Patient Intake Information

General Information

First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
County:	Birthdate:	Social Security #:	
Email address:			
Home Phone:	Work Phone:	Cell Phone:	

Marital Status: □Married □Single □Widowed □Divorced □Separated

Emergency Contact- This is someone who does not have the same phone number as the patient. An "emergency contact" is simply a person a healthcare provider can contact in an emergency situation to relay critical information about the patient's health.

Name:	Relationship:	Cell #:	Secondary #: (work, home)

Consent for Communications

While receiving care at HOPE, my care team may need to contact me for the purposes of coordinating my health care needs; which includes providing treatment, collecting payment and carrying out health care operations . This also includes communications regarding clinical care, including laboratory results, pharmacy, psychiatry, referrals and other communications from my provider(s).

CONSENT FOR CALLS AND TEXT MESSAGES: *With my consent, HOPE may call or text the phone numbers I provide and may leave messages on my voicemail 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..* I agree to receive messages using an automatic telephone dialing system or an artificial or pre-recorded voice. *I understand that granting this consent is not a requirement or a condition to receive services at HOPE. 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. I understand and accept the risks related to sending PHI thru text messages.* **□I Consent □I DO NOT Consent**

CONSENT FOR MAIL COMMUNICATION: *With my consent, HOPE 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 reminders and patient statements as long as they are marked CONFIDENTIAL, in addition to other HIPAA compliant communication.* **□I Consent □I DO NOT Consent**

CONSENT FOR E-MAIL AND PORTAL COMMUNICATION: *With my consent, HOPE may send e-mails to my designated e-mail address with 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 and understand that HOPE will always encrypt email messages containing PHI for my security. Additionally, if I choose to sign up for the patient portal, I agree to communicate with my provider and care team via the portal, understanding that it is a secure and efficient method of communication about my healthcare.*

Pharmacy Name:	**City:**	**Phone #:**

FQHC-Required Demographic Information

It is the policy of HFH to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race: □White □Asian □Black/African American □Native Hawaiian □Pacific Islander □Other:

Ethnicity: □Hispanic or Latino □Non-Hispanic or Latino □Other:

Are you a veteran? □ Yes □No **Are you homeless?** □Yes □No

Do you work in Agriculture? □Migrant Worker □Seasonal Worker □None **Are you a refugee/asylum?** □ Yes □ No

Preferred Language:_____ **Do you need an Interpreter:** □ Yes □ No

Sexual Orientation: □Straight □Bisexual □Lesbian/Gay □Something Else □Don't Know □Choose not to Disclose

Gender Identity: □Male □Female □Transgender Male (F ➡M) □Transgender Female (M ➡F) □Choose not to disclose

Insurance Information

Do you currently have health insurance? □ Yes □No Dental Insurance? □ Yes □No Behavioral Health Insurance? □ Yes □No

Subscriber No.: **Group No.:**

Policyholder's Information:	Name:		Birthdate:	Social Security #:
Mailing Address:	City:	State:	Zip:	
Name of Individual Responsible for payments:			**Relationship:**	

Signature: _____ **Date:** _____

Printed Name of Guardian: _____

Patient and Center Rights and Responsibilities

Welcome to HOPE Family Health. Our goal is to restore dignity, faith, HOPE, and health in those we serve by making them partners in the healing process and providing them with loving, compassionate care. As a patient, you have rights and responsibilities. We have rights and responsibilities as well. We want you to understand these rights and responsibilities so you can help us provide better healthcare services for you. Please read this statement and ask us any questions that you might have.

Human Rights: You have the right to be treated with respect and dignity regardless of race, ethnicity, religion, sex, national origin, sexual orientation, gender identity, political affiliation or ability to pay for services.

Payment for Services: You are required to complete the registration process to determine if you are eligible for discounted fees for services. You are required to give us accurate information about your present financial status and any changes in your financial status as they occur. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, and/or identify other benefits for which you may be eligible. You have the right to receive explanations of your bill. You must pay, or arrange to pay, all agreed fees for all HOPE services, as provided by our policies.

Federal law prohibits us from denying you primary health care services, which are medically necessary, solely because you cannot pay for these services. However, you are responsible for your fees and need to act in good faith to make arrangement for payment of services received.

Privacy: You have the right to have your interviews, examinations, and treatments in privacy. Your medical records are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached in the Notice of Client Privacy Rights. By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you under the Health Insurance Portability and Accountability Act.

Health Care: You are responsible for providing us with complete and current information about your health status, so we can provide you proper healthcare. You have the right to, and are encouraged to, participate in decisions about your treatment.

You have the right to information and explanations in the language you normally speak and in words that you understand. You have the right to information about your health or illness, treatment plan (including risks) and expected outcome, if known. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to a legally authorized person.

You have the right to information about Advance Directives. At this time, would you like information about Advance Directives? If yes, additional information will be provided to you. If you stated no, you may request this information at another time.

You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments, and only requesting a walk in appointment when you are ill. We may not be able to see you unless you have an appointment. If you do not understand or cannot follow the staff's instructions, please tell us so we can help you.

If you are an adult, you have the right to refuse treatment to the extent permitted by law, and to be informed of the risks of refusing such care. You are responsible for the outcome of refusing treatment.

You have the right to healthcare and treatment that is reasonable for your condition and within our capability. You have the right to be transferred or referred to another facility for services that we cannot provide. However, HOPE Family Health is not required to pay for services that you get elsewhere. Note: HOPE Family Health is not an emergency facility.

If you are in pain, you have the right to receive appropriate assessment and management, as necessary.

HOPE Family Health Rules: As with any organization, HOPE Family Health has rules for use of our services. Patients are responsible for understanding the rules and using our services in an appropriate manner. HOPE Family Health property and services may not be abused and it is an expectation that all patients treat our employees and facilities with respect. If you have any questions, please ask.

Parents are responsible for the supervision of children brought with them to HOPE. You are responsible for their safety, the protection of other clients, and our property. Please do not leave your children unattended.

You have a responsibility to keep your scheduled appointments and contact us at least 24 hours prior to your appointment if you know you will not make your appointment. Missed scheduled appointments cause a delay in treating other patients. If you do not keep scheduled appointments twice (2) in three (3) months, you will be notified and warned. After your third missed appointment, you will only be able to schedule an appointment with your providers authorization. Four or more no shows may lead to termination of services.

Complaints: If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. We will tell you how to file a complaint. Completed Client Suggestion/Complaint forms shall be reviewed by the appropriate department director. You shall receive a response from HOPE by mail or phone regarding the outcome of your complaint or suggestions. If you are not satisfied with how we handle your complaint, you may file a complaint with the appropriate staff member of HOPE. At no time will your complaint affect the care you are entitled to receive.

Termination: HOPE Family Health can decide to stop treating you as a patient. If we stop treating you as a patient, you have the right to advance notice that explains the reason for the decision, and will be given 30 days to attempt to find other health services. After notice of termination, we will only provide urgent care for a 30-day period while you find a new provider. We can decide to stop treating you immediately and without notice if HOPE has determined that you have created a threat to the physical or emotional safety of the staff and/ or other clients. You also have the right to receive a copy of HOPE Family Health's termination policy. Other reasons for which we may stop seeing you include but are not limited to:
Failure to obey HOPE Family Health's rules, Intentional failure to report accurate information concerning your health, Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your doctor, Creating a threat to the physical or emotional safety of the staff and/or other clients, and/or Intentional failure to accurately report your financial status.
If we have given you notice of termination, you have the right to appeal the decision to the HOPE Family Health Board of Directors within 30 days of receipt of that notice.

Signature: _____ **Date:** _____
Printed Name of Guardian: _____

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 patients making them partners in the healing process.
We are pleased to provide you and your family health care services. 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 are provided a copy of HOPE's financial policy package, in order to assist patients in understanding their financial obligations to HOPE.
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 HOPE staff at each visit, to ensure the accuracy of patient data for HOPE's communication systems.
Patient Responsibilities Your acceptance of services implies you are accepting financial responsibility 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 submit 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 prevailing rate 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 N patient but will be required to pay full charges if not certified for their next visit. Primary Medical, Behavioral Health, Radiology, Contract Dental, and Laboratory Services provided through HOPE Family Health, as well as any deductibles, are eligible for the SFSD. Co-pays, previous charges, supplies, external medical and dental lab charges, and any other offsite services are NOT eligible for a SFSD.
Insurance Claims Insured patients must complete and sign 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. If 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 insurance payers to the specific charges associated with the 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 with the understanding the Account will be 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 As 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 all HOPE 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.

Collections and Refusal to Pay 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. Patients may be dismissed from HOPE services for refusing to pay fees. Refusal to pay is defined as 1) a patient who verbally expresses an unwillingness to pay; 2) a patient who fails to communicate HOPE even after attempts to call, mail statements, and in-person conversations about their account balance have been made by HOPE staff; 3) a patient who displays consistent non-compliance with the sliding fee scale policy and/or with monthly payment plans; or 4) a commercially-insured patient who refuses or is otherwise unwilling to pay their copay, deductible, or co-insurance who has the ability to pay. However, HOPE will not refuse care to its patients due to their inability to pay.

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 (NSF) will be turned over to the HOPE Finance Department. HOPE does not accept or automatically write off checks previously deposited on patient accounts and returned for NSF reasons. Two NSF checks received from the same patient or account will result in the patient being placed on 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 all health records on each patient who has been established at HOPE Family Health. Creation, destruction, storage, accesses, and maintenance of this record shall remain HIPAA-compliant at all times as well as compliant with all other health center policies and Federal and State laws and regulations. Patients may request copies of their health records at any time. Usually, the first request for records is free of charge; requests thereafter will incur a $0.25 fee per page fee. First requests that exceed 10 pages will incur the same fees as a result of the cost and burden on HOPE to fulfill the request.

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. HOPE has established relationships with some specialty providers to offer discounts to HOPE patients, however this may not be applicable to all referring providers. Patients are financially responsible for the cost of care provided through referrals outside of HOPE.

Minors & Dependents Parents and guardians are responsible for payments for the services their dependents receive 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. Minors and dependents are eligible for the HOPE sliding fee discount program based on household eligibility.

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.

By signing, I understand and acknowledge receipt of the policy.

Signature: _____ **Date:** _____

Printed Name of Guardian: _____

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 at HOPE, I can obtain a copy of this Notice by asking any member of my HOPE care team.*

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

Notice to Patients of Federal Confidentiality Requirements under 42 CFR Part 2

Patient Acknowledgement of Receipt: By signing this form*, I acknowledge that I have been offered a copy of HOPE's Notice to Patients of Federal Confidentiality Requirements under 42 CFR Part 2 of HOPE Family Health Services. I also understand that at any time during the coordination of my care at HOPE, I can obtain a copy of this notice by asking any member of my HOPE care team.*

By signing this form*, I acknowledge my understanding that HOPE's Notice to Patients of Federal Confidentiality Requirements under 42 CFR Part 2 of HOPE Family Health Services provides information about how health information about you may be used and disclosed; your rights with respect to your health information; and how to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information. You have a right to a copy of this notice (in paper or electronic form) and to discuss it with HOPE's Privacy Officer if you have any questions.*

Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

Patient Acknowledgement of Receipt: By signing this form*, I acknowledge that I have been offered a copy of HOPE's Notice of Non-Discrimination. I also understand that at any time during the coordination of my care at HOPE, I can obtain a copy of this Notice by asking any member of my HOPE care team.*

By signing this form*, I acknowledge my understanding that HOPE's Notice Informing Individuals About Non-Discrimination and Accessibility Requirements and Non-Discrimination Statement provides information about the availability of language assistance services and auxiliary aids and services for individuals with limited English proficiency.*

Signature: _____ **Date:** _____

Printed Name of Guardian: _____

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 care. 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.

Appointment and No Show Policy

HOPE is committed to providing prompt medical care to all of our patients. We understand that situations arise in which patients must cancel their appointments. It is requested that patients who must cancel their appointments provide at minimum a 24 hour notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made in less than 24 hours, we are usually unable to offer that appointment slot to other patients who wish to be seen. Patients who do not show up or call to cancel their appointment will be considered a NO SHOW.

A NO SHOW is when a patient fails to keep a scheduled appointment or is more than 15 minutes late. Patients are advised to arrive 30 minutes prior to their scheduled appointment to allow time for parking, check-in and required paperwork.
If the patient is delayed and cannot make an appointment on time, the patient must call to advise us of the situation and provide an estimated time of arrival. Any significant delay may require the patient to wait for the next available appointment, which may be with a different provider. If none become available, the patient will be rescheduled.
In the event that a patient has a special circumstance regarding a missed appointment, the patient may contact the Front Office Manager. We understand that there may be issues beyond the patient's control and want to be understanding of special circumstances.
Patients who no show two times in three months will be sent a warning letter. If a patient no shows three times, it will require the
provider's authorization to schedule an appointment. If a patient no shows four times, it may result in termination of services. When making an appointment, adult patients must choose between a well visit or a sick visit since both cannot be accommodated on the same day since the patients' insurance often may not pay for both. Only pediatric patients can have both types of visit on the same day.
Due to the current nature of insurance-based medical practices, we ask that patients limit their medical problems to 1 TO 2 ISSUES only. Should the patient have more medical issues that need to be addressed, the patient must inform our staff when calling for appointments. Our providers may request patients to return for follow-up visits in order to address additional medical concerns. Multiple family member appointments must be scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, will be required to schedule an appointment at a later time. Up to 3 members of the family may be scheduled at any one time.
I have read & received a copy of HOPE Family Health's Appointment and No Show Policy.

Signature: _____ **Date:** _____

Printed Name of Guardian: _____

General Patient Consent

Consent to Treat: I hereby voluntarily consent to all healthcare and behavioral health services ordered/provided by HOPE Family Health Services providers at any HOPE service location. The healthcare service may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical, behavioral health and/or dental treatment; routine laboratory procedures and test; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The healthcare services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered and that I will receive a "Vaccine Information Statement" (VIS) prior to the administration of each vaccine. I understand that there is a separate consent form that I may be asked to sign for testing for infections conditions.

I understand that if this consent is being signed on behalf of a minor, I may be required to sign a separate paternal consent form in order for the minor to receive certain services.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time, or until HOPE changes its services or asks me to complete a new consent form.

I understand that if this consent is being signed on behalf of a minor, this consent is valid until the minor turns 18, at which time the minor must consent for services on their own behalf. I also understand that HOPE abides by Tennessee mature minor consent laws as outlined in 724 S.W.2d. 739 (Tenn. 1987)) and as such I understand that for certain services my minor child may be able to consent on their own if they are deemed mature enough.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that Student Providers may be involved in treatment and I consent thereto. HOPE Family Health encourages and promotes learning. HOPE fosters student education opportunities and as such is often a preceptor site for various education programs including nursing, physician assistant, nurse practitioner, dental, behavioral health and pharmacy. **If you do not wish to have a student involved in your care, please let a member of your care team know**. By signing below, you are acknowledging that you have been notified and understand that it is your responsibility to notify your care team.
4. I understand that HOPE primarily utilizes a midlevel provider model where the majority of medical services and treatment is administered by Physicians Assistants and Nurse Practitioners and I consent thereto.
5. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
6. I hereby voluntarily give my consent to treatment at HOPE Family Health.

Printed Name of Patient | **Patient Date of Birth**

Signature of Patient, Guardian or Power of Attorney | **Date**

Patient Consent for Communications and Use and Disclosure of Protected Health Information

FOR MEDICAL, PSYCHIATRY,DENTAL,& PHARMACY SERVICES

The individual whose signature appears below hereby attests to the following statements: *With my consent, my HOPE Family Health care team may use and disclose my protected health information (PHI), within the regulatory allowances of HIPAA and Tennessee Healthcare law. I understand that 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. I also understand that I have the right to edit this document at any time by requesting a new document from my HOPE care team.*

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

Even if you have listed someone under Emergency Contact in the section prior, that person would still need to be listed here as someone we can communicate with in detail. An "emergency contact" is simply a person a healthcare provider can contact in an emergency situation to relay critical information about the patient's health, while someone with "communication rights to access health information" has legal authorization to access and discuss detailed medical records about the patient. Whomever you list below will have communication rights to access your health information until this form is updated.

Verbal communication can be shared with the following individuals:

Name:	Relationship:	Phone #:	Type of information to be released
			All or Limited To:_____
			All or Limited To:_____
			All or Limited To:_____
			All or Limited To:_____
			All or Limited To:_____

I understand that I have the right to request that HOPE restrict the way it uses or discloses my protected health information and will use reasonable efforts to accommodate these requests.

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 for communications, and information use and disclosure at any time except to the extent that HOPE has already made disclosure in accordance with 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 liable.

Signature: _____ **Date:** _____

Printed Name of Guardian: _____

Release of Medical Records Form (ROR)

'Medical Records' includes all health care records, including Behavioral Health records.
This excludes Psychotherapy Notes. Requests for Psychotherapy notes require additional consent.

1. Patient Information

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 Records OR ☐ Releasing Records

Name of health facility requesting or releasing records		Phone Number (with area code)
HOPE FAMILY HEALTH SERVICES		615-644-2000
Address 1124 HWY 52 East OR 10427 HWY 52 West 300 Steamplant Rd. Ste #210	City, State, and Zip Code WESTMORELAND TN 37186 OR GALLATIN TN 37066	Fax Number (with area code) 615-644-2078

By initialing, I authorize the following to be released in addition to the specifics below:
___BH Related Records (Diagnoses, Lab/Procedure/DI Results and Medication List)

3. Health Care Facility ☐ Requesting Records OR ☐ Releasing Records

PROVIDER NAME	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 addiction treatment, communicable disease status, or abuse history.

4. Why are you authorizing this RELEASE or REQUEST?

☐ *Referral* ☐ *Diagnostic Testing/Imaging* ☐ *Other*
☑ *Continuity of Care* ☐ *Personal Information Request*

5. Authorization Period

Your authorization (given by completing and signing this form) will expire one year from the date the authorization was given. If you wish to revoke your permission sooner, you must notify HOPE in writing. If you wish to edit your authorization, you may request a new form at any time.

6. Your Rights and Other Important Information

a. Giving your authorization to RELEASE or REQUEST your health information is your choice. You do not have to share your health information.

b. You are not required to give this authorization in order to receive services at HOPE. You will still receive all the benefits and treatment at HOPE that can be provided to the extent your health care provider is comfortable with making decisions without this authorization.

c. 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

d. 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.

e. 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.

f. If the patient has an authorized representative, legal proof must be provided showing this individual can act for you. A representative is someone who signs and makes decisions on behalf of a patient who may not legally do so on their own behalf.

g. If the patient is less than 18 years old, a parent or guardian should sign for the minor unless the minor is seeking care for services by which the minor is allowed under TN 724 S.W.2d. 739 (Tenn. 1987)) to consent.

7. Patient's Authorization

By completing and signing this form, I understand that 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 this form. I understand that this form expires one year from the date the authorization was given. I also understand that at anytime I may change the contents of this form by requesting a new form or by revoking my permission for HOPE to use it by notifying HOPE in writing.

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

HOPE FAMILY HEALTH

Medical, Behavioral Health, Lab & Injection, X-Ray, Mammo
Sliding Fee Discount Schedule
Federal Poverty Guidelines 2026

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%
Medical/Behavioral (1)	$40	$45	$55	$60	$70	Full Fee
Diagnostic Lab & Injection (2)	$10	75%	80%	$85%	90%	Full Fee
Lab Referral (3)	$20	75%	80%	85%	90%	Full Fee
Radiologist & Dietician Fee	$15	$20	$25	$30	$35	Full Fee
Mammography	$50	$60	$70	$80	$90	Full Fee
CCM, BHI and TCM	$0	$0	$0	$0	$0	Full Fee
Number in Family	Nominal Fee	Income Level A	Income Level B	Income Level C	Income Level D	Income Level E
1	$0 $15,960	$15,961 $19,950	$19,951 $23,940	$23,941 $27,930	$27,931 $31,920	$ 31,921
2	$0 $21,640	$21,641 $27,050	$27,051 $32,460	$32,461 $37,870	$37,871 $43,280	$ 43,281
3	$0 $27,320	$27,321 $34,150	$34,151 $40,980	$40,981 $47,810	$47,811 $54,640	$ 54,641
4	$0 $33,000	$33,001 $41,250	$41,251 $49,500	$49,501 $57,750	$57,751 $66,000	$ 66,001
5	$0 $38,680	$38,681 $48,350	$48,351 $58,020	$58,021 $67,690	$67,691 $77,360	$ 77,361
6	$0 $44,360	$44,361 $55,450	$55,451 $66,540	$66,541 $77,630	$77,631 $88,720	$ 88,721
7	$0 $50,040	$55,041 $62,550	$62,551 $75,060	$75,061 $87,570	$87,571 $100,080	$ 100,081
8	$0 $55,720	$55,721 $69,650	$69,651 $83,580	$83,581 $97,510	$97,511 $111,440	$ 111,441
For each additional person, add	$5,680	$7,100	$8,520	$9,940	$11,360	

*Based on 2026 Poverty Guidelines – Federal Register / Vol. 91, No. 10 / Thursday, January 15, 2026
MD = Medical, **BH** =Behavioral Health, **LAB & INJ** = Laboratory & Injection

Service Categories	Categories
Group 1 (Medical & Behavioral Health)	Medical Office Visit E & M, Major/Minor Procedures & Behavioral Health Fees
Group 2 (Diagnostic Labs & Injections)	Diagnostic Labs & Injections
Group 3 Moderate Complexity Labs - Referrals	Lab referrals are medical diagnostic labs performed off site by AEL or other reference labs
Radiologist Fee	For sliding fee patients less than level E, the X-ray charge will be waived. Patient will be responsible for the reading of the X-Ray (Radiologist Fee).
CCM, BHI and TCM	Chronic Care Management, Behavioral Health Integration, Transitional Care Mgmt.

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.**

Board Approved: January 28, 2026 Effective: February 1, 2026

How We Use Computer-Assisted Decision Support in Your Care

At HOPE Family Health we are trialing a computer-assisted documentation support (also referred to as Artificial Intelligence or AI) to help providers keep better records of your medical care and deliver more efficient care. This means that smart computer systems help document the conversations you have with your provider.

However, these computer systems do not make final decisions about your health. We follow the Copilot Principle, which means a licensed doctor or healthcare provider always reviews and approves any recommendations before making decisions about your care.

How Computer-Assisted Decision Support Helps You

- Here are some ways these tools assist in your healthcare:
- **Keeping health records organized** – Our system helps providers organize your visit note more efficiently and gives them more time to listen to you and your concerns

Your Privacy and Security Are Our Priority

Your health information is protected and secure. We follow strict privacy rules to keep your data safe when using computer-assisted decision support.

- We follow all privacy laws (like HIPAA) to protect your medical information.
- We do not sell your data to anyone.
- Only authorized providers and healthcare staff can use the information from these systems.

Your Rights

You have the right to:

- Know when computer-assisted decision support is used in your care.
- Ask for a provider to review any computer-assisted recommendations.
- Choose not to use computer-assisted decision support (when possible).
- Ask how your health information is kept private and secure.

HOPE
FAMILY HEALTH

How We Use Computer-Assisted Decision Support in Your Care

If you have any questions about how we use these systems or how your privacy is protected, please ask a staff member or contact Kaleigh Chitwood, Director of Operations.

Email: kaleighchitwood@hopefamilyhealth.org

Phone: 615-644-0664

Please sign below to signify your acknowledgement of the above policy. Your signature also confirms consent for your care team to utilize AI services.

Printed Name: _____

Signature: _____

Date & Time: _____

TO OUR CUSTOMERS: This notice tells you how your health information is used and disclosed and what your rights are regarding your information. Please read it carefully.

This notice applies to all records of your care created by HOPE Family Health, whether made by the facility or another facility-related provider. Our policies to protect your health information apply to medical providers, psychology providers and therapists, pharmacists, nurses and other health care personnel who need to know to provide care to you. These policies apply to all areas of the center, including all center staff, reception, finance and administration. It also applies to any organization or person we contact for services, such as referral providers.

Your Protected Health Information. As our patient, we create paper and electronic medical records and documents related to you and your health, as well as the care and services we provide to you. We need this record to provide the best care and comply with certain legal requirements. We are required by law to:

o Make sure that your protected health information is kept private,

o Provide you with this Notice of Customer Privacy Rights, and

o Make sure the law and your legal rights are in force.

YOUR PRIVACY RIGHTS

You have the right to:

Request Confidential Communications from us. We will not disclose your health information except as described in this notice. You may ask us to contact you at a different address or telephone number. You can ask us to limit the number or type of people who have access to your health information. If you do not want us to contact you at your current address or telephone number, YOU MUST INFORM US. Please make this request in writing to HOPE Family Health, ATTN: Navigator, Medical Records.

Confidential Services of us. We are required to protect your privacy while you are in our buildings. We cannot reveal to anyone whether or not you are a HOPE client, have an appointment, or are in our buildings. If you expect someone to call or come pick you up, give you a ride, or be with you during your appointment, YOU MUST TELL US. We need your permission to release this information

Inspect and Copy your Health Information. You may request to review and obtain a copy of your health information that the facility maintains for as long as we maintain it. If you request to review your health information, we will determine whether to allow you to review some or all of the health information you request. We may charge you a fee for any copies you request. Please make this request in writing to HOPE Family Health, ATTN: Navigator, Medical Records.

Request a limit on the health information we disclose. You can ask us not to use or disclose your health information. Your request must describe the specific limits you are requesting. Please make this request in writing to HOPE Family Health, Attn: Navigator, Medical Records.

Change your health information if you believe it is incorrect or incomplete. You may request that we amend your health information maintained by the facility. If we accept your request to change your health information, the change will become a permanent document in your health care record. Please make this request in writing to HOPE Family Health, Attn: Navigator, Medical Records.

Request a list of to whom and when we have disclosed your health information. You may request a list of disclosures of your health information that the facility has made. This list will not include routine disclosures of your health information for the treatment, payment or business operations described in this notice. Please make this request in writing to HOPE Family Health, Attn: Navigator, Medical Records.

Receive a paper copy of this notice from us. You may request a copy of this notice at any time.

YOUR RIGHT TO COMPLAIN

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the facility or the secretary of the Department of Health and Human Services. All complaints must be submitted in writing and all complaints will be investigated. You can ask any member of staff to give you a complaint form.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL MEDICAL INFORMATION

Treatment. We use information about you to provide you with health care treatment or services now or in the future. We may, and most likely will, disclose your information to doctors, nurses, and other health care personnel who are involved in your care.

For Audit Purposes: We may disclose your information for audit purposes of any institutional, state or federal program, as applicable.

Pay. We may use and disclose medical information about the services and procedures provided to you so that they

may be billed and collected to you, your insurance company, or a third-party reimbursement entity such as Workers' Compensation.

Operational Uses (Commercial). We may use and disclose your health information to operate the facility efficiently and make sure our patients receive quality care.

Appointment Reminders. We may use and disclose your health information to contact you and remind you of appointments or medical care you need to receive. We may send postcards to your postal address or leave a message at the telephone number you have provided to us. We may leave messages on your answering machine or with friends or family who answer the phone. **IFYOUDONOTWANTUSTOCONTACTYOUINTHISWAY,YOUMUSTLETUSKNOW.**

Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

Victims of Abuse, Neglect or Domestic Violence. We may disclose your health information to law enforcement, social services or other government agencies authorized to receive the report if we have reason to believe that you are a victim of abuse, neglect or domestic violence.

Workers Compensation. We may disclose your information if required to do so by workers' compensation laws and other similar laws and regulations.

Emergency Organizations. In an emergency, we may release information about you for disaster relief so that your family can be notified about your condition, status and location.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a subpoena, court order, discovery request or other lawful process by another person involved in the dispute.

Law Enforcement. In response to a court order, subpoena, subpoena or other similar process, we may disclose your health information to law enforcement officials. This could be done in an effort to help identify or locate a suspect, witness, or missing person. This may also be done to share information about a victim of a crime, a death believed to involve criminal action, ongoing criminal conduct, or crimes committed on Center premises. This could also be done in emergency situations to report a crime or share details about a crime.

To Prevent a Serious Threat to Health or Safety. We may use and disclose your health information to people who need to know when necessary to prevent a serious threat to your health or safety or the health and safety of others. If you are an organ donor, we may disclose medical information to organizations that handle organ procurement and transplants..

Public Health Problems and Risks. We may disclose your health information as required by law or by your authorization regarding certain health conditions to prevent or control disease, injury or disability, births and deaths, child or elder abuse or neglect, reactions to medications or products, product recalls and notice of exposure to a condition.

Research and Government Activities. We may disclose your health information to a local, state, or federal agency for oversight activities authorized by law that may relate to inspections, licensing, unlawful conduct, or compliance with other laws and regulations, including civil rights laws..

Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner or medical examiner or funeral directors as necessary so they can carry out their duties..

Military and National Security. If you currently serve in the armed forces or are a veteran, we may release your health information to the armed forces if you request it. We may also disclose your information to federal officials conducting national security and intelligence activities.

Studies. We may participate in studies on the use of certain treatment protocols that have government and facility approval. In that case, we would secure your informed consent that identifies all aspects of your participation, risks and benefits, and possible release..

CHANGES TO THIS NOTICE

Changes to this Notice. We reserve the right to change this notice at any time. We will post a copy of the current notice in the center with the effective date in the upper right corner of the first page. You can request a copy of the current notice each time you visit the facility for services or by calling the facility and requesting that the current notice be mailed to you..

PRIVACY CONTACT INFORMATION

If you have any questions about this notice or would like to file a complaint, please contact the facility's Privacy Officer:
Name: Kaleigh Chitwood
Address**:** 1124 New Highway 52 East Westmoreland, TN 37186
Phone**:** 615-644-0664
Email**:** kaleighchitwood@hopefamilyhealth.org

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement

Discrimination is Against the Law

HOPE Family Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). HOPE Family Health does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

HOPE Family Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Kaleigh Chitwood, Civil Rights Coordinator.

If you believe that HOPE Family Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kaleigh Chitwood, Civil Rights Coordinator

1124 New Hwy 52 E, Westmoreland, TN 37186

Phone: 615-644-0664 / Fax: 615-644-2078

Email: kaleighchitwood@hopefamilyhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kaleigh Chitwood, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at HOPE Family Health's website: www.hopefamilyhealth.org.