DATE: _____

PATIENT DEMOGRAPHICS and SOCIAL HISTORY

Patient's Information

First	**Middle Initial**	**Last**
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		**Best Method of Contact** (Phone, Text, Email)**:**
In case of an emergency, please contact: *(First and Last Name)*		**Contact Number:**
Address:		**Relationship:**

Race: _____ **(List all that apply)** White, Black, Asian, Native Hawaiian, Alaska/Native Indian, Pacific Islander, Other.	**Ethnicity:** _____ Hispanic, Non-Hispanic, or Choose not to disclose. **If Hispanic, please specify origin:** _____	**Preferred Language:** _____ English, Spanish, Hindi, Other **If other, please list:** _____
Gender at Birth: _____ *Male or Female*	**Gender Identification:** _____ Male, Female, Non-Binary, Transgender Male/Female to Male, Transgender Female/Male to Female, Other.	**Sexual Orientation:** _____ Straight, Lesbian or Gay, Bisexual, Other.

Marital Status: _____	**Household Size:** _____	**Annual Household Income:** _____
Are you a US Military Veteran? _____	**Are you a Seasonal Worker?** _____	**Are you a Migrant Worker?** _____
Do you receive Public Housing?	**Are you currently experiencing Homelessness?**	

Do you have an Advanced Directive (Directive to Physician, Medical Power of Attorney, Out of Hospital DNR)**?** _____
If yes, please bring proof/copy of the directive for the patient file.

Do you have Medical Insurance? _____ **If yes, please list the name of insurance(s):** _____
(Medicare, Medicaid, Private Insurance, VA Benefits, CHIP, None/Self Pay)

Name of Preferred Pharmacy: _____ **Phone Number:** _____

FOR MINORS:

Mother's Name: _____ Contact Number: _____

Father's Name: _____ Contact Number: _____

Guardian's Name: _____ Contact Number: _____

GENERAL CONSENT FOR TREATMENT

Please initial on each line, 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 guarantee has been or will be made as to the result of the 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: _____

(PATIENT NAME)

_____ **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 healthcare 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.

*Only initial the above if you **do not** want your records shared.*

_____ **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. A copy of TAN's Financial Policy will be uploaded to your Healow patient portal, 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 the 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 the 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**
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, whom I(we) have granted authority to consent on behalf of the minor child, will be considered sufficient for medical treatment(s)/procedure(s).

_____ _____

SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

SELF-PAY 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 statements, 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:	

_____ I am choosing to participate in the Self-Pay Discount Program and understand my rights. (initials)

Number of people living in your home: _____ **What is your marital status? _____**

Do you live with someone, rent, or own your home? _____

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? _____

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

Please give Names and Dates of Birth 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 SELF-PAY ELIGIBILITY

The following items are required for you to become eligible as a patient of TAN Healthcare to participate in our SELF-PAY 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**
  - **CURRENT TAX RETURN DOCUMENTS**
  - **LAST TWO CHECK STUBS FROM THE CURRENT MONTH**
  - **RETIREMENT OR SOCIAL SECURITY BENEFIT LETTER**
  - **UNEMPLOYMENT BENEFIT LETTER**
  - **CHILD SUPPORT PAYMENT LETTER**
  - **LETTER OF SUPPORT**
- **SELF-PAY DISCOUNT APPLICATION**
- **SELF DECLARATION FORM**

By signing this document, you are stating that you understand the requirements of our SELF-PAY DISCOUNT PROGRAM. You're also acknowledging that after your 10-day grace period, your fees with TAN Healthcare will automatically revert from the Self-Pay Discount to a Full-cost visit 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:

(Please initial on the line is applicable to you)

_____ I am working (full or part-time).

_____ I am currently not working.

_____ I am currently self-employed.

UNEMPLOYED:

I receive help from family/friends, 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 phone 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 Self-Pay Discount, and if eligible, I will receive a discount for health services for one year from approval.

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: _____

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 rights, titles, and interests 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, titles, and interests 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.