LETTER OF SUPPORT

Date: ____/ ____/ ____

I, _____ provide _____

(Supporter's Name) (Patient's Name)

_____

(Address) (City, State, Zip Code)

With the following services: (Check all that apply)

_____ Food

_____ Housing

_____ Financial Support

I believe the monthly, monetary value of these services to be approximately: $ _____.

Supporter's address: _____

_____

Supporter's Phone: _____

Relation to Patient: _____

Supporter's Signature: _____ Date: _____

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on your medical expenses. This information will be kept on file in our Billing Department in strict confidence. You must verify your income yearly from the day you start using the clinic. Proof of income includes tax filing statement, check stubs, or award letters. Your annual income will be used to calculate your payment for clinic services.

Name:	Address:
Date of Birth:	City/State/Zip:
Last 4 of Social Security Number:	Phone Number:

Today's Date: _____ **Number of people living in your home?** _____

What is your marital status? Circle One: Single/Married/Divorced/Separated/Widow(er)

Do you rent or own your home? Circle One: Rent Own Live with someone

Amount of Monthly Household Income

Yourself	Spouse	Children	Other Person	Total Income

Do you have any type of insurance that will cover all or a portion of your medical expenses? Yes or No

If yes, please list insurance name and ID # - _____

Please give Names and Date of Births for anyone living in the home:

Name	Date of Birth

I declare the above information is true and have given TAN Healthcare permission to verify any and all information given in this application. I also understand that if my income changes I must notify the Front Desk or Billing Department. I understand all my information will be kept in strict confidence.

Signature:	Date:	Income Category – If Eligible (Office Only):

_____ (initials) I understand my rights under the Sliding Fee Program

Self-Declaration Form

Patient Information	
Patient's Name:	Patient D.O.B:
Last 4 of SSN:	Phone Number:

Declaration of Self-Employment/Unemployment:

I declare that my principal employment is in the following industry,

_____and that presently: [ ] I am working [ ] I am not working.

Unemployed: I receive help from family, unemployment benefits, and/or government assistance to cover bills. The following family member provides support of $_____ every month.

_____ and can be reached at the following number _____ for verification of support.

Declaration of Income and Family size: I declare that my household income for last year was $_____ and that my current monthly family income is $_____. I also certify that a total of _____ people are living in my household.

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a discount for health services for one year from approved.

I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center but I will have to pay 100% of my medical bill.

Applicant Signature: _____ **Date:** _____

Insurance Information

Patient Name: _____ Date: _____

Primary Insurance

Name of Insurance Company: _____

Insured's Name: _____ Date of Birth: _____

Policy ID Number: _____ Group Number: _____

Secondary Insurance

Name of Insurance Company: _____

Insured's Name: _____ Date of Birth: _____

Policy ID Number: _____

Group Number: _____

Our office will file with your insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts.

Initial _____ I authorize the release of any medical information necessary to process my claim.

Initial _____ I understand I have to notify my providers office within **3 business days if my insurance changes or cancels.**

Initial _____ **I understand my copayment is due at time of visit**.

Signature of Patient/Legal Guardian: _____

CONSENT for RELEASE OF MEDICAL INFORMATION

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

The below is authorized to disclose this information:

Name: _____

Address:_____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Please send requested information to:

TAN Healthcare - Orange
3737 N 16th ST
Orange, TX 77632
Ph: 409-920-4223 Fax: 888-910-2061

TAN Healthcare - Beaumont
1495 N 7th ST
Beaumont, TX 77702
Ph: 409-832-3377 Fax: 877-547-8271

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Behavioral Health Record from (insert date) _____ to (insert date) _____

□ Other: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

PATIENTS RIGHTS & RESPONSIBILITES

As a member of the TAN Healthcare Medical Team, I the PATIENT, will commit to the following:

Notify TAN Healthcare **at least 24 hours in advance when I am unable to keep a scheduled appointment**.

Notify TAN Healthcare **when I have moved and/or changed telephone numbers**, so that my contact information is always accurate.

Contact the pharmacy for medication refills **at least seven (7) business days before I run out of my medication**.

Treat TAN Healthcare team members with respect as we partner together for my health care.

Notify TAN Healthcare when I see providers outside of TAN Healthcare.

Notify TAN Healthcare if any medications were prescribed or changed, of any tests or treatments were performed, as well as any other service completed for my care.

I understand my health risk and conditions. I will ask questions, learn new ways to improve my health, and work to prevent future illness.

I will provide TAN Healthcare any information regarding; health conditions, medical history, illnesses, medications (including over the counter, herbal, and/or supplements), visits with specialists, recent test results, ER visits, and hospital stays.

TAN Healthcare will continue to:

Respect you as an individual. We will not make judgements based on race, religion, sex, or age.

We will respect your privacy. Medical information will not be shared with anyone unless you give us permission or if required by law.

Provide evidence-based care by a team of nurses, social workers, medical assistants, and support staff led by your provider who will oversee your care.

Answer your calls and questions in a timely manner.

Improve your care by using Electronic Health Records and always strive to improve TAN Healthcare services.

Help you get the care you need, even if it is outside of TAN Healthcare.

_____ _____

Client Name Printed Date of Birth

_____ _____

Signature of Client Date

Adult Consent & Acknowledgment for TAN Services

Completion of this consent is necessary to offer services to a patient. Some items may not apply to your current situation; however, to provide comprehensive care during this visit and future visits we request that you complete this consent in its entirety.

CONSENT FOR TESTING AND TREATMENT

_____ (initial) By initialing, I hereby grant permission to TAN Healthcare to perform such tests, treatments, and procedures as ordered by the medical staff for diagnostic and therapeutic purposes.

_____ (initial) By initialing, I acknowledge that this may include **STD testing, HIV testing, and Hepatitis C screening**. As part of the testing and treatment I may receive disease-specific prevention, education, and risk-reduction services. TAN Healthcare is required by the State of Texas to report my name, address, treatment, and other information to the City of Beaumont or the City of Orange Health & Human Services for the known persons who test positive for TB, HIV/AIDS, and/or syphilis. Persons who test positive may be contacted to ensure they have been successfully treated and that sex partners who may be at risk for the disease have been notified about their potential risk.

ACKNOWLEGEMENT OF RECEIPT

_____ (initial) By initialing, I acknowledge that TAN Healthcare has provided me with its: **Notice of Privacy Practices**, **Patient Rights and Responsibilities**, **Grievance Policy**, and **E-Prescribing Information Sheet**.

FINANCIAL RESPONSIBILITY

_____ (initial) By initialing, I understand that if I qualify for services through a grant funded program, these resources are payers of last resort. Meaning that, if I currently or in the future have Medicare, Medicaid, or third-party insurance, I may not be eligible for services under these grants. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Billing Department. If such changes have not been appropriately reported and those changes in my status result in my ineligibility for services under a grant funded program at TAN Healthcare, I understand that I am fully responsible for the cost of services delivered by TAN Healthcare.

Insured Patients Only

_____ (initial) By initialing, I understand that if I become eligible for Medicaid, Medicare, or third-party insurance while a client of TAN Healthcare, I authorize TAN Healthcare to furnish Medicaid and/or Medicare and/or a third-party insurer all the necessary medical information to process my claim.

_____ (initial) By initialing, I hereby assign to TAN Healthcare all payments from Medicaid, Medicare, and/or any other third-party insurer are for medical services provided. **I understand that I am responsible for the cost of services delivered that are not covered by my insurance. I also understand that I am responsible for my co-payment.**

_____ _____

Printed Name Initials

_____ _____

Signature of Client Date

CONSENT AND ACKNOWLEDGMENT FOR HEALTH INFORMATION EXCHANGE (HIE)

NAME: _____ **Date of Birth:** _____

ACKNOWLEDGMENT OF RECEIPT OF HEALTH INFORMATION EXCHANGE (HIE) INFORMATION SHEET

_____ (initial) By initialing, I acknowledge that TAN Healthcare has provided me with its **HEALTH INFORMATION EXCHANGE (HIE) FACT SHEET**, which explains the purpose and details on how my medical history will be handled electronically.

TERMS OF CONSENT

- ❑ I hereby **AUTHORIZE** TAN Healthcare to **send** my data through HIE to other care settings.
- ❑ I hereby **AUTHORIZE** TAN Healthcare to **retrieve** my data through HIE from other care settings.
- ❑ I hereby **DO NOT AUTHORIZE** TAN Healthcare to either send or retrieve my data through HIE.

By signing below, I agree that I am completing this consent of my own free will as initialed above. I fully release TAN Healthcare, which includes but is not limited to: their employees, Board Members, and agents from any and all damages, losses, liabilities (joint or several), payments, claims litigation, suits, proceedings, of any kind or nature whatsoever resulting from out of my receipt of this service.

I understand that this consent shall remain active until I withdraw my consent in writing at any time.

_____ _____

Signature of Client Date

CONSENT AND ACKNOWLEDGMENT FOR OBTAINING E-PRESCRIBING HISTORY

NAME: _____ **Date of Birth:** _____

ACKNOWLEDGMENT OF RECEIPT OF E-PRESCRIBING INFORMATION SHEET

_____ (initial) By initialing, I acknowledge that TAN Healthcare has provided me with its **E-Prescribing information sheet**, which explains the purpose and details on how my prescriptions and prescription refill history will be handled electronically.

TERMS OF CONSENT

_____ (initial) I understand that providing TAN Healthcare with a history of my current and past prescriptions will assist the agency in confirming the safety of my prescriptions and decreasing dangerous interactions with any other medications I may be taking.

❑ I hereby **AUTHORIZE** TAN Healthcare permission to obtain this medication history electronically from other healthcare organizations, including, but not limited to pharmacies.

By signing below, I agree that I am completing this consent of my own free will as initialed above. I fully release TAN Healthcare, which includes but is not limited to: their employees, Board Members, and agents from any and all damages, losses, liabilities (joint or several), payments, claims litigation, suits, proceedings, of any kind or nature whatsoever resulting from out of my receipt of this service.

I understand that this consent shall remain active until I withdraw my consent in writing at any time.

_____ _____

Signature of Client Date

CONSENT for DELEGATED INDIVIDUAL COMMUNICATION

NAME: _____ **Date of Birth:** _____

☐ I **AUTHORIZE** TAN Healthcare to communicate with the following individuals regarding my medical care; regarding my medical diagnosis, treatment, eligibility status, billing information, and/or medical records.

Full Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Client Date

Initials: _____

Are you a US Military Veteran: ❑ YES ❑ NO

Preferred Language: ❑ English ❑ Spanish ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Domestic
❑ Divorced ❑ Widow/Widower ❑ Other

Gender: ❑ Male ❑ Female

What is your Gender Identity: ❑ Male ❑ Transgender Male / Female to Male
❑ Female ❑ Transgender Female / Male to Female
❑ Non-Binary ❑ Other ❑ Choose not to disclose

Sexual Orientation: ❑ Straight ❑ Lesbian or Gay ❑ Bisexual ❑ Do not know
❑ Other ❑ Choose not to disclose

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Choose not to disclose

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Race (choose all that apply): ❑ White ❑ Asian ❑ Native Hawaiian
❑ Other Pacific Islander ❑ Black/African American
❑ American Indian ❑ Choose not to disclose

Seasonal Worker ❑ Yes ❑ No

Migrant Worker ❑ Yes ❑ No

Public Housing ❑ Yes ❑ No

Welcome To Our Office!

Date: _____

How can we help you today? Please select one of the following:

Primary Care Visit _____ Prevention Care (HIV/Hep C) _____ Specialty Care (STD Testing) _____

Other (please explain)

_____

Which facility are you wanting to be seen at? Beaumont Orange Mobile Medical

Name (First, M.I, Last): _____

Preferred Name: _____ **Date of Birth**: ___/___/_____ **SSN**: _____-_____-_____

Mailing Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Physical Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ **Cell Phone**: (____) _____ **Other:** (_____) _____

Email Address: _____

Preferred Method of Contact: ❑ Phone: Leave a detailed message? YES NO ❑ Mail ❑ Email

Medical Insurance: ❑ Medicare ❑ Medicaid ❑ Private Insurance ❑ VA ❑ CHIP

❑ None / Self Pay ❑ Other

How did you learn about our practice: ❑ Friend ❑ Relative ❑ Radio/TV ❑ Internet

❑ Referral ❑ Community Event ❑ Other: _____

In case of an emergency, contact: _____ **Relationship**: _____

Primary Phone: (_____) _____ **Secondary Phone**: (_____) _____