be reviewed.

Right to Request Amendment. If you feel that your medical information is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, your request must be made in writing and submitted to our office.
You must explain why you believe that the medical information is incorrect or incomplete. If we deny your request, you have a right to give us a short statement to be placed with your medical information or to have us include your request for amendment with your medical information.

Right to an Accounting of Disclosures. You have the right to request, and we must provide you with, a list of certain of our disclosures of your medical information. We are not required to include on that list disclosures to carry out your treatment, payment for your care, and our health care operations and certain other disclosures. To request this list or accounting of disclosures, you must submit your request in writing to our office.

Your request must state a time period covered by your request. That time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** To request restrictions, you must make your request in writing to our office.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. To request confidential communications, you must make your request in writing to our office. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You may ask us to give you a copy of this notice at any time by asking for in person or in writing. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a compliant with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, contact our office in writing.
You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact our Privacy Officer at the address listed above.

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PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received a copy of Glendale Area Medical Association, Inc's Notice of Privacy Practices.

Patient/legal representatives signature:

_____

Date: _____

HIPPA Questionnaire

Glendale Dental Center
850 Main Street, PO Box 375, Coalport, PA 16627 814-672-5480

Patient Name: _____ DOB: _____

Form Completed By: Patient Other: _____ Relationship: _____

Purposes Approved for Release- This will be reviewed at each visit
_____ Continued Care _____ Legal _____ Other: _____

_____ Insurance (note that any insurance billing request is automatically approved for release)

I approve the release of this information beginning _____ and ending _____.

In the case of an emergency, GAMA may contact: (Please place these contacts in the order you wish for them to be reached).

1. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding my health care or can call on my behalf regarding my healthcare, medications, referrals, etc. YES NO

2. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding my health care or can call on my behalf regarding my healthcare, medications, referrals, etc. YES NO

3. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding my health care or can call on my behalf regarding my healthcare, medications, referrals, etc. YES NO

Can we leave a voice message for you and if so at what phone # _____.

Email Address: _____

May we reach you via email? (only after secured portal is activated) Yes or No

***Changes can be made upon written request. GAMA staff will ask you at every visit to confirm or update this information.**

Patient/Representative Signature: _____ Date: _____

HIPPA & Visit Authorization Form for Minors

Glendale Area Medical Center
850 Main Street, PO Box 375, Coalport, PA 16627
814-672-5141

Patient Name: _____ DOB: _____

The above child has my permission to be seen by a GAMA provider in my absence if he/she is accompanied by the following adult person(s):

Only the person(s) listed below will be permitted to bring the child to an appointment at GAMA. If someone other than a person on the list below brings the child, GAMA will NOT be able to treat your child at that time and you will have to reschedule the appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In the case of an emergency, GAMA may contact: (Please place these contacts in the order you wish for them to be reached).

1. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding this child's health care or can call on behalf of this child regarding healthcare, medications, referrals, etc. YES NO

2. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding this child's health care or can call on behalf of this child regarding healthcare, medications, referrals, etc. YES NO

3. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding this child's health care or can call on behalf of this child regarding healthcare, medications, referrals, etc. YES NO

I approve the release of this information beginning _____ and ending _____.

Form Completed By: _____ Relationship: _____

Signature: _____ Date: _____

Staff initials updated in computer: _____ Date: _____

GLENDALE AREA MEDICAL CENTER
850 Main Street
PO Box 375
Coalport, PA 16627

Sliding Fee Application

Applicants Name: _____ Todays Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____

Before approval can be given, the following MUST be received at time of or within 30 days of application.

- Current photo ID along with 1 proof of income for applicant and other household members over age 19.
- Proof of identity for all household dependents listed under the age of 19.

Proof of income: Copy of 2 or more checks/paystubs, recent tax return or W2, Medical/Public Assistance letter, Social Security Letter, Bank Statements, Child Support Alimony, Unemployment, Depart of Social Services Certification Letter. (INCLUDE **ALL HOUSEHOLD INCOME**.)

- Must be current within 30 days of application
- If unable to provide documentation of income (Complete Declaration of Income Form)
- Note: Total Gross Income will be calculated to determine approval

List yourself on Line 1, spouse/significant other on Line 2 and all dependents under the age of 19 on Lines 3-7.

Household Members	Names	DOB	Monthly Gross Income	Student (S)	Employed (E)	Other (O)	Office Use Only Patient/Chart #
1							
2							
	Dependents under age 19						
3							
4							
5							
6							
7							
	Total						

Documentation of No Income: If you report $0 income, please explain how you are surviving.

_____
_____
_____
_____

_____ _____

Signature of patient Date signed

Certification: I certify that the household size and income information shown above to be correct. **I understand that documentation supporting my household financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

I understand that I must update this information if my situation changes and that a new Sliding Fee Application must be completed at least every 12 months. I have received information explaining the program and I understand and agree to abide by the terms. I understand that if I am a self-pay patient, I will be responsible to pay at least a minimum of $15 for healthcare services. If an unpaid balance exists on my account after applying my sliding fee discount, I agree to make payment agreements and honor the terms. I understand that if I am unable to make a payment in any given month, I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

_____

Patients Name (Print)

_____

Signature of Patient of Guarantor

_____

Date of Signature

Application Reviewed By:	Date:
Documentation Received By:	Date:
Sliding Fee Approved	Date: