GETTING STARTED

At Faith Health Center

731-215-2500

> ***If any among you is sick? Then let them call for the leaders of the church..." James 5:14***

Faith Health Center of Jackson, Tennessee is a non-profit 501c3 medical clinic that provides medical care, wellness counseling, and health education to insured, low income uninsured, elderly, and disabled patients in Madison and bordering rural counties of West Tennessee.

The care is provided by Dr. David Larsen and staff. They are supported by volunteer professionals. The center is a full time medical facility. Patient appointments are from 9:00 am – 4:00 pm Monday, Tuesday, Thursday, and Friday. Faith Health Center works with the whole person addressing their physical, emotional, and spiritual needs by utilizing the training, education and experience of staff and volunteers.

Who is eligible to be an established patient at Faith Health Center?

Uninsured, Medicare/Tenncare and a limited number of patients with private insurance can be established patients at FHC.

Benefits of Established Patients

Established patients receive ongoing care and may be eligible for dispensary services. Uninsured patients pay on a sliding fee scale that is based on total household income and/or benefits and the number of members in the family. A limited number of insured patients will be seen. All payments will be collected on all Medicare and private insurance patients. Insurance will be filed. Co-pays and deductibles will be collected at the time of visit. Those Medicare patients accepted are expected to pay their deductible portion at the time of visit. Payment will only be accepted by cash, debit card and credit card. (Visa and MC) **NO CHECKS WILL BE ACCEPTED**

Registration process

All patients must complete the necessary forms and return them to the center. The patient will then meet with a staff member to discuss the required documentation and clinic guidelines.

Phones are open from 8:30 until 12:00 and 2:00 until 5:00.

This is a non-smoking facility. Smoking is not allowed on the property. Please extinguish cigarettes before exiting your vehicle.

Disabled people must bring someone to help them in and out of the car. The wheelchair entrance is at the rear. Please use the door bell and someone will come to assist you.

Patients who do not speak English must bring an interpreter who is 16 years or older.

Clinic Rules

IMPORTANT: As a ***new patient*** if you cannot keep your appointment, you must call 731-215-2500 to cancel it and reschedule at least 4 hours in advance. If you need to cancel after hours please call the clinic and leave a message. If you do not cancel ahead of time and do not show up for your ***new patient*** appointment with the doctor, you will be ineligible to be a patient.

Once established, it you fail to keep or cancel any appointment with us or with any provider that we have referred you to, you will receive a warning letter. If you fail to keep or cancel a second appointment, you will be dismissed and can no longer be a patient at FHC.

Please be on time for your appointment. **If you are 15 or more minutes late, you will not be able to see the doctor and you will have to reschedule the appointment.** This will count as not showing up for the appointment and you will receive a warning letter.

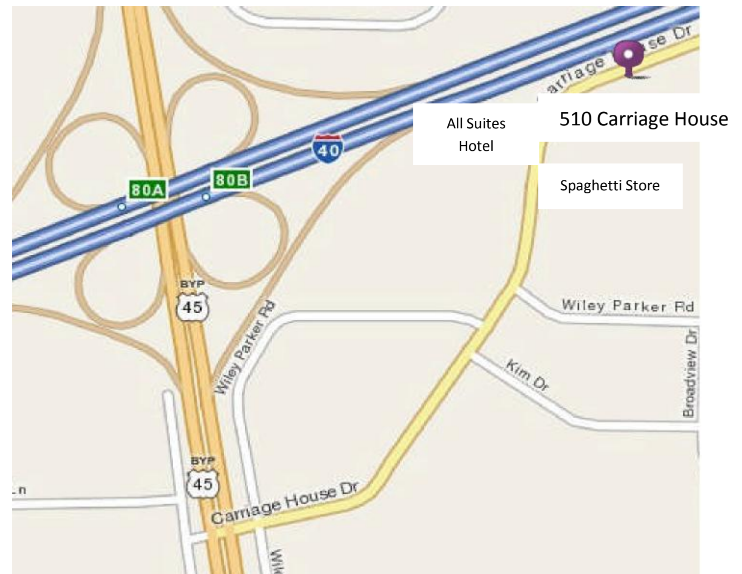
Children must be supervised at all times.

No cell phone usage.

Patients are expected to update contact information, address insurance information and phone number at each visit.

No smoking.

Faith Health Center Mission Statement:
We strive to serve the needy and promote health and healing for all through our Lord and Savior, Jesus Christ. We seek to reclaim the Church's biblical commitment to care for the bodies and spirits of its community through the operation of a non-profit medical clinic



MEDICINE

Faith Health Center has a dispensary to help our patients get their medicine. The medicine in the dispensary comes from different sources and not all patients are eligible for medicine. Samples may be provided for the initiation of treatment only. Because of limited resources, we are not able to provide medications on request.

Medication is not dispensed without income verification for uninsured patients.

Patients are asked to bring all medications to every visit. This is to insure we know all your medications and that you are taking them as prescribed.

No controlled medication (pain, nerve, ADD medications) will be renewed without your last refill bottle with you. No controlled medication will be renewed on Friday. You must be seen every three (3) months for refills of controlled substances.

Patients who have any prescription drug coverage may not receive medication from the dispensary.

Medication is not given to patients who miss their appointments.

Lost or stolen medication is not replaced.

No narcotic pain medicine or controlled substance is provided or kept at Faith Health Center.

For refills on your medicine, you must call ahead **at least 4 days** before the refill is needed. Please check all your other medication at the same time to find out if you will need other refills. No medications will be refilled after hours or on weekends.

Some medications will require an appointment for refills.

Required Documentation for all patients

1. A picture ID (driver's license from any state, ID card issued in any state, Military ID, Passport)
2. Current insurance card or patient assistance Application
3. **Bring all the medications you are taking.**
4. Immunization records if under age 18.

Fee Policy for Uninsured Patients

It is the policy of Faith Health Center to provide essential medical services. ***Assistance is offered based upon total household income and/or benefits and the number of members in the family.*** A sliding fee schedule is used to calculate the basic benefits and is updated each year using the federal poverty guidelines. Once approved, the reduction will be honored for one (1) year, after which the patient must reapply**. Patients who decline to offer this information are ineligible for this program.**

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before assistance will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

ENROLLMENT REQUIREMENTS FOR UNINSURED PATIENTS

Completed IRS 4506T-EZ form (Last page of packet) for each household member over age 18

Proof of Current Medication and Immunizations

Proof of Household Income

(If Employed) One of the following:

- 1040
- W2
- 2 recent pay stubs
- Notarized statement by employer

(If Unemployed) One of the following:

- Public Assistance check stub/copy
- Social Security check stub or letter of award
- Certification Letter from Medical Assistance or Department of Social Services
- Letter of reference from an organization, such as a church, community organization, or any other organization in which you are receiving benefits.

Proof of Address One of the following:

- Driver's License
- Other Photo ID
- Any document (envelope) recently addressed to patient such as a utility bill

Recertifying for Patient Assistance

- Patients are re-certified at least once per year.

****Proof of income must be provided for everyone in your household over the age of 18*****

Remember if you do not show up for your first appointment and have not cancelled it, you will be ineligible to be a patient here. We will not reschedule a missed new patient appointment.

Now faith is the substance of things hoped for, the evidence of things not seen.
Hebrews 11.1

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information.
PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments. Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily activities of Faith Health Center.

As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal. Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization. Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information

Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Faith Health Center Duties

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:
US Department of Health & Human Services   202-619-0257
Toll Free: 1-877-696-6775

Patient Profile

DATE ____/____/____

Name: First: ____________________________ Middle: _______________ Last: _______________________________

Suffix: Sr. Jr. III other _____ Preferred name: _____________________________________

DOB: ____/____/______ SSN: _______________________________

Address 1: _______________________________________ Address 2: _____________________________________

City: ____________________________ State:___________ Zip Code: ______________

County: (circle) Madison Gibson Crockett Henderson Haywood Chester Dyer Carroll Other _____________________

Home Phone: _____________________ Work Phone: ____________________

Cell Phone: ___________________ E-mail: ___________________________

Best time to contact:

Sex: M F

Race: White African-American Hispanic /Latino Asian Native American Other

Circle correct response

Marital Status: Married Single Divorced Widow Sep In Relationship

Number of Children: ______ Number in Family: _________

Insurance Medicare Part A B D Tenncare BCBS Cigna United Health Health Partners Aetna Tricare

Which is Primary? _________________________ Which is secondary? ______________________

ID #____________ Group # ____________ ID #____________ Group # ____________

Guarantor Name (if other than self)____________________________

Date of Birth ___________________ Social Security No. ___________________

Do you have prescription coverage? YES__ NO __ Disability Benefits: YES ___ NO ___ Applied ___ Pending___

PLEASE BRING INSURANCE CARD TO EACH OFFICE VISIT

Employment: Full Part Time Contract Self Temp Student Homemaker Retired Unemployed

Education: Elementary Middle school High school College

Language: English Spanish Other__________

Housing: Own Rent Other_________

Emergency Information Contact Name: ______________________________ Relationship: ________________

Phone Number: _____________________

I have received a copy of Notice of Privacy Practices. Initial_______________

Release of Medical Information by Alternative Means

Patient Name______________________________________ SSN:______________ DOB :___________________________

I authorize Faith Health Center to release the following medical information as listed below:

(Circle yes or no)

Return Appointments:	**yes**	**no**	**X-ray Results:**	**yes**	**no**
Out Pt. Testing:	**yes**	**no**	**Return Calls:**	**yes**	**no**
Lab Appointments:	**yes**	**no**			

Signature (Patient or Parent/Guardian if minor) _____________________________________ Date:_________

Faith Health Center can release the above information to the following people:

Name/Relation____

Name/Relation____

Name/Relation____

Name/Relation____

Signature (Patient or Parent/Guardian if minor) _____________________________________ Date:_________

Faith Health Center can release the above information by the following means:

Answering Machine _______________ Cell Phone ___________________ Fax _______________________

Voice Mail _______________________ E-Mail Address _______________

Signature (Patient or Parent/Guardian if minor) _____________________________________ Date:_________

To be completed only if any changes are to be made.

I revoke this Release of Medical Information by Alternative Means as of ___________
Date

Signature (Patient or Parent/Guardian if minor) _____________________________________

Patient Health History

Patient Name ____ Date _____________

Age ________ Birth date _____________ Date of Last Physical Examination ______________

Have you EVER had. or do you have, any of the following? If yes, please check the box below.

- ❑ Chicken pox or shingles
- ❑ Skin problems or chronic rash
- ❑ Mumps
- ❑ Hearing loss or ear problems
- ❑ Chronic cough
- ❑ Lung problems
- ❑ Asthma
- ❑ Tuberculosis or positive TB skin test
- ❑ Shortness of breath
- ❑ Chest pain
- ❑ High Cholesterol
- ❑ Heart attack
- ❑ High blood pressure
- ❑ Palpitations/irregular heart beat
- ❑ Stroke or paralysis
- ❑ Heart murmur
- ❑ Stomach or intestinal problem
- ❑ Irritable Bowel Syndrome
- ❑ GERD
- ❑ Diverticulitis
- ❑ Liver disease
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Kidney disease
- ❑ Thyroid problems
- ❑ Broken bones _____________
- ❑ Neck pain___ injury____
- ❑ Back pain___ injury____
- ❑ Hip pain___ injury____
- ❑ Knee pain___injury____
- ❑ Foot pain___injury____
- ❑ Shoulder pain___injury____
- ❑ Elbow pain___injury____
- ❑ Wrist pain___injury____
- ❑ Hand pain ___injury____
- ❑ Bone or joint problems
- ❑ Numbness tingling legs or feet
- ❑ Numbness tingling arms/ hands
- ❑ Arthritis Osteo__ Rheumatoid __
- ❑ Gout
- ❑ Fibromyalgia
- ❑ Migraine Headache
- ❑ Tension headaches
- ❑ Severe weakness or tiredness
- ❑ Dizziness or fainting
- ❑ Depression or anxiety
- ❑ Eating disorder
- ❑ Epilepsy or seizures
- ❑ Bipolar Disorder
- ❑ Bleeding or blood disorder
- ❑ Immune suppression
- ❑ Anemia
- ❑ Chronic/recurrent infection
- ❑ Diabetes Type 1
- ❑ Diabetes Type 2
- ❑ Drug or alcohol dependency
- ❑ Any other illness not listed

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____

____

____

____

❑ Cancer Breast__ Prostate__ Lung__ Cervical__ Ovarian__ Colon__ Skin__ Other______________________

❑ Heart Disease Pacemaker__ Defibrillator__ Stent__ By-pass__ Valve problem ____________________

❑ Venereal Disease Gonorrhea__ Syphilis__ Herpes__ HPV__ Warts__ Other______________

Complete the other side

Previous surgeries

- ❑ Hysterectomy Partial__Complete__
- ❑ D&C
- ❑ Appendectomy
- ❑ Tonsillectomy
- ❑ Prostate
- ❑ Joint Replacement ____________
- ❑ Tubal
- ❑ Heart Bypass ___ vessels
- ❑ Breast Biopsy
- ❑ Breast Augmentation
- ❑ Breast Reduction
- ❑ Mastectomy Right __ Left __ Both __
- ❑ Kidney stone__ Lithotripsy __
- ❑ Rotator Cuff
- ❑ Gallbladder
- ❑ Cesarean section
- ❑ Vasectomy
- ❑ Hernia type _________________

1. ____________________________
2. ____________________________
3. ____________________________
4. _____________________________

Allergies

- ❑ No Known Allergies
- ❑ No Known Drug Allergies
- ❑ Penicillin
- ❑ Sulfas
- ❑ Aspirin
- ❑ ACE inhibitor
- ❑ Erythromycin
- ❑ Keflex
- ❑ Latex
- ❑ Statin
- ❑ Codeine
- ❑ X-ray Dye (IVP dye)
- ❑ Peanuts
- ❑ Other Nuts _______
- ❑ Shellfish
- ❑ Bee sting

Other (list)

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last Pap smear Date _______________ Normal ___ Abnormal___

Last Mammogram Date _______________ Normal ___ Abnormal___

Age at first menstrual period: ________

Date of last menstrual period or age at menopause: _______________

Number of pregnancies: ______ births: _______ miscarriages: ______ abortions: ______

Cesarean sections If yes, then number: ______

Faith Health Center
Family Medicine For The Whole Person: Body, Mind, And Spirit

CURRENT MEDICATIONS

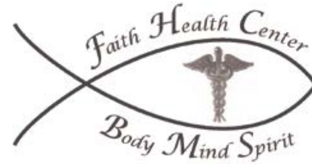
Patient Name ______________________________________ Date ____________

List medications you are currently taking with dose and frequency

	MEDICATION NAME	STRENGTH	TIMES PER DAY	WHO PRESCRIBED
1.				
2.				
3.				
4.				
5.				
6.				
7				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

What pharmacy do you prefer to use? ____

Family and Social History



Name:_______________________________________ **Date:**____________________

Birth Date: ___________________________

The questions below are designed to help us get to know you better as our patient, so we can best serve your health needs. Please answer each question as honestly as you can. There are no right or wrong answers.

1. Please check the following health conditions that apply to you or your immediate family members. Do you have a natural parent/brother/sister with a history of any of the below conditions?

If deceased put age at death	Father _____	Mother _____	Brother _____	Sister _____	Child _____	Grandparent
Diabetes						
High blood pressure						
High cholesterol						
Heart attack						
Stroke						
COPD/Emphysema						
Lung Cancer						
Breast cancer						
Colon cancer						

2. Smoking: Current everyday___ Current someday___ Formerly ___ Never ___
   Cigarettes ___ packs per day Cigars, chew, pipe ___ times each day How many years? ______

3. Alcohol: Current everyday____ Current some days____ Formerly ____ Never ____ Social ____
   One alcoholic drink equals a 12 oz. beer, 12 oz. a wine cooler, 5 oz. of wine, or 1.5 oz of liquor. <u>In an average week,</u> how many alcoholic drinks do you usually consume? ___________

4. Drug use: Formerly____ Never_____ Current _____ IV Drugs ____
   Drugs of choice______________________________

5. Exercise: Never___ 0-1/week ____ 2-5/week___ 6-7/week ___

6. Have you ever been abused? YES __ NO __

7. Sexual orientation: Heterosexual __ Not sexually active __ Bisexual __ Gay/Lesbian __ Transgender __

8. Are you satisfied with your spiritual life?
   Very satisfied ___ Satisfied ___ Not very Satisfied ___ Dissatisfied ___ Very dissatisfied ___ Can't answer___

9. How strongly religious (or spiritually oriented) do you consider yourself to be?
   Very strong___ Strong ___ Somewhat weak ___ Weak ___ Very weak ___ Can't answer___

   The following questions ask about your spirituality and how it relates to your healthcare:

10. How often is your religion, faith, or spirituality helpful to you when you are sick?
    Always ___ Most of the time___ Sometimes ___ Never ___

11. Which of these following three items would you most prefer from your healthcare team?
    - o Never ask you about your spiritual or religious beliefs
    - o Sometimes ask you about your beliefs depending on the situation
    - o Always know about your beliefs

12. Please check the sentence below that best describes your level of on-the-job physical activity.

- o I do not have a job or regular work.
- o I spend most of the day at work sitting or standing.
- o I spend most of the day at work walking or using my hands and arms in work that requires moderate exertion. (Examples: delivering mail, patrolling on guard duty, house painting, etc.)
- o I spend most of the day at work lifting or carrying heavy objects or moving most of my body in some other way. (Examples: stacking cargo, building structures, yard work without machines, etc.
- o I spend most of the day at work doing hard physical labor. (Examples: digging with heavy tools, carrying heavy loads, etc.)

In an average week, how often do you:	Usually/ Often	Sometimes	Rarely/ Never	Does not apply to me
13. Eat at least 5 servings of fruit and vegetables each day? (Serving = 1/2 cup)	❑	❑	❑	❑
14. Eat fried foods such as fried chicken, fried fish, or French fries?	❑	❑	❑	❑
15. Drink 16 ounces or more of non-diet soda, fruit drink/punch or Kool-Aid a day? (1 can = 12 ounces)	❑	❑	❑	❑

16. Which answer best describes how you feel about making changes to your eating habits?

- ❑ I have no plans to change how or what I eat.
- ❑ I plan to within the next 6 months.
- ❑ I plan to in a month.
- ❑ I have been changing my eating habits, but for less than 6 months.
- ❑ I have been changing my eating habits for more than 6 months now.

	Always	Often	Rarely	Never
17. How often do you experience levels of stress and/or anxiety that affect your ability to function each day?	❑	❑	❑	❑
18. How often do you feel overwhelmed with work and/or your home life?	❑	❑	❑	❑
19. In the last year, have you lost interest in things that you used to enjoy?	❑	❑	❑	❑
20. Are you taking care of someone who is elderly, sick, or disabled? ❑ Yes ❑ No If yes, does this cause problems for you?	❑	❑	❑	❑
21. Do you have adequate housing (safe and functioning water, lights, and sewage)?	❑	❑	❑	❑
22. How often do you run out of food?	❑	❑	❑	❑
23. In the last year, how often have you needed help to pay your rent, mortgage, and/or utilities?	❑	❑	❑	❑

Release of Information & Assignment of Benefits
For Insured Patient
Private, Medicare, or TennCare

Commercial Insurance and Tenncare

I hereby authorize the release of the medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian ____________________________

Medicare Insurance

Beneficiary _______________________Medicare Number _______________________

I requested that payment of authorized Medicare benefits be made either to me or, on my behalf, to Faith Health Center, David Larsen M.D.,for any service furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _________________________

Medicare Supplemental Insurance

Beneficiary _______________________Medicare Number _______________________

Medigap ID Number _____________________

I request that payment of authorized Medigap benefits be made either to me, or on my behalf, to Faith Health Center, David Larsen M.D., for any service furnished to me by that physician. I authorize any holder of medical information about me to release to Medigap insurance carrier any information needed to determine these benefits payable for related services.

Beneficiary Signature _________________________

Release of Information & Assignment of Benefits
<u>For Insured Patient</u>
<u>Private, Medicare, or TennCare</u>

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Faith Health Center, David Larsen M.D, for services furnished me by Faith Health Center, David Larsen M.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Faith Health Center, David Larsen M.D accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

______________________________ _______________
(Patient's signature) (Date)

Patient Assistance Application

For Uninsured Patients Only

Date ___/___/___

First Name:	Middle:	Last:	Date of Birth_____/_____/_____	
Home Address:		City:	State:	Zip:
Home Phone #: ( )		Cell Phone #: ( )	Social Security # - -	
E-mail____				

NOTE: To comply with federal regulations, in order to give you a assistance on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your annual income and your family size will be used to calculate your assistance.

Household Size	
Number of adults	**1 2 3 4 5** __________
Number of children under 18	**1 2 3 4 5** __________

Household Income

Name	**Amount**	**Frequency (Circle)**	**SSN:**
You	$	Wkly Mon Year	
Spouse/Partner	$	Wkly Mon Year	
Child	$	Wkly Mon Year	
Child	$	Wkly Mon Year	
Child	$	Wkly Mon Year	
Other	$	Wkly Mon Year	
TOTAL	$	Wkly Mon Year	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security Disability					
SSI					
Retirement Pension					
Social Security					
Child Support, Alimony					
Food Stamps					
Unemployment					
Interest Income					
Family First					
				TOTAL	**$**

Required documentation:

<u>Proof of income and/or benefits is required for everyone in household over 18.</u>

- **If Employed (Need one for each person)**
  A. 1040
  B. W-2
  C. 2 recent pay stubs
  D. Notarized statement from employer
- **If Unemployed (Need one for each person)**
  A. Public assistance check stub
  B. SSI check Stub
  C. Certification Letter from DHS, Soc Sec.
  D. Letter of reference from an organization such as church, community organization, or any agency from which you receive benefits.
- **Proof of Address (For patient)**
  - Driver's License
  - Other Photo ID
  - Copy of recent address on bill
- **IRS 4056T-EZ** (Need one for each person) Last page of packet.

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Faith Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Faith Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name (Print):____

Signature:____ Date:____________________

Reviewed By:___________________________________ 25 45 70 Date:___________________

Faith Health Center
Family Medicine For The Whole Person: Body, Mind, And Spirit

Falsification of Financial or Insurance Information

Faith Health Center is a medical clinic founded on Christian principles. The intentional falsification of financial or insurance information will disqualify you for services.I have read and understand the above statement.

____
Print Name

____________________________ ____________
Signature Date

Form **4506T-EZ**

(Rev. January 2012)

Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

▶ **Request may not be processed if the form is incomplete or illegible.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number or individual taxpayer identification number on tax return**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name	Telephone number

Address (including apt., room, or suite no.), city, state, and ZIP code

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

______ ______ ______ ______

☐ Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return.

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS may notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** husband or wife must sign. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Sign Here

▶ **Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
▶ **Spouse's signature**	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

What's New

The IRS has created a page on IRS.gov for information about Form 4506T-EZ at *http://www.irs.gov/form4506*. Information about any recent developments affecting Form 4506T-EZ (such as legislation enacted after we released it) will be posted on that page.

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Individuals can use Form 4506T-EZ to request a tax return transcript for the current and the prior three years that includes most lines of the original tax return. The tax return transcript will not show payments, penalty assessments, or adjustments made to the originally filed return. You can also designate (on line 5) a third party (such as a mortgage company) to receive a transcript. Form 4506T-EZ cannot be used by taxpayers who file Form 1040 based on a tax year beginning in one calendar year and ending in the following year (fiscal tax year). Taxpayers using a fiscal tax year must file Form 4506-T, Request for Transcript of Tax Return, to request a return transcript.

Use Form 4506-T to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506T-EZ to the address below for the state you lived in when the return was filed.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

If you filed an individual return and lived in:	**Mail or fax to the "Internal Revenue Service" at:**
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 559-456-5876
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506T-EZ must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506T-EZ within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506T-EZ exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. If you request a transcript, sections 6103 and 6109 require you to provide this information, including your SSN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506T-EZ will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 9 min.; **Preparing the form,** 18 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506T-EZ simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Products Coordinating Committee
SE:W:CAR:MP:T:M:S
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.