TEST, Test (id #2050, dob: 09/12/2007)

TEST, TEST 09/12/07 #2050

* 615454w1955 Admin

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name: **TEST**
First Name: **TEST**
Middle Name:
Address: **TEST**
City: **TULLAHOMA** State: **TN**
Zip: **37388**
Home Phone: **(931) 455-5014**
Work Phone:
Mobile Phone:
Sex: **F**
Date of Birth: **09/12/2007**
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race: **Other Race**
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name: **TEST TEST**
Address: **TEST**
TULLAHOMA, TN 37388
Relationship to patient: _____
Date of Birth: **09/12/2007**
Social Security No.:
Phone: **(931) 455-5014**

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone: _____

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by: _____

Primary Care Provider: FAITH LEGRONE

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information

Name: PARTNERS FOR HEALING, INC

Crossroads: _____

Phone: (931) 962-3001

Primary Insurance Information

Insurance Plan Name:
Insurance Policy #:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Insurance Policy #:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed _____ **Date** _____

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Medical Records Release Authorization
Internal Form

I hereby authorize (Physician/facility's full name) _____ Phone _____

Fax # _____ Address: _____

to release or disclose to the below-named facility all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection for the purpose of medical treatment.

Please "Print" and complete **all sections** to insure your request is handled in a timely manner

MAIL RECORDS TO: **Partners for Healing**
109 W Blackwell ST
Tullahoma, Tennessee 37388
-- Attention: _____

Special Instructions if any:
(Specific information requested, etc.) _____

Patient's Name: **TEST TEST**
Address: **TEST TULLAHOMA TN 37388**
Telephone Number: **H: (931) 455-5014**

Patient's S.S. # _____ Patient's Date of Birth: **09/12/2007**

If you Do Not Want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

*I here authorize (Physician/facility's full name) _____ to release the information specified to the organization, agency, or individual named on this request with the exception of:

Initials _____ Substance abuse, if any

Initials _____ Psychological or psychiatric conditions, if any

Initials _____ AIDS/HIV/STD's if any

This Authorization will expire on the following date or upon the occurrence of the following event: _____

* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Partners for Healing or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Partners for Healing at the address shown below.

* I understand that I am not required to sign this Authorization. Partners for Healing will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

* I understand that my records may be subjected to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Partners for Healing or its physicians',employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

Patient or Authorized Representative's Signature: _____ Date: _____

Relationship to the patient: _____ Date: _____

Witness's Signature: _____ Date: _____

TEST, Test (id #2050, dob: 09/12/2007)

TEST, TEST 09/12/07 #2050

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PATIENT ACKNOWLEDGEMENT FORM

Due to a Federal Regulation called Health Information Portability and Accountability Act (HIPAA), we are required to provide you with the opportunity to review our Privacy Notice as well as get a signature from you that you were given this opportunity. This notice essentially provides information about how we may use and disclose Protected Health Information about you. As provided in our Notice, the terms of the Notice may change. If we change our Notice, you may obtain a revised copy by sending a letter to:

Privacy Officer — Lynn Brumfield
Partners for Healing
109 W Blackwell Street
Tullahoma, TN 37388
(931) 455-5014 x 103
director@partnersforhealing.org

By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this consent at any time by sending notice to the above address. Revocation of consent will not affect disclosures that have already been made.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations; however, if this restriction should interfere with norm al treatment, payment and health care operations, we have the right to refuse your restriction. If we refuse, our privacy officer will contact you to discuss the restriction with you. For additional details, please feel free to review the Privacy Notice in the reception area.

I, **TEST TEST**, have read or had the opportunity to read the Notice of Privacy Policies and Practices and consent to the disclosure of Protected Health Information for normal treatment payment and health care operations.

Signed this _____ day of _____

X _____ _____

Signature of Patient or Representative | Relationship to Patient

☐ The patient declined to read/sign the consent form.

_____ _____

Facility Representative | Date

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PARTNERS FOR HEALING
PATIENT DATA FORM

Partners for Healing, welcomes individuals of all backgrounds. The information on this form will be kept conditional and is used for statistical purposes only. please ◯ circle the answers that apply to you.

Patient Name: TEST TEST **Age** 14yo **Today's Date** 06/03/2022

1. **Marital Status:** a. married b. single c. divorced d. widowed e. separated
2. **Race:** a. African-American b. Caucasian c. Hispanic d. Other _____
3. **What is the primary language spoken in your home?** _____
4. **Do you speak English / INGLES?** YES / NO **Do you need an interpreter / Interpret?** YES/NO
5. **What is your family size? Total** _____ **(Adults** _____**Children under 18** _____**)**
6. **Your Living Situation**
   - a. Own your home
   - b. Rent your home
   - c. Live with a family member
   - d. Live with a friend
   - e. Live in a homeless shelter
7. **Primary Source of Income**
   - a. Full-time employment
   - b. Part-time employment
   - c. Self-employed
   - d. Spouse's income
   - e. parents income
   - f. Relative income
   - g. Non-Relatives income
8. **Yearly Household income Range**
   - a. $5,000 - $10,000
   - b. $10,001 - $20,000
   - c. $20,000 - $30,000
   - d. $30,001 - $40,000
   - e. $40,001 - $50,000
   - f. over $50,000
9. **Patient Place of employment**_____. **If patient is not employed then**
10. **Education level-last Grade Completed.** _____ a. High School b. GED c. Vocational/Technical d. College
11. **When was your last visit with a Doctor? DATE:**
    Physician's Office if yes, which Physician? _____
12. **Number of Visits to the Emergency Room in the LAST YEAR?** _____

Hospital	Reason for your visit	Date
Tennova Regional-Harton		
Unity Medical Center		
United Regional Medical Center		
Southern Tennessee Medical Center		
Other:		

13. **I do not usually go to a doctor.** YES/NO
14. **How did you hear about Partners for Healing Inc.?**
    - a. Community Event
    - b. Brochure
    - c. Word of Mouth
    - d. Referral from an agency
    - e. Referral from a Hospital
    - f. Other _____
    - g. Tullahoma Times
    - h. Manchester Times

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Partners *for* Healing

Permission Agreement

The following information will be used to contact the patient, parent or legal guardian, in regard to personal information (i.e., test results, referrals, medication refills, etc.). Please indicate below how you would like this facility to contact you regarding these matters.

I,**TEST TEST** ,give my authorization to my physician/physician's staff to discuss any medical issues

	Name
_____ My spouse	_____
_____ My son /daughter/ children	_____
_____ Other	_____

I,**TEST TEST** ,also give permission for _____ ,and to pick up medications for me; after providing proper identification. This agreement shall be in effect for **ONE YEAR.** If circumstances change and I no longer want the above- named person to pick up any medications. I will notify the clinic personnel immediately.

I,**TEST TEST** ,also give permission to physician/physician's staff to speak for me and supply required information for the Patients' Prescription Assistance Program in order to obtain my medications.

I,**TEST TEST** ,also give permission to physician/physician's staff to contact me at my place of employment. If I am unable to be reached there, I give permission to my physician/physician's staff to leave a message for me to return their call.

If there is any medical information I do not want to be discussed or a message to be left at my home or at my place of employment, I will notify my physician/ physician's staff of this in in writing. If there is any change in information pertaining to this consent, I will also notify my physician/physician's staff, of this in writing.

I,**TEST TEST** , also give permission to physician/physician's staff to fax any information regarding me to another physician's office that may be covering for my physician/physician's staff, or physician I may be referred to by my physician/physician's staff.

I,**TEST TEST** , also give permission to physician/physician's staff to contact my pharmacy which is **None recorded.** (Pharmacy/City) regarding my prescription(s).

TEST TEST 06/03/2022

Name & Date

TEST, Test (id #2050, dob: 09/12/2007)

TEST, TEST 09/12/07 #2050

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Partners *for* Healing

Partners for Healing is a non-profit primary care center that is committed to providing compassionate and quality health care to our patients. Services provided here at the Clinic are free of charge. These services include primary health care, physicals, nutritional counseling, and mental health counseling. The Clinic cannot treat emergencies or pregnant patients. We will treat you with respect and care and ask you to be respectful and courteous to use.

Initial/Date: **06/03/2022**

Patient Responsibility

PFH Staff are here to help you receive the best care and treatment. We need your participation and cooperation to ensure this. To better serve you, it is important that you understand our services and agree to abide by our policies. Your obligations, as the patient, are listed below please initial:

_____ **Be respectful and courteous to Partners for Healing staff at all times, including phone calls.**

_____ Update your proof of income once a year and/or if your income changes.

_____ Update your information (phone number and address) as it changes.

_____ Arrive 10 minutes prior to your appointment to update paperwork (if you are a new patient allow 30 minutes) **if you are more than 30 minutes late for your appointment you will be rescheduled for another day.**

_____ As a courtesy, you may receive a reminder call from athenanet, but it is your responsibility to record and attend all scheduled appointments.

_____ Medication Requests and Refills (Provide your pharmacy number)

- For medication refills at your local pharmacy, call at least **1 week BEFORE** medication runs out to ensure you receive refills on time. Medication and refill requests have a minimum of 1 business day of processing time. Waiting until the day you run out will not speed up the processing time.
- For medications refilled through our patient assistance program, call at least **2-3 weeks BEFORE** medication runs out to ensure you receive refills on time.
- Know what medicines you are taking and why.

_____ Allow up to 7 days to receive lab results before calling. Multiple calls will only delay our ability to respond to your request.

_____ Attend each and every scheduled appointment with a provider, specialist, and/or nurse. If you cannot keep your appointment, please cancel at least 24 hours before your appointment time. Failure to cancel before your appointment time results in a no show. Three no shows within a 12-month period will result in you no longer be able to receive a scheduled appointment.

_____ Patients who seek care in the Emergency Rooms of the local Hospitals will be responsible for the total cost of these visits. Our patients are not given a discount for these visits. **However, if one of the providers here at the Clinic refers you to the Emergency Room and gives you a referral form, those services will be discounted.**

_____ Tests & Specialty Care can be provided to our patients by Tennova Healthcare-Harton, Southern TN Medical Center, Unity Medical Center, ST. Thomas and other providers. You may be responsible for some portion of the cost for the care or test. **Please do not go to the Emergency Room for these tests.**

_____ I understand that Partners for Healing is not to be listed as an Insurance coverage. We are not a policy outside of our clinic.

I understand my obligations as a patient at Partners for Healing. I understand that failure to comply with these obligations may result in termination from this practice.

Signature: _____ Date: _____

Updated:12/28/2016