HOPE Family Health

Patient Information, Demographics & Payment Information

ALL PATIENTS MUST COMPLETE THIS SECTION

Patient's Last Name	Patient's First Name	Patient's Maiden Name	Patient's Birthdate

Patient's Street Address	City	State	ZIP Code

Patient's Home Number	Patient's Cell Phone	Patient's Social Security #

Patient's Email Address

MUST BE COMPLETED BY A PARENT OR GUARDIAN

Parent or Legal Guardian's Last Name	Parent or Legal Guardian's First Name	Relationship to Patient if Other than Parent

Parent/Legal Guardian's St. Address *(If different from than above)*	City	State	ZIP Code

Home Phone	Cell Phone	Does the Patient Live with This Person?
		☐ Yes ☐ No *If "NO" than Who:* _____

ALL PATIENTS MUST COMPLETE THIS SECTION

Patient's Payment Status ☐ Private Insurance ☐ Cover Kids ☐ Medicare ☐ Tenncare ☐ Self-Pay *(no insurance)*	Who is the Responsible Party? ☐ The Patient ☐ Someone other than the patient
PRIMARY Insurance Name	**SECONDARY** Insurance Name
Primary Insurance Subscriber's Name / Subscriber DOB	Secondary Insurance Subscriber's Name / Subscriber DOB
Subscriber's ID No.	Subscriber's ID No.
Patient's Relation to Primary Insurance Subscriber ☐ Self ☐ Spouse ☐ Child/Dependent ☐ Other	Patient's Relation to Secondary Insurance Subscriber ☐ Self ☐ Spouse ☐ Child/Dependent ☐ Other

Sign Below to verify this information is accurate:

_____ _____

Signature of Patient or Legal Guardian — Today's Date

HOPE
Family Health

Patient Name: _____ DOB: _____

Primary Language
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Ethnicity
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Other: _____
- ☐ Chose not to answer

Race
- ☐ Black / African American
- ☐ Asian
- ☐ White
- ☐ American Indian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Chose not to answer

Gender Identity
- ☐ Male
- ☐ Female
- ☐ Transgender Male (F to M)
- ☐ Tansgender Female (M to F)
- ☐ Choose not to disclose

Sexual Orientation?
- ☐ Heterosexual (Straight)
- ☐ Homosexual
- ☐ Bisexual
- ☐ Other: _____
- ☐ Choose not to answer

Any religious or cultural belief that affect your care?
- ☐ Yes ☐ No

Are you
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Are you
- ☐ Employed
- ☐ Unemployed
- ☐ Student
- ☐ Retired

Are you a veteran
- ☐ Yes
- ☐ No

Do you feel safe at Home?
- ☐ Yes ☐ No

Are you a victim of sexual trafficing?
- ☐ Yes ☐ No

Are you experiencing domestic abuse / violance?
- ☐ Yes ☐ No

Have you been to the hospital in the last 2 weeks?
- ☐ Yes ☐ No

Do you have
- ☐ Trouble getting enough to eat
- ☐ Trouble having a place to live
- ☐ Financial problems
- ☐ NONE

Housing
- ☐ Own
- ☐ Rent
- ☐ Homeless
- ☐ Group Home
- ☐ Live with friends/family
- ☐ Seasonal Migratory
- ☐ Immigrant

Do you live alone
- ☐ Yes ☐ No

If no how many in household?_____

Do you
- ☐ Have trouble hearing
- ☐ Wear a hearing aid
- ☐ Have trouble seeing
- ☐ Wear glasses / contacts
- ☐ Need help to hear or see
- ☐ NONE

Do you have
- ☐ Down's Syndrome
- ☐ Autism
- ☐ Learning disabilities
- ☐ Developmental delays
- ☐ NONE

Are you exposed to second- hand smoke?
- ☐ Yes ☐ No

Highest level of education?
- ☐ K-5 ☐ 6-8 ☐ 9-12
- ☐ Highschool ☐ College

Can you read and write?
- ☐ Yes ☐ No

Do you get help with Transportation
- ☐ U-CARTS
- ☐ Mid-Cumberland
- ☐ Must get ride with family/friend
- ☐ Other _____
- ☐ No transportation help needed

Have you fallen in the last 6 months?
- ☐ Yes ☐ No

Do you use
- ☐ Wheel Chair
- ☐ Cane
- ☐ Walker
- ☐ Other: _____
- ☐ NONE

Do you wear your Seatbelt?
- ☐ Yes ☐ No

Do you obtain routine dental care?
- ☐ Yes ☐ No

_____
Signature / Guardian Signature Date

HOPE
Family Health

Medical, Behavioral Health, Laboratory & Injection
Sliding Fee Discount Schedule
Federal Poverty Guidelines 2021

The sliding fee is a discount of charges for those who either have no insurance or who have insurance but have a high deductible. Also, it is for those whose insurance does not cover provided services. Regardless of whether you have insurance or not, you must still meet the income guidelines.

Name:_____ **DOB:** _____**Date:** _____

Sliding Fee Levels	Nominal Fee	A	B	C	D	E
Poverty Level*	<=100%	101 - 125%	126 - 150%	151 - 175%	176 - 200%	>200%
Group 1 Medical/BH	$35	$40	$50	$55	$65	Full Fee
Group 2 LAB & Injection	$6	70%	85%	90%	95%	Full Fee
Number in Family	**Nominal Fee**	**Income Level A**	**Income Level B**	**Income Level C**	**Income Level D**	**Income Level E**
1	$0 $12,880	$12,881 $16,100	$16,101 $19,320	$19,321 $22,540	$22,541 $25,760	$ 25,761
2	$0 $17,420	$17,421 $21,775	$21,776 $26,130	$26,131 $30,485	$30,486 $34,840	$ 34,841
3	$0 $21,960	$21,961 $27,450	$27,451 $32,940	$32,941 $38,430	$38,431 $43,920	$ 43,921
4	$0 $26,500	$26,501 $33,125	$33,126 $39,750	$39,751 $46,375	$46,376 $53,000	$ 53,001
5	$0 $31,040	$31,041 $38,800	$38,801 $46,560	$46,561 $54,320	$54,321 $62,080	$ 62,081
6	$0 $35,580	$35,581 $44,475	$44,476 $53,370	$53,371 $62,265	$62,266 $71,160	$ 71,161
7	$0 $40,120	$40,121 $50,150	$50,151 $60,180	$60,181 $70,210	$70,211 $80,240	$ 80,241
8	$0 $44,660	$44,661 $55,825	$55,826 $66,990	$66,991 $78,155	$78,156 $89,320	$ 89,321
For each additional person, add	$4,540	$5,675	$6,810	$7,945	$9,080	

*Based on 2021 Poverty Guidelines **MD** = Medical, **BH** =Behavioral Health, **LAB & INJ** = Laboratory & Injection

Service Categories	Comments
Group 1 MD/BH	Medical Office Visit E & M, Major/Minor Procedures, and Behavioral Health Fees
Group 2 LAB & INJ	Diagnostic Laboratory and Injection Fees

To determine the sliding fee category of the patient:

1. Match the number reported living at the home with the "number in family" category above.
2. Move across the scale until the yearly income corresponds with the income category.
3. Look at the top of the column to the fee listed. This is the amount you will pay for your office visit.
4. **REMEMBER-All family income is to be included. Income is the AMOUNT EARNED BEFORE TAXES DEDUCTED.**

HOPE Family Health

Dental Sliding Fee Discount Schedule
Federal Poverty Guidelines 2021

The sliding fee is a discount of charges for those who either have no insurance or who have insurance but have a high deductible. Also, it is for those whose insurance does not cover provided services. Regardless of whether you have insurance or not, you must still meet the income guidelines.

NAME_____DOB_____ DATE: _____

DENTAL SLIDING FEE DISCOUNT SCHEDULE

Sliding Fee Levels	Nominal Fee	A	B	C	D	E
Poverty Level*	<=100%	>100% - 125%	>125% - 150%	>150% - 175%	>175% - 200%	>200%
Poverty Level*	<=100%	101-125%	126-150%	151-175%	176-200%	>200%
Preventive Services Office Visit/Exam/X-Rays Dental Sealants Topical Fluoride	$0	$0	$0	$0	$0	Full Fee
Cleaning Cleaning Deep Cleaning (per quad)	$45	$50	$55	$60	$65	Full Fee
Additional Services Extractions (per tooth) Fillings (per tooth)	$60	$70	$80	$90	$100	Full Fee
Number in Family	**Nominal Fee**	**Income Level A**	**Income Level B**	**Income Level C**	**Income Level D**	**Income Level E**
1	$0 $12,880	$12,881 $16,100	$16,101 $19,320	$19,321 $22,540	$22,541 $25,760	$ 25,761
2	$0 $17,420	$17,421 $21,775	$21,776 $26,130	$26,131 $30,485	$30,486 $34,840	$ 34,841
3	$0 $21,960	$21,961 $27,450	$27,451 $32,940	$32,941 $38,430	$38,431 $43,920	$ 43,921
4	$0 $26,500	$26,501 $33,125	$33,126 $39,750	$39,751 $46,375	$46,376 $53,000	$ 53,001
5	$0 $31,040	$31,041 $38,800	$38,801 $46,560	$46,561 $54,320	$54,321 $62,080	$ 62,081
6	$0 $35,580	$35,581 $44,475	$44,476 $53,370	$53,371 $62,265	$62,266 $71,160	$ 71,161
7	$0 $40,120	$40,121 $50,150	$50,151 $60,180	$60,181 $70,210	$70,211 $80,240	$ 80,241
8	$0 $44,660	$44,661 $55,825	$55,826 $66,990	$66,991 $78,155	$78,156 $89,320	$ 89,321
For each additional person, add	$4,540	$5,675	$6,810	$7,945	$9,080	

* Based on 2021 Poverty Guidelines

To determine the sliding fee category of the patient:

1. Match the number reported living at the home with the "number in family" category above.
2. Move across the scale until the yearly income corresponds with the income category:
3. Look at the top of the column to the fee listed. This is the amount you will pay for your office visit.
4. **REMEMBER-All family income is to be included. Income is the AMOUNT EARNED BEFORE TAXES DEDUCTED.**

HOPE FAMILY HEALTH SERVICES FINANCIAL POLICY

Thank you for choosing HOPE Family Health to provide for your health care needs. HOPE works to improve access to primary health care in rural Middle Tennessee, focusing on its most vulnerable populations. HOPE seeks to restore dignity, faith, HOPE, and health in our patient and make them partners in the healing process.

We are pleased to be your family's primary health care provider. As part of the provider-patient relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. **It is HOPE's policy that all patients be provided a copy of HOPE's financial policy package,** to assist patients in understanding their financial obligations to HOPE. ***Please review and sign the following financial policy prior to your office visit.***

Patient Registration

It is the policy of HOPE to maintain a system for patient registration and for gathering, maintaining and reporting patient data**. All patients are required to complete or update patient demographic and insurance information with the front desk staff at each visit,** to ensure the accuracy of patient data for HOPE's billing system.

Patient Responsibilities

Your acceptance of service implies financial responsibility obligating you to ensure full payment of our already discounted fees. HOPE will apply payments to the oldest balance on the account. HOPE's finance office will process all patient or insurance payments received via mail. Any patient unable to make full payment must execute a Request for Payment Plan. **HOPE serves all patients regardless of ability to pay.**

Sliding Fee Scale Discount (SFSD) Program

HOPE will not deny requested health care services and shall not discriminate in the provision of services to an individual who is unable to pay for services, or whose services are paid for by Medicare, Medicaid, TennCare, or State Children's Health Insurance Program ("SCHIP"). HOPE will generally charge persons receiving health services at the usual and customary rate prevailing in this area. **HOPE offers a sliding fee scale discount (SFSD) program to all individuals and families with annual incomes at or below 200% of current DHHS Federal Poverty Guidelines.** To qualify for the SFSD, patients must bring to their first visit the required information verifying family size and income. A patient who does not have the information may be seen for the first visit as a Category A patient but will be required to pay full charges if not certified for their next visit. Primary Medical Services, Mental Health Services and Laboratory Services provided at HOPE Family Health, as well as any deductibles, ARE eligible for the SFSD. Co-pays, previous charges, supplies, external medical and dental lab charges, off-site medical x-rays and any other outside services are NOT eligible for a SFSD.

Insurance Claims

Patients must complete and sign information and insurance forms prior to seeing the provider. **You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.** Jf your insurance pays the claim, you will receive reimbursement from HOPE at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. According to **Tennessee Code 56-7-109**, insurers must pay a claim properly submitted on paper within 30 days or within 21 days if properly submitted electronically. You have a responsibility to provide information to our office so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf within 90 days *because of information that you have not provided*, the balance will transfer to your account and you will be responsible for payment.** If we receive payment at a later date, HOPE will reimburse you. HOPE will apply all payments received from third-party payers to specific charges associated with a specific patient and date of service.

Payment Plans

If a patient has a past due balance and cannot pay, HOPE will review the account and offer a payment plan offered, with the account tracked by billing and collection staff. Typically, the minimum payment allowed is $25, but if a patient falls at or below 100% of the Federal Poverty Level, the payment plan may offer a lower amount, such as $5 or $10, to prevent a financial barrier to care.

Discounts Available

Because it is HOPE's policy to encourage patients to pay old balances due, HOPE offers a discount for payment of amounts due if paid in full at an office visit or by contacting the billing company. **For primary care services the discount is 25% off**

the old balance due. HOPE offers discounts for essential services depending upon family size and income. You may apply for a discount at the front desk. As a courtesy, we provide you with this payment plan. However, you are ultimately responsible for payment of your bill.

Advance Beneficiary Notice (ABN)
It is HOPE's policy, prior to treatment, to inform patients of all non-covered Medicare services and the patient's responsibility for payment for those services, and to obtain documentation of the patient's acceptance of financial responsibility for those services.

Returned and Post-Dated Checks
Checks returned due to Non-Sufficient Funds will be turned over to the Finance department. HOPE does not accept or automatically write off checks previously deposited on patient accounts and returned for "non-sufficient funds" (NSF) reasons. Two NSF checks received from the same patient or account will result in the patient being placed in a **"cash only"** status for all future visits. **HOPE will accept post-dated checks as payment for HOPE services for up to 5 days (post-date hold status).**

Copies of Medical Records
It is the policy of HOPE Family Health to establish, maintain and protect a health record on each patient that has been established at HOPE Family Health. This record shall comply with all other policies and procedures of HOPE Family Health as well as Federal and State laws and regulations. Creation, destruction, storage, access to and maintenance of this record shall remain HIPAA-compliant at all times as well as compliant with all other health center policy and Federal and State laws and regulations.

Referrals
It is the policy of HOPE Family Health to follow a formal, standardized procedure for setting up referrals to other health care providers such as specialists and diagnostic centers, and for following up afterward to ensure the patient received the care ordered by the HOPE provider. HOPE staff will guide patients through the referral process, at each step ensuring they have everything they need to complete the plan of care if they so choose. **Patients must pay the entire amount of outside referrals if needed.**

Minors & Dependents
Parents and guardians are responsible for payments for their dependents at the time the service is rendered. **The parent or guardian of minors and dependents must present a valid insurance card at each visit if a claim is to be filed.** See item **Insurance Claims** above if an insurance card is not presented.

Collections
HOPE will make every effort to collect all monies due from services provided to patients by offering payment plans, as well as cash discounts for payments of accounts significantly in arrears. Patients that qualify for the sliding fee scale are established at a level of payment based on their ability to pay for services. In the collections process, as in all other aspects of HOPE's operations, patients will be treated with dignity and respect. HOPE will make all reasonable attempts to collect past due accounts using a procedure consistent with all patient types. If a patient does not make any attempt to make payments after 150 days or defaults on the payment plan, charges for medical services will be written off to bad debt. **However, HOPE will not refuse care to its patients due to their inability to pay.**

The financial policy package will be explained to patients upon their registration at HOPE. Staff will address any questions patients have on the policies and encourage them to pay in full at the time of the visit. The patient must sign that they understand and acknowledge receipt of the policy.

Printed Name: _____ Signature:_____
Patient, Parent or Legal Guardian Patient, Parent or Legal Guardian

Date: _____

HOPE Family Health
1124 New Highway 52 East
Westmoreland | TN | 37186

615.644.2000 | OFFICE
615.644.2078 | FAX
info@hopefamilyhealth.org | EMAIL
hopefamilyhealth.org | ONLINE

Release of Medical Records Form (ROR)

1. Who is the patient?

Patient Last Name	Patient First Name	Patient Middle Initial
Patient ID Number (SSN)	Patient Date of Birth (MM/DD/YYYY)	

CHECK ONE: ☐ I am the patient Filling out this form **OR** ☐ I have the legal right to act for the patient. *(If not the patient, check one below:)*
I am the patient's: ☐ Parent **OR** ☐ Guardian **OR** ☐ Other
if other, describe relationship to patient: _____

2. Health care facility requesting and / or releasing records

Name of health facility requesting or releasing records		Phone Number (with area code)
HOPE FAMILY HEALTH		**615-644-2000**
Address **1124 HWY 52 East OR** **10427 HWY 52 West**	City, State, and Zip Code **WESTMORELAND TN 37186**	**Fax Number (with area code)** **615-644-2078**

3. What health information to/from whom is HOPE authorized to RELEASE or REQUEST

. Provide those details below:

PROVIDER WHO MANAGED THE CARE:	DATE RANGE OF CARE:	DESCRIPTION OF HEALTH CARE INFORMATION

Be advised that this AUTHORIZATION may include prescribing history, both past and present. If applicable, this AUTHORIZATION may also include health information about any alcohol and/or drug treatment, HIV/AIDs status, Sexual/physical/mental abuse history.

4. Why are you authorizing this RELEASE or REQUEST?

Simply state what the reason for this authorization. Is it for OR from a referral of another health care provider or specialist? Is it for diagnostic testing or imaging? Is it to request records from a hospital stay?

CONTINUITY OF CARE ☐ ***OTHER*** ☐

5. When does my AUTHORIZATION end?

Your authorization (given by completing and signing this form) will self-expire by law one year from the date the authorization was given. If you wish to revoke your permission sooner, you must notify Hope in writing.

6. Your RIGHTS and other Important Information

1. **Giving your authorization to RELEASE or REQUEST your health information is your choice. You do not have to share your health information.**
2. **You are not required to give this authorization for this purpose. You will still get benefits and treatment at HOPE that can be provided to the extent your health care provider is comfortable with making decisions without this authorization.**
3. **If you choose to revoke your consent authorized by this form, you must do so by notifying HOPE in writing. You must express this by writing to: HOPE Family Health | Attn: Health Records | 1124 New Hwy 52 E | Westmoreland | TN | 37186**
4. **If you revoke this authorization, be aware that it will not take back the health information we have already shared or received. HOPE will however stop any additional REQUESTS or DISCLOSURES.**
5. **If we share your health information with the authorized parties you named above, HOPE has no ability to ensure they act responsibly within the confines of state and federal patient privacy laws.**
6. **If the patient has an authorized representative, legal proof must be provided showing this individual can act for you. A representative signs for a patient who may not legally sign on his or her own behalf.**
7. **If the patient is less than 18 years old, a parent or guardian should sign for the minor.**

8. Patient's signature of AUTHORIZATION?

I give my AUTHORIZATION to HOPE Family Health to RELEASE or REQUEST my health information for the purposes and to/from the parties indicated on the first page of this form. By completing and signing, this form expires when you inform HOPE that you wish to revoke your permission to use it. Otherwise, this authorization will self-expire by law one year from the date the authorization was given. Indicate your AUTHORIZATION by signing below:

Signed by: _____

Signature of Patient or Legal Guardian *(if patient is under the age of 18)* / Authorized Patient Representative

Patient Name: _____

Printed Name of Patient

Legal Guardian: _____

Printed Name of Legal Guardian *(if patient is under the age of 18)* / Authorized Patient Representative

Today's Date: _____

Printed date this form was signed

You may fax medical records to 615-644-2078

HOPE Family Health
1124 New Highway 52 East
Westmoreland | TN | 37186

615.644.2000 | OFFICE
615.644.2078 | FAX
info@hopefamilyhealth.org | EMAIL
hopefamilyhealth.org | ONLINE

Patient Name: _____ DOB:_____

Notice of Privacy Practices

Patient Acknowledgement of Receipt

By signing this form, *I acknowledge that I have been offered a copy of HOPE's Notice of Privacy Practices. I also understand that at any time during the coordination of my care here at HOPE, I can obtain a copy of this Notice by asking any member of the HOPE team.*

By signing this form, *I acknowledge my understanding that HOPE's Notice of Privacy Practices provides information about how the health center and their care team may use and disclose my protected health information while carrying out tasks involved with the coordination of my care; which includes providing treatment, collecting payment and carrying out health care operations (TPO).*

_____ **Date:** _____
Patient or Guardian Signature

Students

HOPE FAMILY HEALTH encourages and promotes learning. Hope fosters students and is often a preceptor site for various nursing, provider, dental, behavioral health, pharmacy and various other students**. IF YOU DO NOT WISH TO HAVE A STUDENT** INVOLVED IN YOUR CARE, PLEASE LET THE RECEPTIONIST KNOW by writing a brief statement indicating that you do not want a student involved in your care. You must provide this notice at EACH office visit.

- By initialing this, you are acknowledging that you have been notified of this procedure and understand that it is your responsibility to notify staff if you do not want a student involved in your care**.** _____ **Initial**

Prescription History Consent

Hope Family Health is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using or have used in the past in order to provide the best possible treatment.

By signing this consent, you are agreeing that Hope Family Health may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Hope Family Health to obtain my prescription history.

_____ Date: _____
Patient or Guardian Signature

HOPE Family Health
1124 New Highway 52 East
Westmoreland | TN | 37186

615.644.2000 | OFFICE
615.644.2078 | FAX
info@hopefamilyhealth.org | EMAIL
hopefamilyhealth.org | ONLINE

Patient Name: _____ Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

THIS CONSENT IS FOR MEDICAL & DENTAL SERVICES & PHARMACY & CLINICAL PHARMACY

The individual whose signature appears below hereby attests to the following statements: *With my consent, HOPE Family Health, clinical staff, pharmacy and clinical pharmacist may use and disclose my protected health information (PHI), within the regulatory allowances of HIPAA and Tennessee Healthcare law. Any and all use and disclosure will be for the purposes of coordinating my health care needs; which includes providing treatment, collecting payment and carrying out health care operations (TPO). I always have the right to access and receive a copy of HOPE's Notice of Privacy Practices for a more complete description of such uses and disclosures.*

Please indicate name, contact numbers, and the relationship of individuals to whom HOPE Family Health may release your protected health information

HOPE has my full consent to disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Emergency Contact- This is someone not in your household or that does not have the same phone number as the patient.

Name:	Relationship:	Home #:	Cell #:

Person's HOPE may share information with:

Name:	Relationship:	Home #:	Cell #:

I understand that I have the right to review and receive a copy of HOPE's Notice of Privacy Practices prior to signing this consent. HOPE reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained at any HOPE location.

CONSENT FOR CALLS AND TEXT MESSAGES: *With my consent, HOPE and all HOPE departments may call or text the phone numbers I provide, and may leave messages on my voice mail or with a person in reference to any item that may assist HOPE staff in carrying out the coordination of my care. This includes calls regarding appointment reminders, preventative care reminders, insurance questions, and any calls pertaining to my clinical care, including laboratory results and pharmacy, among others.* I agree to receive telemarketing messages using an automatic telephone dialing system or an artificial or pre-recorded voice. *IF I CHOOSE NOT TO GRANT HOPE THIS CONSENT, I understand that granting this consent is not a requirement as a condition of receiving goods or services. I also understand that by refusing consent, Hope staff may not be able to reach me to notify me of vital information which may impact my health. If I CHOOSE TO REFUSE CONSENT, I must submit this refusal in writing. I understand and accept the risks related to sending PHI thru text messages.*

CONSENT FOR MAIL: *With my consent, HOPE and all HOPE departments may mail to my home or other designated location any item that may assist HOPE staff in carrying out the coordination of my care. This includes items such as appointment reminder and patient statements as long as they are marked CONFIDENTIAL, in addition to other HIPAA compliant communication.*

CONSENT FOR E-MAIL: *With my consent, HOPE and all HOPE departments may send e-mail to my designated e-mail address any message that may assist HOPE staff in carrying out the coordination of my care. I understand and accept the risks related to sending PHI to a personal email address.*

HOPE may contact me for the purposes of coordinating my health care needs; which includes providing treatment, collecting payment and carrying out health care operations (TPO). This also includes communication regarding clinical care, including laboratory results, pharmacy, clinical pharmacist, referrals and other communication from my medical provider(s).

I have the right to request that HOPE restrict how it uses or discloses my PHI to carry out the coordination of my care, However, HOPE is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am giving my full consent to HOPE to use and disclose my PHI within the regulatory allowances of HIPAA and Tennessee Healthcare law, so long as any and all use and disclosure will be for the purposes of coordinating my health care needs. I understand that I may revoke my consent in writing except to the extent that HOPE has already made disclosure in reliance upon my prior consent. If I do not sign this consent, I understand that my health may be impacted by the inability of Hope's staff to reach me to convey important information and I will not hold Hope or its staff accountable.

_____ _____

Signature of Patient or Legal Guardian Today's Date

HOPE
Family Health

Patient Name:_____ **DOB:**_____

General Medical Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, pharmacy, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment by Hope's medical staff, behavioral health staff, pharmacy staff, and clinical pharmacist.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your providers, pharmacist, clinical pharmacist and other clinical staff about the purpose, potential risks and benefits of any test, referral, medication or any other treatment ordered for you. If you have any concerns regarding any treatment recommend by your health care provider, pharmacist, clinical pharmacist or other clinical staff, we encourage you to ask questions.

I voluntarily request a physician, mid level provider, pharmacist, clinical pharmacist and other health care staff or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

Signature of Patient or Personal Representative Date:

_____Date: _____

Printed Name of Patient or Personal Representative Relationship to Patient

_____

Informed Consent for Telehealth Services

I, _____, understand that Telehealth is the use of electronic information and communication technologies (including video conference, smart phone application or telephone conversation) by a healthcare or mental health provider to deliver services to a patient at a different site than the provider.

I understand that Telehealth has many benefits, including easier access to healthcare and/or mental health care without having to travel out of my local health care community.

I understand that it is HOPE's policy that all prospective Telehealth patients have an in-person consultation with a HOPE provider at a HOPE office prior to beginning virtual visits. This applies both to established and first-time HOPE patients. Thereafter, HOPE requires any patient wishing to continue Telehealth visits to have at least one in-person visit at a HOPE site per year.

I understand that my provider may be limited in how thoroughly he or she can examine me via Telehealth, and that even after a Telehealth consultation I may still need to have a face-to-face consultation due to my medical condition. I understand that in rare cases, a telemedicine visit may result in a worse medical outcome than an in-person visit due to inability to perform a complete physical exam or perform office-based testing, and I am willing to accept that risk.

I understand that a risk of Telehealth includes technical difficulties that might result in insufficient transmission of information and/or delays in medical evaluation and treatment.

I understand that all federal and state laws that protect my privacy and confidentiality of medical information also apply to Telehealth. I understand that in rare instances, security protocols may fail, causing a breach of privacy of my personal medical information.

I understand that if I have health insurance, my insurance carrier will have access to my medical/mental health records. I understand that I will be responsible for any applicable payment for any services rendered through Telehealth just as I would be for an in-person visit, including deductible, copayment or coinsurance, or any charges not covered by my insurance. I authorize HOPE Family Health to file any claims for payment to my insurance.

I understand I am responsible for preparing a confidential space in which to have my Telehealth visit, and to inform my provider of any other persons in the location, either on or off camera, who might be able to see or hear my Telehealth session. I agree to ensure any artificial intelligence devices, including Alexa or Echo, will be disabled or not in the location of my telehealth visit. I agree not to make a recording of this visit without my medical provider's permission.

I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment, or to any insurance or program benefits to which I am entitled.

I have reviewed this consent form, I have received answers to any questions I might have had, and I consent to the provision of my healthcare by means of Telehealth.

_____ _____

Patient or Parent/Guardian signature Date