



Patient Demographics and Social History

Patient Name: Preferred Name:

Date of Birth: SSN: Date:

Mailing Address:

Physical Address (if different):

City/State/Zip:

Phone (Home): Cell: Other:

Best Contact: Phone / Text / Email

Email Address:

Emergency Contact Name: Phone:

Relationship: Address:

Background Information

Race (select all that apply):

- ☐ White
☐ Black/African American
☐ Asian
☐ Native Hawaiian
☐ American Indian/Alaska Native
☐ Pacific Islander
☐ Other

Ethnicity:

- ☐ Hispanic Origin:
☐ Non-Hispanic ☐ Prefer not to answer

Preferred Language:

Sex at Birth: ☐ Male ☐ Female

Marital Status:

Household Size: Annual Income:

Veteran Status: ☐ Yes ☐ No

Seasonal Worker: ☐ Yes ☐ No

Migrant Worker: ☐ Yes ☐ No

Housing Status: ☐ Public Housing ☐ Experiencing Homelessness ☐ Neither

Advanced Directive on file: (If yes, please provide copy) ☐ Yes ☐ No

Insurance: ☐ Medicaid ☐ Medicare ☐ Private ☐ VA Benefits ☐ None / Self-Pay

Insurance Plan Name:

Preferred Pharmacy: Phone:

Patient Consent and Authorization Form



Patient Name: Date of Birth:
Preferred Name:

1. Consent for Care

- ☐ I hereby consent to receive medical, behavioral health, and supportive services deemed necessary by TAN Healthcare providers.
- ☐ I acknowledge that screenings (STD, HIV, Hepatitis C, TB, Syphilis) may be performed and that positive results must be reported to the Texas Department of State Health Services.

2. Authorization for Use of Data

- ☐ I authorize TAN Healthcare to take and retain photographs for medical documentation, quality improvement, and educational purposes.
- ☐ I understand that my demographic and clinical information may be collected and utilized for reporting and quality assurance.

3. Medical Record Sharing

- ☐ I consent to the secure sharing of my medical record with other healthcare providers for continuity of care.
- ☐ I do **not** authorize my records to be shared with other providers.

4. Electronic Prescriptions

- ☐ I authorize electronic prescribing, which allows prescriptions to be transmitted to my pharmacy of choice and permits review of my medication history.

5. Financial Policy Acknowledgment

- ☐ I acknowledge TAN Healthcare's financial policy and authorize the release of necessary medical and financial information for billing and claims processing. I understand this authorization may be revoked in writing.

6. Privacy Practices Acknowledgment

- ☐ I acknowledge that I have been offered a copy of TAN Healthcare's *Notice of Privacy Practices* and that I understand how my health information may be used and disclosed.

7. Consent for Use of Artificial Intelligence (AI)

- ☐ Yes, I consent to the use of AI tools to support my care (e.g., scheduling, referrals, patient education, and clinical decision support). I understand that AI will not replace professional medical judgment.
- ☐ No, I do not consent to the use of AI tools in my care.

Please complete item #8 and sign the back of this form.

8. Delegation of Consent

I authorize the following individual(s) to access my health information or, in the case of a minor, to consent for care if I am unavailable:

1. Name:		Relationship:		Phone:	
2. Name:		Relationship:		Phone:	
3. Name:		Relationship:		Phone:	

Signature of Patient/Parent/Guardian: Date:

Printed Name:

Help Us Understand Your Coverage

For Patients with or without insurance



Section A – Patient Information

Person Responsible for Bill: Marital Status:

Email Address:

Housing: ☐ Live with someone ☐ Rent ☐ Own Home Household Size:

Do you have insurance that covers part/all medical expenses? ☐ Yes ☐ No

If yes, please provide the insurance name and ID number in **Section C** below.

Section B – For Uninsured and Underinsured Patients

☐ Sliding Fee Discount – I understand TAN Healthcare offers discounts based on income and family size.

To qualify, I must provide: Photo ID, Proof of Residency, Proof of Household Income.

☐ I understand I have 10 days from my first visit to submit documents. If not, I will be subject to pay full cost.

Employment Status (choose one):

- ☐ Working (full-time or part-time)
☐ Receiving benefits and not working
☐ Receiving support from someone and not working
☐ Self-employed

Monthly Household Income:

Yourself Spouse Children Other Person Total

Additional Household Members:

Names and Date of Birth *(if additional space is needed please notify staff):*

NAMES	DOB	NAMES	DOB

☐ I declare the above information is true and agree to notify TAN Healthcare if my income or household size changes.

Section C – For Insured Patients Only

Primary Insurance Company: ID#: Group#:

Policy Holder: Policy Holder DOB: Relation to Patient:

Secondary Insurance, if any (list insurance name and ID#:

TAN Healthcare – Financial Policy



Patient Responsibility

- You are responsible for payment at the time of service for any charges not covered by insurance.
- Please bring your insurance card and accurate demographic information at each visit.
- Co-pays, deductibles, and non-covered services must be paid on the day of service.
- Notify TAN Healthcare immediately of any changes in insurance coverage or financial status.

Minors

- Minors must have written consent from a parent/guardian.
- Parents/guardians are responsible for providing insurance details and paying required costs.

Insurance & Coverage

- It is your responsibility to confirm that TAN Healthcare is in-network with your insurance plan.
- If TAN is out-of-network, full payment may be required at the time of service.
- TAN will provide a statement so you can seek reimbursement.
- Grant-funded programs (such as Title X) are payers of last resort.
- If you have or gain other coverage (Medicare, Medicaid, private insurance), you may not qualify for grant-funded services.
- If coverage changes are not reported, you will be responsible for all costs of care.
- Financial assistance is available for all patients, regardless of insurance.

Assignment of Benefits

- By receiving care, you authorize TAN Healthcare to bill your insurance and receive direct payment for services.
- You also assign TAN Healthcare your rights to claims and appeals related to your care.

Release of Information & Communication

- You consent to the release of necessary medical and financial information (including HIV results) to process claims.
- TAN Healthcare may send appointment reminders or other healthcare notifications by phone or text message.

Acknowledgment

I have read and understand this Financial Policy and accept responsibility for payment.

Patient/Guardian Signature:

Date:

Printed Name: