HHS
Horizon Health Services

Welcome to Horizon Health Services, Inc. and thank you for choosing us as your healthcare provider.

In order to move you smoothly through our registration process, please fill out the enclosed new-patient paperwork in its entirety and **bring it with you** to your appointment.

***PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.***

Included in the packet you will find:

1. Patient Registration Form
2. Consent and Authorization Form
3. Authorization for Permission to Discuss Protected Health Information
4. Authorization for Release of Information
5. Patient Rights and Responsibilities
6. "No-Show" Policy
7. Sliding Fee Discount Program Application

Please remember to bring to **every** appointment:

1. Insurance cards
2. Picture ID
3. Medications
4. Account balances and/or co-pays

Thank you and we look forward to establishing a lifetime of quality care for you!

| **Ivor Medical Center** | **Ivor Dental Center** | **Surry Medical Center** | **Waverly Medical Center** |
|---|---|---|---|
| 8575 Ivor Rd. | 8579 Ivor Rd. | 440 Colonial Trail W. | 344 W. Main St. |
| Ivor, VA 23866 | Ivor, VA 23866 | Dendron, VA 23839 | Waverly, VA 23890 |
| 757-859-6161 | 757-859-9070 | 757-294-3981 | 804-834-8871 |
| Mon-Thurs 8am - 5:30pm | Mon-Thurs 8am - 5:30pm | Mon 8am - 3:30pm<br>Tues-Fri 8am - 2:30pm | Mon-Fri 8am -5:30pm |

If you experience a medical **emergency** outside of our normal hours of operation, please call 911 or go to the nearest emergency room. If you need to speak with a healthcare provider regarding a non-emergency medical matter that can't wait until our offices reopen, please call the office phone number and follow the prompts to reach the medical provider on call.

Revised 09/01/2021

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# *PATIENT REGISTRATION*

## *Patient Information*

**PATIENT NAME:** _____ **BIRTH DATE:** _____

**STREET ADDRESS:** _____

**MAILING ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**WHICH PHONE WOULD YOU LIKE TO BE CONTACTED ON?** Home Cell Work

**HOME PHONE:** _____ **CELL PHONE:** _____

**WORK PHONE:** _____ **ADVANCED DIRECTIVES/DNR ON FILE?**

**SOCIAL SECURITY #:** _____ Yes No

**EMAIL ADDRESS:**

## *Employer Information*

**EMPLOYER NAME:** _____ **CONTACT PERSON:** _____

**EMPLOYER ADDRESS:** _____ **PHONE:** _____

## *Other Patient/Financial Information*

**RACE:** White African American Asian American Indian
Other Pacific Islander Refused to Report Other:_____

**ETHNICITY:** Hispanic? Yes No **SEX:** Male Female

**GENDER IDENTITY:** Male Female Transgender Male (Female-to-Male)
Transgender Female (Male-to-Female) Choose Not to Disclose Other

**MARITAL STATUS:** Single Married Separated Divorced Widowed **VETERAN:** Yes No

**SEXUAL ORIENTATION:** Lesbian or Gay Straight Bisexual Something Else Don't Know Choose Not to Disclose

For the purpose of determining eligibility for the Sliding Fee Discount Program please complete:

**HOUSEHOLD INCOME (annual):** Below $10,000 $10,000 - $15,000 $15,000 - $25,000
Choose Not to Disclose $25,000 - $35,000 $35,000 -$50,000 Exceeds $50,000

**NUMBER OF MEMBERS IN THE HOUSEHOLD:** 1 2 3 4 5 6 7 8 9+

## *Insurance Information*

**INSURANCE NAME:** _____

**POLICY #:** _____ **GROUP #:** _____

**NAME AS LISTED ON INSURANCE CARD:** _____

**NAME OF POLICY HOLDER:** _____ **DOB:** _____ **SSN:** _____

## *Responsible Party Information*

**RESPONSIBLE PARTY:** _____ **RELATIONSHIP:** _____

**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

**PREFERRED PHONE:** _____ **SSN:** _____ **DOB:** _____

## *Additional Information*

**EMERGENCY CONTACT NAME:** _____ **RELATIONSHIP:** _____

**ADDRESS:** _____ **PHONE:** _____

**PREFERRED PHARMACY:** _____ **Street:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

Patient Name: _____

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# Consents/Authorizations

Please read and initial each line and sign at the bottom of the page.

_____ **Failure to Notify HHS of Appointment Cancellation/Rescheduling**: I understand that failure to cancel or reschedule an appointment within 24 hours of the scheduled appointment will result in a $25.00 charge and if this occurs 3 times within 1 year I may be dismissed from the practice.

_____ **Payment Agreement/Insurance Authorization and Assignment:** I understand that I am responsible for all charges incurred. I agree to be responsible for payment of all services rendered to me or my dependents at Horizon Health Services, Inc. (HHS). I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize HHS to file my insurance for services rendered. I request that payment be made directly to Horizon Health Services, Inc. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay. I understand that if HHS is unable to obtain payment within a reasonable amount of time, I will be referred to a collection agency.

_____ **Notice of Privacy Practices:** I hereby acknowledge that I have had the opportunity to review a copy of the HHS Notice of Privacy Practices and a paper copy is available to me upon request.

_____**Consent/Authorization for Treatment:** I hereby consent to and authorize HHS through its appropriate personnel and/or its health care staff to perform, administer, and/or prescribe such medical examination, tests, immunizations, injections, diagnostic procedures, dental services, as well as behavioral health evaluations and treatment, as are deemed necessary by my healthcare providers. I understand that this may include testing or screening for diseases such as Hepatitis and HIV/AIDS unless I opt out or decline these screenings. I understand that I have the right and the opportunity to make informed decisions regarding my care and treatment. I have the right to discuss the risks and benefits of any recommended procedure(s) and/or therapeutic courses of treatment along with any available alternatives. This right also includes the right to refuse any recommended treatments.

_____ **Authorization to Leave Messages**: If we are unable to contact you and you have an answering machine or voicemail, do we have your permission to leave a message containing medical information (circle appropriate): **YES** **NO**

If yes, where may we leave messages (circle appropriate): **HOME** **CELL** **WORK**

_____ **Deemed Consent for Blood Testing**: I understand that under Virginia Law, if a health care provider, a person employed by, under the direction of, or control of a health care provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consented for testing for HIV or Hepatitis B or C, and the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

_____ I give HHS the authority to exchange information with the pharmaceutical companies that manufacture my medications in an effort to access free medication. I authorize HHS to sign any necessary forms on my behalf when ordering medications for me. I understand that this will speed up the ordering process by making it unnecessary for the forms to be sent to me and then back to HHS. This signature authorization is valid as long as I am receiving medication assistance from HHS.

_____ I understand that HHS may request and receive any and all records held by the Virginia Department of Health Professions Prescription Monitoring Program relating to Schedule II-IV prescriptions previously dispensed to me (or my minor child).

Patient/Responsible Party Signature: _____ Date: _____

Staff Initials: _____

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# *Authorization for Permission to Discuss Protected Health Information*

**PATIENT NAME:** _____

**SOCIAL SECURITY #:** _____ **DATE OF BIRTH:** _____

The new government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends, or caregivers regarding your protected health information, except in the case of an emergency.

By signing this form below, I give Horizon Health Services, Inc. the permission to disclose/discuss my private health information with the person (s) listed below. I understand that I may revoke my authorization at any time by submitting my request to change, add, or terminate such permission in writing. I also understand that in cases where this form is not accessible or in cases of an emergency that the physicians and staff will use their best judgement in complying with my wishes in this matter.

| *Name* | *Telephone Number* | *Relationship* | *Date of Permission* |
|---|---|---|---|
| | | | |
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Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient or Responsible Party: _____ Relationship (if not self): _____

## I have reviewed the above information and confirm this information is accurate.

| Signature of Patient or Responsible Party | Relationship (if not self) | Date |
|---|---|---|
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# *Parental Consent Form for Minors*

**PATIENT NAME:** _____

**SOCIAL SECURITY #:** _____ **DATE OF BIRTH:** _____

For occasions when you may not be with your child, please list below those individuals to whom you grant permission to bring your child to their appointment and who may give us consent to treat your child.

| *Name* | *Telephone Number* | *Relationship* | *Date of Permission* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

_____ **Initial here** if you wish to give consent for your child (applicable to minors aged 16 and older) to receive care without an accompanying adult, which shall be in effect indefinitely, until revoked by written consent.

The adult bringing the child for treatment or the child, if they are seen without an adult present, is responsible for payment of the copay at the time of service. I have read, understand, and give my consent as stipulated above.

| | |
|---|---|
| Parent/Legal Guardian Printed Name | Relationship to Patient |
| Parent/Legal Guardian Signature | Date |

## I have reviewed the above information and confirm this information is accurate.

| Signature of Parent/Legal Guardian | Parent/Legal Guardian Printed Name | Relationship (if not self) | Date |
|---|---|---|---|
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# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____Date of Birth:_____SS#: _____

**I HEREBY AUTHORIZE:**

NAME: _____FAX: (____)_____

**TO RELEASE INFORMATION FROM MY MEDICAL RECORD TO:**

☐ **Ivor Medical Center**
8575 Ivor Rd
PO Box 210
Ivor, Virginia 23866
Voice: 757-859-6161
Fax: 757-859-6452

☐ **Ivor Dental Center**
8579 Ivor Rd
PO Box 210
Ivor, Virginia 23866
Voice: 757-859-9070
Fax: 757-859-9075

☐ **Surry Medical Center**
440 Colonial Trail W
Dendron, Virginia 23839
Voice: 757-294-3981
Fax: 757-294-3985

☐ **Waverly Medical Center**
344 W Main Street
PO Box 29
Waverly, VA 23890
Voice: 804-834-8871
Fax: 804-834-8875

**INFORMATION TO BE RELEASED:**

| | Description | Date |
|---|---|---|
| ☐ Progress/Office Notes | _____ | _____ |
| ☐ Laboratory Results | _____ | _____ |
| ☐ X-ray/Imaging Reports | _____ | _____ |
| ☐ Hospital Records | _____ | _____ |
| ☐ Immunization Record | _____ | _____ |
| ☐ Discharge Summary | _____ | _____ |
| ☐ 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)

_____
Signature of Patient or Legal Guardian

Date: _____

**PURPOSE OF DISCLOSURE:** ☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care

☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation ☐ Other _____

1. I understand that this authorization is valid for a period of one year and may be withdrawn, in writing by me at any time except during an action taken in response thereon.
2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
3. I understand that in compliance with Virginia statute, I may be required to pay a reasonable fee for medical records. There is no fee for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____
Signature of Patient/Responsible Party Date

Patient Name: _____

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# Patient Rights and Responsibilities

## *You, the patient, have the right to…*

Respectful Treatment

- Medical/Dental care without regard to race, culture, national origin, gender, age, or disability, and to have your personal individuality respected.
- Be treated with kindness and respect by all staff members.
- Prompt, considerate, and quality medical/dental care.

Participation in Decision Making

- Know the name of the provider or nurse/assistant responsible for your care while in our office.
- Information about your condition, treatment, and expected outcome as well as your personal right to accept or refuse medical treatment.
- Make treatment decisions that respect your personal needs and life situation.

Confidentiality

- Privacy and confidentiality of all records and communications concerning your treatment to the extent provided by law.
- View or request a copy of your medical record.

Financial Information

- Ask for information regarding financial assistance with your account.
- Speak with a patient account specialist regarding your bill.
- Obtain a copy of your itemized bill and have it explained to you.

File a Complaint or Grievance

- To file a formal complaint or grievance about the safety or quality of care you received in our office call (757) 859-5015 or submit in writing to:

  Horizon Health Services, Inc.
  Administration Office
  PO Box 210
  Ivor, VA 23866

## *You, the patient, have a responsibility to…*

- Be respectful and considerate of staff members as well as other patients.
- Provide staff with necessary medical/dental and personal history that may affect your treatment.
- Participate actively in your own care, cooperating with and following directions of HHS clinical staff.
- Communicate to clinical staff your inability or refusal to follow the treatment plan recommended for you.
- Make sure that staff have the correct insurance billing information and that a copy of your card is available to them for reference.
- Pay co-payments at the time of the visit or other bills upon receipt.
- Keep all scheduled appointments.
- Call 24 hours in advance to cancel or reschedule appointments that you cannot keep.
- Refrain from smoking and cell phone use while in our facility.

Patient/Responsible Party Signature: _____ Date: _____

Staff Initials: _____

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Patient Name: _____

# "No-Show" Policy

Quality care of our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

## Definitions of a "No-Show" Appointment

HHS defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours notice
- Arrives more than 15 minutes late and is consequently unable to be seen

## Impact of a "No-Show" Appointment

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" for a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair to other patients that could have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire staff

## How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours notice** if you need to cancel an appointment

1. Appointment Confirmation

   HHS will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will need to contact HHS to confirm your appointment.

2. Always Arrive 5-10 Minutes Early

   When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit. If you arrive more than 15 minutes late to your appointment, you will be considered a "no-show" and you will not be able to be seen.

3. Give 24 Hours Notice if You Need to Cancel

   When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to fill the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call. (Please note that this cancellation will still be considered a "no-show".)

## Consequences of "No-Show" Appointments

1. You will be charged a $25.00 fee for "no-show" appointments.
2. If you fail to keep appointments for routine follow-up care, your medications will not be refilled until you are seen by your provider.
3. If you "no-show" to 3 or more appointments within a year, you may be dismissed from our practice.
   - If you are dismissed from our practice, your remaining appointments will be cancelled.
   - Only emergency medical/dental treatment will be offered within the first 30 days of dismissal.

I have read and understood the Horizon Health Services, Inc. "No-Show" Policy as described above.

Patient/Responsible Party Signature: _____ Date: _____

Staff Initials: _____