PATIENT DEMOGRAPHICS

Date:_____

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

☐Primary Care Visit ☐ Prevention Care ☐Pediatrics ☐Specialty Care ☐Behavioral Health

Select Health Center? ☐Beaumont ☐Orange ☐Mobile Medical

Patient's Name

First	**Last**	**Middle Initial**
Preferred Name	**DOB**	**SSN:**
Mailing Address	**City**	**State/Zip**
Physical Address if different from above	**City**	**State/Zip**
( ) **Home Phone**	( ) **Cell Phone**	( ) **Other**
Email Address		**Contact me:** ☐**Phone** ☐**Text** ☐**Email**
In case of emergency, please contact: First/Last Name:		**Contact Number:**
Address:		**Relationship:**

FOR MINORS:

Mother's Name: _____Contact Number: (____) _____

Father's Name: _____Contact Number: (____) _____

Guardian's Name: _____Contact Number: (____) _____

Medical Insurance ❑Medicare ❑ Medicaid ❑ Private Insurance ❑ VA
❑ CHIP ❑ None / Self Pay ❑ Other: _____

How did you learn about our practice ❑ Friend ❑ Relative ❑ Radio ❑ TV Commercial
❑Internet ❑ Referral ❑ Event ❑ Other: _____

Do you have a preferred pharmacy: ☐Yes:_____ ☐No

Do you have an advanced directive: ☐**Yes** ☐**No** ☐**NDA**
If yes, please bring proof/copy of directive for patient file.

If Yes, check all that apply:
☐Directive to Physician ☐Medical Power of Attorney ☐Out of Hospital DNR

SOCIAL HISTORY:

Please complete the entire document and check boxes.

Are you a US Military Veteran	❑ Yes	❑ No	
Preferred Language:	❑ English	❑ Spanish	❑ Other_____
Marital Status	❑ Single ❑ Divorced	❑ Married ❑ Widow/Widower	❑ Domestic ❑Other
Gender at Birth	❑ Male	❑ Female	
Gender Identification	❑ Male ❑ Female ❑ Non-Binary	❑ Transgender Male / Female to Male ❑ Transgender Female / Male to Female ❑ Other	❑ Choose not to disclose
Sexual Orientation	❑ Straight ❑ Do not know	❑Lesbian or Gay ❑ Other	❑ Bisexual ❑ Choose not to disclose
Ethnicity	❑Hispanic	❑Non-Hispanic	❑Choose not to disclose
Race (choose all that apply):	❑ White ❑Asian ❑Native Hawaiian	❑ Black ❑ Other Pacific Islander ❑Choose not to disclose	❑ Alaska/Native Indian ❑ Other_____
Seasonal Worker	❑Yes	❑ No	
Migrant Worker	❑Yes	❑No	
Public Housing	❑Yes	❑ No	
Experiencing Homelessness	❑Yes	❑ No	
Annual Household Income	❑$0 – 20,000 ❑$50,000 – 74,999 ❑$150,000 or More	❑ $20,000 – 34,999 ❑ $75,000 – 99,999	❑ $35,000 – 49,999 ❑ $100,000 – 149,999
Household Size	❑ 1	❑ 2 ❑ 3	❑ 4 ❑ 5 or more

GENERAL CONSENT FOR TREATMENT, *please check each box, as applicable.*

☐I have presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), and all TAN Healthcare providers determine to be necessary. I **acknowledge** that I may receive STD, HIV, and Hepatitis C screenings as part of prevention and diagnostic services and that positive results for TB, HIV/AIDS, and/or Syphilis must be reported as required by the State of Texas. I **acknowledge** that no warranty or guaranty has been or will be made as to the result of cure or treatment. I have the **legal right to consent to medical treatment** because I am the patient, or I am the parent/guardian of the patient. All reference to "patient", "me", and "my" in this document means: _____

(name of the patient)

☐**DATA USE:** I **consent to the taking of photographs** related to the care and treatment and understand that such photographs may be made part of the medical record and/or used for internal purposes, such as performance improvement or education. I acknowledge that demographic information and other health data/information describing patient care, services, and outcomes are collected and used for healthcare operations, reporting, and comparisons with other providers. Performance data may be aggregated and reported per physician. I understand that TAN Healthcare will take every reasonable effort to maintain patient and physician anonymity.

☐**ELECTRONIC MEDICAL RECORD:** TAN Healthcare shares medical records electronically with other health care providers to allow and promote continuity of care among providers. **I understand** that if I visit another provider who also participates in an electronic medical record system, TAN Healthcare may have access to my medical record.

☐I do not want medical records shared with other providers.

☐**ELECTRONIC PRESCRIPTIONS (E-Prescribing):** I **authorize** E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and medication dispensing history as long as a physician/patient relationship exists.

☐**FINANCIAL POLICY ACKNOWLEDGEMENT:** I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. This consent to release and obtain information is valid until revoked and I may revoke this consent in writing at any time, except with regard to disclosures already made. I have received and read the Financial Policy and I had the opportunity to ask questions.

☐**PRIVACY PRACTICE ACKNOWLEDGMENT**: I acknowledge that I have been offered a copy **Notice of Privacy Practices** ("Notice"). The Notice explains how TAN Healthcare may use and disclose the patient's protected health information for treatment, payment, and healthcare operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact the Privacy Office at (409) 832-8338.

I have read and understand this form.

Patient's Name (Printed): _____ Patient's Date of Birth: _____

Name of Parent/Guardian if patient is a minor: _____

Signature: _____ Date: _____

DELEGATION OF CONSENT

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

I hereby authorize one or all the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This Personal Health Information (PHI) includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.

This authorization shall remain in effect from the date signed below until revoked. You have the right to revoke this authorization in writing.
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand information disclosed to designees is no longer protected by federal or state law and may be subject to redisclosure by the designee.

Full Name	**Relationship**	**Telephone Number**
Full Name	**Relationship**	**Telephone Number**
Full Name	**Relationship**	**Telephone Number**

For Minors:

I(WE) understand that in the event that I(we) am/are unavailable to grant consent on behalf of my minor child, the consent of the individual identified above, who I(we) have granted authority to consent on behalf of minor child, will be considered sufficient for medical treatment(s)/procedure(s).

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness Signature (TAN Staff Member if signed at practice) Date

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Provider Name: _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: _____

Address _____

City _____ State _____ Zip Code: _____

Phone: _____ Fax: _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

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 (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

FINANCIAL POLICY

WE at Triangle Area Network (TAN Healthcare) are committed to providing you and your family with the highest quality of care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

You are personally responsible for payment at the time of service for all charges that result from care provided by TAN Healthcare.

To assist us in establishing your TAN Healthcare financial account, please:

- Supply all information for the accurate billing of your insurance claim, including your insurance card, and demographic information.
- Satisfy all co-payments, deductibles, and non-covered services by your health plan on the day services are rendered.
- Provide your insurance company and TAN Healthcare with any additional information requested to complete the processing of claims filed on your behalf.
- Agree to immediately report any changes in your financial status and/or insurance coverage.

UNACCOMPANIED MINORS:
Minors must have an authorization for medical treatment signed by their parent/guardian. The minor's parent/guardian is responsible for providing current insurance information. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING HEALTH PLANS AND INSURANCE:
For each visit to TAN Healthcare, it is your responsibility to make sure TAN Healthcare is currently under contract with your insurance plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your insurance carrier.

If we are not contracted with your health plan, we may require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your health plan. Should your health plan require a more detailed description of services, please have your health plan request it in writing.

Please note that if you qualify for services through a grant funded program or the Department of State Health Service Family Planning (Title X) these resources are payers of last resort. Meaning that, if you currently or in the future have Medicare, Medicaid, or third-party insurance, you may not be eligible for services under these grants.

If such changes have not been appropriately reported and those changes in your status result in ineligibility for services under a grand funded program at TAN Healthcare, you will be fully responsible for the cost of services delivered by TAN Healthcare.

Financial Assistance is available for all patients regardless of insurance; please speak with us to see if you qualify.

ASSIGNMENT OF BENEFITS:
You attest to the following:

In consideration of services rendered or to be rendered by TAN Healthcare, I hereby irrevocably assign, transfer and set over to TAN Healthcare all right, title and interest in all benefits payable for the health care rendered by TAN Healthcare to the patient(s) named below, which benefits are provided in any and all insurance policies, employee benefit plans, re-insurance/stop loss contract and/or third party actions against any other person or entity, for whom my spouse, dependents or I are entitled to recover.

I also hereby irrevocably assign, transfer and set over to TAN Healthcare all right, title and interest in any and all claims, administrative appeals and causes of action against all insurance companies, employee benefit plans, re-insurance/stop loss carriers, third party administrators and/or other persons or entities responsible for the payment of health insurance benefits.

I authorize my insurer, plan administrator to release to TAN Healthcare any and all insurance policies, plan documents, summary plan descriptions, and/or settlement information upon written request of TAN Healthcare in order to claim such medical benefits.

I authorize payment to be made directly to TAN Healthcare or my treating physician.

RELEASE OF INFORMATION

I agree to the release of all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. This consent to release and obtain information is valid until revoked and I may revoke this consent in writing at any time, except about disclosures already made.

- As a free service from TAN Healthcare to our patients, TAN Healthcare—or a third party with whom TAN Healthcare contracts—provides courtesy appointment reminder calls and possibly other important calls regarding healthcare related notifications such as well-check reminders and vaccine reminders. Such calls or texts may be placed using a prerecorded auto messaging system to the phone number provided to TAN Healthcare.
- I have read and understand that I am personally responsible for payment.

Today's Date: _____

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions 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 ANNUALLY from the day you start using the health center. Proof of income includes tax filing statement, check stubs, or award letters. Your annual income will be used to calculate your payment for health center services.

Name:	DOB:	Last four of SSN:
Address:	City:	State/Zip:
Phone Number:	Cell Phone:	

_____(initials) I am choosing to participate in the Sliding Fee Discount Program and understand my rights.

_____(initials) I have been informed of TAN Healthcare's Sliding Fee Discount Program and fully understand my rights, however, I am choosing to NOT participate. *You may skip the following section and complete with signature.*

Number of people living in your home: _____

What is your marital status? ☐Single ☐Married ☐Divorced ☐Separated ☐Widow(er)

Do you rent or own your home? ☐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 ☐ No

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

Please give Names and Date of Births for EVERYONE 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):

REQUIRED DOCUMENTS FOR SLIDING FEE ELIGIBILITY

The following items are required for you to become eligible as a patient of TAN Healthcare to participate in our SLIDING FEE DISCOUNT PROGRAM.

Each patient will be allotted a **10-day grace period** from the date of their first day of service to complete this list of required documents.

After 10 days, you will automatically be placed on our SELF PAY PROGRAM, which means that you will be responsible for paying the full price for all of your visits, labs, imaging, and any other service that you receive from TAN Healthcare.

To become an Established Patient with TAN Healthcare, you must provide our office with the following:

- ☐ **PHOTO IDENTIFICATION**
- ☐ **PROOF OF RESIDENCE**
- ☐ **PROOF OF HOUSEHOLD INCOME**
  - _____**LAST TWO CHECK STUBS FROM CURRENT MONTH**
  - _____**RETIREMENT OR SOCIAL SECURITY BENEFIT LETTER**
  - _____**UNEMPLOYEMENT BENEFIT LETTER**
  - _____**CHILD SUPPORT PAYMENT LETTER**
  - _____**SNAP AWARD LETTER**
  - _____**CURRENT TAX RETURN DOCUMENTS**
  - _____**LETTER OF SUPPORT**
- ☐ **SLIDING FEE APPLICATION**
- ☐ **SELF DECLARATION FORM**

By signing this document, you are stating that you understand the requirements of our SLIDING FEE DISCOUNT PROGRAM. You are also acknowledging that after your 10-day grace period, your fees with TAN Healthcare will automatically revert from Sliding Fee to Self-Pay if all your documents have not been received by our office.

_____ _____

PRINTED NAME **DATE**

_____ _____

SIGNATURE **DOB**

Patient Self-Declaration Form

Patient Information

Name	**DOB:**	**Last four of SSN:**
Phone Number:	**Email Address:**	

Declaration of Self-Employment/Unemployment:

I declare that my principal employment is in the following industry,_____ and that presently:

☐ I am working (full or part time) ☐ I am currently not working ☐I am currently self-employed

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: _____

Support Statement

I, _____provide _____
(Supporter's Name) (Patient's Name)

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:

Address:	City:	State/Zip
Phone:	Email:	Relation to Patient:

Supporter Signature:_____ Date:_____