ATTENTION: NEW AND EXISTING PATIENTS

ITEMS TO BRING TO YOUR APPOINTMENT:

1) Picture ID (Driver's License, Passport or School ID) NOTE: Copies of ID Will Be Made
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 Required (Such as: Power Bill, Letter from Social Security Office, Phone Bill, etc.)

REGISTRATION:

1) All patients with text messaging access and/or an email address will be given information to complete the registration forms prior to appointment time.
2) ***OR***, you may print a copy and complete if instructed to do so by staff.
3) For any additional information please call 256/492-0131 or 1-800-490-0131

Authorization for Release, Use, and Disclosure of Protected Health Information

PATIENT NAME:______________________________ ______________________________
LAST FIRST MI MAIDEN OR OTHER NAME
DATE OF BIRTH:_____-_____-_____SS#:_____-_____-_____MEDICAL RECORD #:____________________
MO DAY YR
ADDRESS:______________________________CITY:______________STATE:______ZIP:__________

DAY PHONE:______________________________EVENING PHONE:______________________________

I hereby authorize____________________________(Print Name of Provider) to release information from my medical record as indicated below to:

NAME:____

ADDRESS:______________________________CITY:______________STATE:______ZIP:__________

PHONE:______________________________FAX:______________________________

INFORMATION TO BE RELEASED:

	DATES:
☐ History and physical exam	______________
☐ Progress notes	______________
☐ Lab reports	______________
☐ X-Ray reports	______________
☐ Other:____________	______________
______________	______________

I specifically authorize the release of information relating to:
- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health (including psychotherapy notes)
- ☐ HIV related information (AIDS related testing)

X____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

By signing below, you hereby authorize QOL to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion), and purpose of the use and disclosure:

____

Information that *may not be used or disclosed:*

____

The name or other specific identification of the person(s), or class of persons, *authorized to make the requested use or disclosure:*

____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

____
____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

______________________________ ______________________
Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

____
__

Quality of Life Health Services, Inc.

Patient Information

Prefix: ☐ Mr. ☐ Ms. ☐ Mrs.	**Last Name:**	**First Name:**	**Middle Name:**	**Suffix:**	**Nickname:**

SSN: ______/___/______	**Birth Sex:** ☐ Male ☐ Female	**Gender Identity: Check One** ☐ Choose not to disclose ☐ Female ☐ Female-to-Male ☐ Neither exclusively male or female ☐ Male ☐ Male-to-Female	**Sexual Orientation: Check One** ☐ Bisexual ☐ Choose not to disclose ☐ Don't know ☐ Lesbian/Gay/Homosexual ☐ Something else ☐ Straight/Heterosexual	**Preferred Pronoun: Check One** ☐ She, Her, Hers ☐ Asked but unknown ☐ He, Him, His ☐ Other ☐ They, Them, Theirs ☐ Declined to answer
Birthdate: ______/___/______ MM/DD/YYYY	**Current Gender:** ☐ Male ☐ Female ☐ Undifferentiated			

Billing Address:

Secondary Billing Address: (if applicable)

Home Phone: ______________________________

Cell Phone: ______________________________

E-mail Address: ____________________________

Marital Status: Check One ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	**Mother's Maiden Name:**	**Student Status: Check One** ☐ Full-time ☐ Part-time ☐ Not a student		
Preferred Language:	**Religion:**	**Church:**	**Veteran:** ☐ Yes ☐ No	**Smoker:** ☐ Yes ☐ No

Primary Insurance			Secondary Insurance (if applicable)		
Insurance Company:			Insurance Company:		
Policy #:	Group #:		Policy #:	Group #:	
Effective Date:	Expiration Date:		Effective Date:	Expiration Date:	
Address of Insurance Company:			Address of Insurance Company:		
City, State, Zip:			City, State, Zip:		
Name of Insured:			Name of Insured:		
Birthdate: ___/___/______ MM/DD/YYYY	Sex: ☐ Male ☐ Female	SSN: _______/______/________	Birthdate: ___/___/______ MM/DD/YYYY	Sex: ☐ Male ☐ Female	SSN: _______/______/________

Housing Status	**Farmworker Status**	**Interpreter Required: ☐ Yes ☐ No**
☐ Doubling up (multiple family home) ☐ Not homeless ☐ Live in a shelter ☐ Live on the street ☐ Transitional (move from house to house) ☐ Unknown/Unreported	☐ Migrant ☐ Not a Farmworker ☐ Seasonal	**Employed:** ☐ Yes ☐ No ☐ Full-time ☐ Part-time **Employer:** ________________________ **Work Phone:** ____________ **Address:** ______________________________ **City, State, Zip:** ______________________________

Responsible Party (Guarantor)

Name:	Address:	City, State, Zip:
Home Phone:	Cell Phone:	Relationship to Patient:

Emergency Contact (Support Role)

Name:	Phone Number:	Relationship to Patient:	School Based Health Center: ☐ Yes ☐ No

Race:	Ethnicity: Check One
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Multi-Racial ☐ Native Hawaiian ☐ Other Pacific Islander (Not Hawaiian) ☐ Unreported/Unknown ☐ White ☐ Declined to specify	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other ☐ Unknown ☐ Declined to specify **Public Housing Residence: Check One** ☐ Yes ☐ No

How did you hear about Quality of Life (Marketing) Check One?
☐ Billboard ☐ Cross Referral ☐ Family ☐ Flyer/Pamphlet ☐ Friend ☐ Mail Outs or Post Card ☐ Other

Signature of Patient/Guardian: ______________________________ **Date:** ________________________

Quality of Life Health Services, Inc.

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 **Date**
(if applicable

____

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

MEDICATION HISTORY

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

____
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, Inc. 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:____ Date: ___________________

QUALITY OF LIFE HEALTH SERVICES, INC.

REDUCED/SLIDING FEE DISCOUNT APPLICATION

To qualify for the sliding fee discount, this application must be completed and returned (within 10 business days) from the date of service. If this information is not provided, the charges incurred for that visit will remain as they are, and no discount will be provided; therefore, the applicant/patient will be responsible for the full charges. The sliding fee discount is good for one (1) year from the date of the application. To continue receiving a sliding fee discount applicant must re-apply and furnish proof of income.

Patient Name: ____ Birth Date: __________________________________
Address: ____ Social Security #: ______________________________
City: __________________________________ State: ______________________ Zip Code: ________________________________

Do you have health insurance and/or prescription drug coverage (such as Medicaid, BCBS, Private Insurance, Medicare, VA benefits)? Yes ☐ or No ☐ If yes, please list insurance name/type? ____

____

Number of persons living in your family/household: ___________________________

Please list names and date of birth of all individuals living in your household:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
Self:		**Dependent:**	
Spouse:		**Dependent:**	
Dependent:		**Dependent:**	
Dependent:		**Dependent:**	
Dependent:		**Other:**	
Dependent:		**Other:**	

ANNUAL HOUSEHOLD INCOME

HOUSEHOLD MEMBER	ANNUAL HOUSEHOLD INCOME
SELF	
SPOUSE	
DEPENDENT CHILD	
DEPENDENT CHILD	
OTHER	
TOTAL	

NOTE: Include income from all sources including the following:

- Gross income (Form W-2/Form 1099/Schedule C
- Gross wages and tips from current check stub
- "Statement of Sustainability" as applicable
- Net income from farm and non-farm self-employment
- Government Assistance Document (ex; Food Stamp Certification Letter with stated earned and unearned income)
- Dividends or interest on savings or bonds
- Social Security benefits
- Income from estate or trust or net rental income
- Private pensions or annuities
- Alimony, child support
- Unemployment letter
- Net royalties or settlements
- Veteran payments

By signing this form, I acknowledge to the truthfulness and completeness of all information requested. I certify that I will contact/notify QOLHS, Inc. if I have an insurance and/or income change. I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for Patient Assistance Medication Programs, if applicable. I also attest that I was informed of my rights and requirements to apply for the Sliding Fee Discount Program, and as stated above. ***Furthermore, I understand I have ten (10) working days to bring back my verification of income or mail back to corporate address and designated staff.***

____ ___________________________________
Signature **Date**

DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)

A copy of the provided income documentation must be attached to this application.

Eligible for discount of: __________________ Beginning: ____________ Ending: ____________ Medical Record #: _____________________

____ ____ ________________________
Staff Name (Please Print) **Signature of Staff** **Date**

- **Decline sliding fee discount with the understanding of my right to apply.** _______________________________________ **(Patient Signature)**

QUALITY OF LIFE HEALTH SERVICES, INC.

Statement of Sustainability Form
Reduced/Sliding Fee Discount Application

Please fill out this statement of sustainability if proof of income is not available. Please indicate how day-to-day basic living needs are being met with no income. This will enable Quality of Life Health Services, Inc. to process the sliding fee application. Patients must provide written proof of financial assistance from outside agency or the individual providing assistance. Written proof of financial assistance from outside agency or the individual providing assistance must be provided within 10 business days from the date of service. Patients completing a statement of sustainability form shall be evaluated after six (6) months. ***Information may be mailed back to the corporate office to designated staff.***

Patient Name ________________________________ Birth Date ____________________
Address ____ Social Security # ____________________
City ________________________ State _____________ Zip _________________

Do you have health insurance and/or prescription drug coverage (such as Medicaid, BCBS, Private Insurance, Medicare, VA benefits)? Yes ☐or No ☐
If yes, please list insurance name/type?
____

Number of persons living in your family /household: ___________________________

Please explain why income verification cannot be provided and means of daily basic needs:
____

____

____

By signing this form, I acknowledge to the truthfulness and completeness of all information requested. I certify that I will contact/notify QOLHS, Inc. in the event that I have an insurance and/or income change. I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for Patient Assistance Medication Programs, if applicable.

____ ____________________________
Patient Signature **Date**

DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)

A copy of the provided income documentation must be attached to this application.

☐Approved ☐Disapproved **(attached explanation of disapproval)**

Eligible for discount of: _________ Beginning: _____________ Ending: __________________

Medical Record #: _________________ PSR Name (please print): ________________________________ Date: __________________

____ ____________________
Signature: ***VP of Operations or Designee*** **Date**

EMPLOYMENT VERIFICATION LETTER

Date:____________________________

This letter is notification that____ **(patient name),**

___________________ **(date of birth),** ___________________ **(social security number)** is

employed by ____ **(company and/or individual name)**

as ______________________________ **(ex. waiter, cook, contract labor, cleaning, etc.)** and has been

employed since ___________________ **(date of hire).**

_______________________________ **(patient name)** gross pay is $________________ per

hour/week/every 2 weeks/month (circle one) and he/she works ______hours per week at _________ per hour.

Sincerely,

_______________________________________ **(Employer Signature)**

_______________________________________ **(Employer Printed Name)**

_______________________________________ **(Employer Address)**

_______________________________________ **(Employer City, State, Zip)**

_______________________________________ **(Employer Phone Number)**

_______________________________________ **(Employer Tax ID#)**

NOTE: Documentation of source of income must be provided to Quality of Life Health Services, Inc. **within 10 business days** from the date of visit. The completed Employment Verification Letter may be hand-delivered or mailed to Quality of Life Health Services, Inc. at the address provided below. If you need any further information, please call 256-492-0131, extension 6314.

Please return completed Employment Verification Letter to:

Quality of Life Health Services, Inc.
Attention: Vice President of Operations
Post Office Box 97, Gadsden, AL 35902