Patient Application

Personal/Contact Information

Patient Name: _____SS#: ____-____-____ DOB: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Best Phone to Contact: _____ Email: _____
__

Employer: _____ Occupation: _____

Spouses Name: _____ Phone: _____ Email: _____

Spouses Employer: _____ Occupation: _____

Medical Information

The following questions are designed to assess the various needs of the applicant.

Diagnosis: _____ Date of diagnosis: _____

Please provide a brief history of your treatment to date:

_____
_____
_____
_____
_____
_____

Future Treatments

Briefly describe the treatment for which you are seeking assistance:

_____
_____
_____

Referring Provider: _____ Date of referral: _____

How did you learn of the treatment? _____

Estimated cost of the treatment: _____

Who provided the estimate of the cost of the treatment? _____

Has any health insurer reviewed this treatment for reimbursement or payment? _____

If yes, please provide the following information.

Name of health insurer: _____

Policy Number: _____ Group number: _____

If **approved,** is there any co-pay associated? _____Estimated co-pay amount: _____

I **denied**, date of denial: _____ was there an appeal of the denial? _____

Reason given for denial: _____

Financial Contact

Please designate the person (spouse, close friend or family member) who will handle your financial affairs in the event of your absence, such as in the case of a hospitalization:

Name: _____ Relation to patient: _____

Address: _____ City: _____ State: ___ Zip: _____

Best Phone to contact: _____ Email: _____

Patient Agreement

I agree to allow STF to receive copies of my (or my child's) medical information and records. I further agree to allow STF to use my (or my child's) name, photograph, general medical description, or general likeness in any media coverage or fundraising activities for the purposes of raising funds and to benefit the general purposes of STF. I affirm that the above information is true and correct.

_____ **X** _____

Print name of Patient **Signature (parent / guardian of patient is less than 18 years old)**

Medical Authorization HIPAA

To: Setting Them Free

Patient: _____DOB ____/____/____ SS# _____-____-_____

I hereby authorize you to disclose my protected health information, as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), including billing, payment, insurance, and medical records information to be sent to: **Setting Them Free** 2753 E. Broadway Road Ste. #101 Mesa, Arizona 85204

I understand that I may revoke or terminate this authorization at any time, except to the extent the Healthcare Provider or **Setting Them Free,** 2753 E. Broadway Road Ste. #101 Mesa, Arizona 85204**.**

This authorization is entered at my request as the patient, and for the purpose of resolving my third party liability claim and/or my outstanding account with the Healthcare Provider. This authorization is effective until my third party liability claim is resolved by settlement of final court decision, or my account with the Healthcare Provider is finally resolved, whichever occurs later if both apply.

I understand that information that is disclosed by Setting Them Free under this authorization may no longer be protected after it is disclosed and that it is not possible for the Healthcare Provider to ensure the privacy of any disclosed information or that the information, once disclosed, is used by the recipient identified above solely for the intended purpose. A photocopy of this document shall be as valid as the original.

X _____

Signature (parent / guardian of patient is less than 18 years old) _____Date