QUALITY of LIFE
HEALTH SERVICES, INC.

ATTENTION:
NEW AND EXISTING PATIENTS

IF YOU ARE PLANNING A VISIT TO ONE OF OUR SIXTEEN 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

Quality of Life Health Services, Inc.
P.O. Box 97
Gadsden, Alabama 35902
(256) 492-0131

PATIENT INFORMATION				
NAME (Last, First, Middle)	SSN#	Birthdate	Marital Status	Sex
LOCAL ADDRESS	SECONDARY / BILLING ADDRESS (if applicable)			
CITY, STATE, ZIP	CITY, STATE, ZIP			
HOME PHONE	HOME PHONE			
PRIMARY EMPLOYER	SECONDARY EMPLOYER (if applicable)			
ADDRESS	ADDRESS			
CITY, STATE, ZIP	CITY, STATE, ZIP			
WORK PHONE	WORK PHONE			

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	HOME PHONE		
RELATIONSHIP TO PATIENT			

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

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

EMERGENCY CONTACT:		**RACE / ETHNICITY (CHECK ONE):**	**NON-HISPANIC**	**HISPANIC**
PHONE NUMBER		ASIAN		
RELATIONSHIP TO PATIENT:		AMERICAN INDIAN		
RELIGIOUS PREFERENCE:		BLACK		
		WHITE		
NON-SMOKER:	SMOKER:	MULTIPLE RACES		

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.

QUALITY of LIFE
HEALTH SERVICES, INC.

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:_____

ADV ANCE 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.

Patient Name:_____ **MR#**_____ **Date:**_____

_____ _____
Patient/Client Signature **Date**

_____ _____
Interviewer Signature **Date**

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**_____