ATTENTION:
NEW AND EXISTING PATIENTS

IF YOU ARE PLANNING A VISIT TO ONE OF OUR EIGHTEEN LOCATIONS, PLEASE PRINT OFF THE REGISTRATION FORMS AND BRING THEM TO THE FRONT DESK RECEPTIONIST; THIS WILL SAVE TIME WHEN YOU CHECK IN ON THE DAY OF YOUR APPOINTMENT.

IF YOU ARE AN EXISTING PATIENT, YOU NEED TO PROVIDE UPDATED INFORMATION AT LEAST ANNUALLY. BY PRINTING OFF THESE FORMS PRIOR TO YOUR APPOINTMENT YOU CAN SAVE SOME TIME WHEN YOU COME IN FOR YOUR APPOINTMENT.

OTHER ITEMS TO BRING TO YOUR APPOINTMENT:

1) **PICTURE ID *(DRIVER'S LICENSE, PASSPORT OR SCHOOL ID) (THIS WILL BE COPIED)***
2) **INSURANCE CARD *(INFORMATION WILL BE VERIFIED TO DETERMINE CO-PAYS AND DEDUCTIBLES)***
3) **CURRENT MEDICAID CARD**
4) **MEDICARE CARD AND APPLICABLE CO-PAY *($10.00+)***
5) **SLIDING FEE SCALE APPLICANTS MUST BRING REQUIRED PROOF OF INCOME FOR A ONE-MONTH PERIOD OR AN ANNUAL TAX RETURN.**
6) **VERIFICATION OF YOUR CURRENT ADDRESS AND PHONE NUMBER IS ALSO REQUESTED *(A POWER BILL, A LETTER FROM SOCIAL SECURITY, A PHONE BILL, ETC.)***

PEOPLE CARING ABOUT PEOPLE

P.O. Box 97
Gadsden, Alabama 35902
(256) 492-0131
www.qolhs.org

PATIENT INFORMATION

NAME (Last, First, Middle)	SSN#	Birthdate	Marital Status	Sex	Mother's Maiden Name
LOCAL ADDRESS	SECONDARY / BILLING ADDRESS (if applicable)				VETERAN ☐ YES ☐ NO
CITY, STATE, ZIP	CITY, STATE, ZIP	EMERGENCY CONTACT:			
		PHONE NUMBER:			
HOME PHONE	DAYTIME PHONE	RELATIONSHIP TO PATIENT:			

EMPLOYER INFORMATION

	RACE (LOCATE ROW):	ETHNICITY (CHECK ONE) NON-HISPANIC	HISPANIC	
PRIMARY EMPLOYER				NON-SMOKER:
ADDRESS	ASIAN			SMOKER:
	AMERICAN INDIAN			
CITY, STATE, ZIP	BLACK			RELIGIOUS PREFERENCE
	WHITE			
WORK PHONE	MULTIPLE RACES			
	UNREPORTED RACE			
☐ FULL-TIME ☐ PART-TIME	**EMAIL ADDRESS:**			

RESPONSIBLE PARTY INFORMATION (if different from above)

NAME (Last, First, Middle)	SSN#	Birthdate	Sex
LOCAL ADDRESS	SECONDARY / BILLING ADDRESS (if applicable)		
CITY, STATE, ZIP	CITY, STATE, ZIP		
HOME PHONE	CELL PHONE		
RELATIONSHIP TO PATIENT	**HOW DID YOU HEAR ABOUT QOL?**		

PRIMARY INSURANCE / SECONDARY INSURANCE (if applicable)

PRIMARY INSURANCE			SECONDARY INSURANCE (if applicable)			
NAME OF INSURANCE COMPANY	POLICY #	GROUP #	NAME OF INSURANCE COMPANY			
NAME OF INSURED	SSN#		NAME OF INSURED		SSN#	
ADDRESS OF INSURANCE COMPANY	Birthdate	Sex	POLICY #	GROUP #	Sex	Birthdate
CITY, STATE, ZIP	COPAY AMOUNT $		ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
RELATIONSHIP TO PATIENT	DEDUCTIBLE $		RELATIONSHIP TO PATIENT		COPAY $	DEDUCTIBLE $
EFFECTIVE DATE	EXPIRATION DATE		EFFECTIVE DATE		EXPIRATION DATE	

HOUSING STATUS	PUBLIC HOUSING RESIDENCE	SCHOOL BASED HEALTH CARE
DOUBLING UP	☐ YES ☐ NO	☐ YES ☐ NO
NOT HOMELESS		
SHELTER	FARMWORK STATUS	NAME OF SCHOOL
STREET	MIGRANT	
TRANSITIONAL	SEASONAL	
UNKNOWN / UNREPORTED	NOT A FARMWORKER	

Signature of Patient/Guardian: ______________________________ Date: ______________________

NOTICE OF PRIVACY PRACTICES SUMMARY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice, please contact Quality of Life Health Services, Inc. (QOLHS) or the Corporate Compliance Officer at (256) 492-0131.

This is a summary of our Notice of Privacy Practices which describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time. We will post a copy of the current notice in our facility.

We will use your protected health information as part of rendering patient care, including treatment, payment, healthcare operations, and health-related services and treatment alternatives.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that QOLHS, Inc., has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to amend your protected health information.
You have the right to inspect and copy your protected health information.
You have the right to obtain a paper copy of this notice from QOLHS, Inc.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
You have the right to request a restriction of your protected health information.
You may file a complaint with QOLHS, Inc. or with the Secretary of the Department of Health and Human Services, if you believe your privacy rights have been violated by us. To file a complaint with us, contact the Patient Education Specialist at QOLHS, Inc., in writing. You will not be penalized for filing a complaint.

I, ____________________________, acknowledge I have received a copy of the Notice of Privacy Practices.

________________________________ __________________
Signature of Patient Date

________________________________ __________________
Signature of Parent or Patient's Representative (if applicable) Date

Description of Legal Authority to Act on Behalf of Patient
This summary was published along with the Notice of Privacy Practices.

INTAKE AND CONSENT FORM

CONSENT

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

Signature:____Date:________________________
(Patient, parent or guardian)

Witness:____Date:________________________

LABORATORY FEES

I, the undersigned understand that there is a fee for laboratory tests ordered by the attending provider. I also understand, that I may receive an additional fee from an outside lab. I will talk to the provider about any questions before any test is ordered on my behalf.

Signature:____Date:________________________

Witness:____Date:________________________

TELEMEDICINE

CONSENT FOR TELEMEDICINE CONSULTATION: By signing in this section, you are consenting to participate in telemedicine consultation services. You are acknowledging that you have read and understand the provisions for telemedicine. You are acknowledging that your health care provider has explained to you how telemedicine video conferencing works.

I hereby consent to participation in a telemedicine consultation.
Signature: ____ Date: _________________________
Witness: ____ Date: _________________________

ADVANCE DIRECTIVES

In regard to end of life issues and advance directives it is the corporate policy that these decisions cannot be honored at our facilities in case of emergencies. Basic life support measures will be undertaken until definitive prognosis of the condition can be determined.

Do you currently have Advance Directives (Living Will)? Yes_______ No_______

If yes, I agree to provide a copy of this document to the office within 10 days. If no, would you like to have someone explain this to you?
Yes________ (If yes, referral to Social Services) No____________

____
Initial

PATIENT'S RIGHTS AND RESPONSIBILITIES

I have been informed of the Patient's Rights and Responsibilities of Quality of Life Health Services, Inc., and offered a copy.

Name_______________________________MR#____________________________Date:________________________

____ ________________________
Patient/Client Signature Date

____ ________________________
Interviewer Signature Date

INTAKE AND CONSENT FORM

MEDICATION HISTORY

I hereby authorize QOLHS, Inc. access to my medication history and all prescriptions filled at pharmacies within the state of Alabama.

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Initial

I authorize any holder of medical information about me or my dependent to release to the health Care Financing Administration (Medicare), if applicable, or any other insurance company and its agents, any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Quality of Life Health Services, for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and unauthorized or non-covered services. If for any reason the account should become delinquent,, I agree to pay for all collection and legal fees. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Signature of Patient or Legal Representative:

X____Date__________________________

Cross-reference:
Policy/Procedure # 399.07: Intake and Consent Forms