Lifespan HEALTH
HARDIN COUNTY REGIONAL HEALTH CENTER

Lifespan Health
PO Box 655
Savannah, TN 38372
USA
(731) 925-2300

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP		RACE	
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE	
SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	CURRENT GENDER	POVERTY PERCENT	POVERTY CAT		

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT	$
CITY, STATE ZIP	PHONE		DEDUCTIBLE	$
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

in Household: _____ Household Income $_____/week $_____/month $_____/year
RACE _____ ETHNICITY _____ HOMELESS? _____ (Optional)

___I authorize medical services to be rendered by the providers of Hardin Co Regional Health Center.
___I authorize payment of insurance benefits to HCRHC and the release of information as permitted or required under HIPAA.
___I have received a copy of HCRHC's privacy policy.

_____ _____
SIGNATURE OF PATIENT/GUARDIAN DATE

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PATIENT NAME _____
Head of Household (if different from patient):
_____
DOB _____

Please circle the income that fits your household - *HOUSEHOLD OF . . . ?*

1	2	3	4	5
0-$13,590 $13,591-$18,075 $18,076-$22,695 >$27,180	0-$18,310 $18,311-$24,352 $24,353-$30,578 >$36,620	0-$23,030 $23,031-$30,630 $30,631-$38,460 >$46,060	0-$27,750 $27,751-$36,908 $36,909-$46,343 >$55,500	0-$32,470 $32,471-$43,185 $43,186-$54,225 >$64,940

If household number is MORE THAN 5 fill in here

Household _____ Estimated Annual Income_____

☐ **PLEASE CHECK HERE TO DECLINE TO GIVE YOUR INCOME and *NOT* WANT USE SLIDING FEE.**

Do you have Medicaid/TennCare? ☐ ***Yes*** ☐ ***No***

Are you a Veteran? ☐ Yes ☐No ☐ Choose Not to Answer

Check your race: ☐ White ☐Black ☐Asian ☐American-Indian ☐Other ☐ Decline

Are you Hispanic? ☐ Yes ☐No ☐ Choose Not to Answer

Do you think of yourself as:

☐ Straight/Heterosexual ☐ Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know/Decline

What is your current gender identity? (Check all that apply)

☐ Male ☐ Female ☐ Transgender ☐ Decline to Answer ☐ Other

What sex were you assigned on your birth certificate?

☐ Male ☐ Female ☐ Decline to Answer

Initials (Patient) _____ Initials (LS Emp)_____ Date_____

Lifespan HEALTH

PATIENT CONSENT & HIPAA INFORMATION

PLEASE PROVIDE THE RECEPTIONIST WITH A PHOTO ID & YOUR INSURANCE CARD(S)

(Legal) Last Name:	First Name, Middle Initial:	Date of Birth:

PATIENT AUTHORIZATION TO BILL & HIPAA DISCLOSURE

☐ I authorize that payment of authorized insurance benefits be made to LIFESPAN health for services furnished to me. I authorize LIFESPAN health to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I will be directly responsible for any portion deemed patient liability by my insurance carrier. I further acknowledge the below signature to be mine and to be used as my "Signature on File" for electronic billing purposes. I understand this signature will be used indefinitely unless I revoke this arrangement.

☐ I acknowledge that I am a "self-pay patient" and as such will be responsible for all services rendered to me. I understand I may qualify for patient assistance but this assistance is in no way guaranteed.

☐ I hereby acknowledge that I was provided with LIFESPAN health's Notice of Privacy Practices.

☐ I hereby authorize LIFESPAN health to release my Protected Health Information to the following individuals:

Name	Relationship	Telephone

☐ I do not wish my Protected Health Information released to anyone.

CONSENT TO TREATMENT & TO OBTAIN ELECTRONIC MEDICATION HISTORY

☐ I request and authorize treatment and services as may be deemed necessary and appropriate by the providers of LIFESPAN health. This care may include radiology, laboratory, x-ray, etc.

☐ I authorize LIFESPAN health to obtain my medication history utilizing an electronic information exchange. I further authorize LIFESPAN Health to transmit, view and disclose this information as part of my medical record and treatment.

CONTACT PREFERENCES: I wish LIFESPAN to adhere to the following contact preferences:

Home Phone:
- ☐ Ok to leave detailed information
- ☐ Leave only a call back number

Work Phone:
- ☐ Ok to leave detailed information
- ☐ Leave only a call back number

Written Communication:
- ☐ Ok to send information to my home address
- ☐ Do not send anything to my work address
- ☐ Ok to send anything to my work address
- ☐ Only send mail to my home address
- ☐ Ok to send me an e-mail:_____

Pt. Signature:	Date:

HCRHC USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Authorization to Release PHI, but it could not be obtained for the following reasons: ___ Individual refused to sign ___Communication barriers prohibited obtaining the acknowledgment ___An emergency situation prevented us from obtaining acknowledgment ___Other (Please specify) _____

Staff representative signature _____ Date_____