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 - Nominal Fee	**E**		**D**		**C**		**B**		**A**
% Of FPL	*<=100%*	*101%*	*125%*	*126%*	*150%*	*151%*	*175%*	*176%*	*200%*	*Over 200%*
1	$12,490	$12,491	$15,613	$15,614	$18,735	$18,736	$21,858	$21,859	$24,980	$24,981
2	$16,910	$16,911	$21,138	$21,139	$25,365	$25,366	$29,593	$29,594	$33,820	$33,821
3	$21,330	$21,331	$26,663	$26,664	$31,995	$31,996	$37,328	$37,329	$42,660	$42,661
4	$25,750	$25,751	$32,188	$32,189	$38,625	$38,626	$45,063	$45,064	$51,500	$51,501
5	$30,170	$30,171	$37,713	$37,714	$45,255	$45,256	$52,798	$52,799	$60,340	$60,341
6	$34,590	$34,591	$43,238	$43,239	$51,885	$51,886	$60,533	$60,534	$69,180	$69,181
7	$39,010	$39,011	$48,763	$48,764	$58,515	$58,516	$68,268	$68,269	$78,020	$78,021
8*	$43,430	$43,431	$54,288	$54,289	$65,145	$65,146	$76,003	$76,004	$86,860	$86,861
For each additional person, add:	$4,420	$5,515		$6,630		$7,735		$8,840		
Dental Services	**$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**