PRIMARY CARE & HOPE CLINIC

Phone: 615-893-9390 Fax: 615-893-4162

PATIENT INFORMATION FORM

1. PATIENT INFORMATION

Last Name: First Name: Middle Initial:

Address: Apt: City: Zip: Phone:

Email Address: Cell Phone:

Preferred Method of Contact: Home Phone ☐ Cell Phone ☐ **May we leave a voicemail:** Yes ☐ No ☐

Message type: Detailed Message ☐ Brief Message ☐ N/A ☐

Do you want to receive text message reminders?: Yes ☐ No ☐

Social Security #: Date of Birth: Marital Status:

Gender: Male ☐ Female ☐ Transgender ☐ What gender is listed with your insurance? M ☐ F ☐

Employer: Occupation: Work Phone:

Do you have an Advanced Directive? Yes or No Are you a Veteran? Yes or No Referred by:

Race **(circle all that apply):** Black, White, Asian, Pacific Islander, American Indian Ethnicity **(circle one**): Hispanic or Not Hispanic

Please list your language primarily spoken:

Please circle the answer that best applies to you: Own Home Rent Home Public Housing Homeless

2. IF MINOR, PARENTS INFORMATION (GUARANTOR)

Last Name: First Name: Middle Initial:

Address: City: Zip: Phone:

Social Security #: Date of Birth: Gender: M or F Relationship:

Employer: Occupation: Work Phone:

3. EMERGENCY CONTACT INFORMATION

Last Name: First Name: Relationship:

Address: City: ST: Zip: Phone:

4. PROTECTED HEALTH INFORMATION MAY BE RELEASED TO (a person or Dr.'s office we may discuss personal health info)

Last Name: First Name: Middle Initial: Relationship:

Last Name: First Name: Middle Initial: Relationship:

5. FINANCIAL INFORMATION MAY BE RELEASED TO

Last Name: First Name: Middle Initial: Relationship:

Last Name: First Name: Middle Initial: Relationship:

6. IF MINOR, WHO HAS PERMISSION TO BRING YOUR CHILD FOR MEDICAL TREATMENT?

Last Name: First Name: Middle Initial: Relationship:

Last Name: First Name: Middle Initial: Relationship:

7. NAME OF INSURANCE (IF UNINSURED, PLEASE LEAVE BLANK)

Primary Insurance: Secondary Insurance:

8. Preferred Pharmacy

Name: Address: Phone:

9. Please use the chart below to answer the next question:

How many people are in your household? Select your level of income by circling one of the following: A B C D E F

I acknowledge I have been given the opportunity to review patient rights and responsibilities. _____
*****I may request a copy of these at any time.**
Patient Initials

I have received a copy of Primary Care & Hope Clinic Privacy Notice. _____
Patient Initials

ACKNOWLEDGMENT INFORMATION

I, the undersigned, give permission to treat and assign directly to Primary Care & Hope Clinic, all medical and/or behavioral benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges not paid by my health or behavioral benefits provider. I hereby authorize the use of this signature (or copy thereof) to provide necessary medical/ behavioral information to my insurance carrier upon their request. With my signature, I attest that I have sought the services of Primary Care & Hope Clinic at my own will. I have not been solicited to receive these services.

_____ _____
Signature Date

Pt Pays	**$25**	**$30**		**$40**		**$50**		**$60**		**Full Charge**
	F - Nom. Fee	**E**		**D**		**C**		**B**		**A**
% Of FPL	*<=100%*	*101%*	*125%*	*126%*	*150%*	*151%*	*175%*	*176%*	*200%*	*Over 200%*
1	$12,140	$12,141	$15,175	$15,176	$18,210	$18,211	$21,245	$21,246	$24,280	$24,281
2	$16,460	$16,461	$20,575	$20,576	$24,690	$24,691	$28,805	$28,806	$32,920	$32,921
3	$20,780	$20,781	$25,975	$25,976	$31,170	$31,171	$36,365	$36,366	$41,560	$41,561
4	$25,100	$25,101	$31,375	$31,376	$37,650	$37,651	$43,925	$43,926	$50,200	$50,201
5	$29,420	$29,421	$36,775	$36,776	$44,130	$44,131	$51,485	$51,486	$58,840	$58,841
6	$33,740	$33,741	$42,175	$42,176	$50,610	$50,611	$59,045	$59,046	$67,480	$67,481
7	$38,060	$38,061	$47,575	$47,576	$57,090	$57,091	$66,605	$66,606	$76,120	$76,121
8*	$42,380	$42,381	$52,975	$52,976	$63,570	$63,571	$74,165	$74,166	$84,760	$84,761
For each add'tl person, add:	$4,320	$4,320		$4,320		$4,320		$4,320		$4,320
Dental Cleaning	**$25**	**$26**		**$27**		**$28**		**$29**		**Full Charge**
	Pt Pays Cost of Medicine Plus									
Pharmacy	**$6**	**$7**		**$8**		**$9**		**$10**		**$15**
X-Ray See price list	**F: $20**	**E: 40%**		**C&D: 35%**				**B: 30%**		**A: Full Charge**
Labs	**$5**	**$7**		**$9**		**$10**		**$12**		**Full Charge**