FIVE HORIZONS
HEALTH SERVICES

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

FIRST NAME:_____ LAST NAME:_____ MIDDLE INITIAL:_____

DATE OF BIRTH:_____ GENDER:_____ RACE:_____

PRIMARY PHONE:(___)_____ ☐CELL ☐HOME OTHER PHONE:(___)_____ ☐CELL ☐ HOME

MAILING ADDRESS:_____ APT #:_____

CITY:_____ STATE:_____ ZIP CODE:_____

SOCIAL SECURITY NUMBER:_____ MARITAL STATUS:_____

DRIVER'S LICENSE #:_____ STATE:_____ EMAIL ADDRESS:_____

EMPLOYER INFORMATION

EMPLOYER:_____ PHONE:(___)_____

PHARMACY INFORMATION

PHARMACY:_____ LOCATION:_____

EMERGENCY CONTACT:

NAME:_____ PHONE:(___)_____

RELATIONSHIP TO PATIENT:_____

PERSON RESPONSIBLE FOR ACCOUNT: (IF PATIENT IS A MINOR)

NAME:_____ DATE OF BIRTH:_____

PHONE:(___)_____ RELATIONSHIP TO PATIENT:_____

MAILING ADDRESS:_____ APT#:_____

CITY:_____ STATE:_____ ZIP CODE:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE

TYPE OF INSURANCE:_____

POLICY HOLDER:_____

POLICY HOLDER DOB:_____

SECONDARY INSURANCE

TYPE OF INSURANCE:_____

POLICY HOLDER:_____

POLICY HOLDER DOB:_____

_____ _____

Patient Signature Date

2720 6th St #100, Tuscaloosa, AL 35401 Phone: (205) 759-8470 Fax: (205) 366-9001

FIVE HORIZONS
HEALTH SERVICES

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Five Horizons Health Services for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at the time of service. Payment Methods: Cash, Debit/Credit Cards, Flex Spending Cards, and Checks. Returned check fee: $25.00
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing. Any outstanding balance after 30 days from receipt of billing will be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney will be subject to a collection fee of 10%, which will be added to the total balance due at the time of write-off. Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - FMLA Paperwork: $25.00
    - Itemized Statement $5.00
    - Non-routine medication request: $15.00
    - No-show fee: $50.00

By my signature below, I hereby authorize assignment of financial benefits directly to **Five Horizons Health Services** and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____

Patient Name Date

_____

Patient/Guardian Signature

FIVE HORIZONS
HEALTH SERVICES

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I, the undersigned patient and/or responsible party, hereby authorize Five Horizons Health Services, it's physician, nurse practitioners, agents, employees, or representatives to discuss or release any or all patient information about me including, but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person or persons indicated below:

NOTE: Patients 14 years and older MUST be the one to sign this form.
If you DO NOT want anyone to have access to your records, please put an "X" through the box and sign.

NAME	RELATIONSHIP TO PATIENT
1.	
2.	
3.	
4.	
5.	

_____ _____

Patient Signature Date

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ACKNOWLEDGEMENT AND CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

You are receiving healthcare services from **Five Horizons Health Services**. You agree that all records concerning your care within **Five Horizons Health Services** shall remain the property of **Five Horizons Health Services**. You understand and agree that such information is used for: (1) your treatment – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, nurse practitioner, consulting physician(s), and other healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient, (2) payment for your services – billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payer or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations – accreditation, certification, licensing, or credentialing activities of **Five Horizons Health Services**; and (4) medical research and educational purposes. You acknowledge that you have been provided with a **Five Horizons Health Services Notice of Health Information Practices** that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the notice has been reviewed prior to the signing of this consent. You understand that **Five Horizons Health Services** reserves the right to change the notice and that **Five Horizons Health Services** will provide you with a revised notice when you come to **Five Horizons Health Services**. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

Five Horizons Health Services: Agree: _____ Not Agree: _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

FIVE HORIZONS
HEALTH SERVICES

NURSE PRACTITIONER CONSENT FOR TREATMENT

Five Horizons Health Services employs a nurse practitioner to delivery of medical care.

A nurse practitioner is not a physician. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a nurse practitioner can diagnose, treat, and monitor acute and chronic disease as well as provide health maintenance care. Our nurse practitioner is board certified by the American Academy of Nurse Practitioners.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provider. A collaborating physician is always available to the nurse practitioner for consultation regarding your care.

A nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Prescribing medications
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Making appropriate referrals

I have read the above, and hereby consent to the services of a nurse practitioner for my health care needs.

_____ _____

Patient Name Date

_____

Patient Signature

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Revised 5/3/2018

FIVE HORIZONS
HEALTH SERVICES

NO SHOW AND CANCELLATION POLICY

No Show Policy

A "no show" is someone who misses an appointment without canceling it 24 hours in advance of your scheduled appointment. No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your chart as a "no show". The first occurrence will result in a letter alerting you of your first "no show". If there is a second "no show", a fee of $50.00 will be billed to your account. No-show fees are not covered by insurance and will be billed directly to the patient. This fee will need to be paid in full before scheduling any further appointments or medication refill requests. Three "no shows" in a 12 month period will result in patient termination from Five Horizons Health Services.

Cancellation of an Appointment

In an effort to provide medical care to our patients in a timely manner, Five Horizons Health Services asks all of our valued patients to please be courteous and call promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance Five Horizons Health Services is a growing practice and appointments are in high demand. Your early cancellation could give another patient the access to medical care in a timely manner.

How to Cancel your Appointment

To cancel appointments, please call (205) 759-8470. If you do not reach the receptionist, you may leave a detailed message on the voice mail.

Late Cancellations

Late cancellations will be considered as a "no show".

Please sign that you have read, understand and agree to this No show and Cancellation Policy.

_____ _____

Patient Name Date

_____

Patient/Guardian Signature

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Revised 5/3/2018

FIVE HORIZONS HEALTH SERVICES

Patient Name: _____ **Birth date:** _____/_____/_____

Reason for today's visit: _____

MEDICAL CONDITIONS	PRIOR SURGERIES	DATE

Please list ALL medications that you are currently taking. Please include vitamins, herbal remedies and over the counter medications also. Please put N/A if you are not taking medications.

MEDICATION	DOSAGE	HOW MANY TIMES A DAY

Do you have any drug, food or environmental allergies? ☐ YES ☐ NO (If yes, please explain below.)

ALLERGY	TYPE	REACTION

Please describe any family health issues below:

FAMILY HISTORY	NONE /UNKNOWN	MEDICAL CONDITION(S)	LIVING OR DECEASED
MOTHER			
FATHER			
OTHER FAMILY MEMBER			

Are you a smoker? ☐ YES ☐ NO, never (If yes, please explain below.)

TYPE OF SMOKING (cigarette, cigar, marijuana, chew, etc.)	HOW MANY PER DAY	HOW LONG

Do you drink alcohol? ☐ YES ☐ NO, never ☐ Past history of alcohol use (If yes, is it ☐ Social or ☐ Daily use?)

Do you use injection drugs or any illegal drugs? ☐ YES ☐ NO, never ☐ Past history of drug use
If yes, what kind? _____

For females ONLY, when was your last menstrual period? ____/_____/____ **Are you pregnant? ☐ YES ☐ NO ☐ UNSURE**
When was your last Pap Smear? _____/_____/_____ **Was it abnormal? ☐ YES ☐ NO**
When was your last Mammogram? _____/_____/____ **Was it abnormal? ☐ YES ☐ NO**

Patient Signature: _____ **Today's Date:** _____/_____/_____

Provider Signature: _____ **Today's Date:** _____/_____/_____

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PATIENT CONSENT FORM TO TEST BLOOD FOR THE PRESENCE OF THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

This is a consent form. Please read it carefully and initial each number.

_____1. It has been explained to me that HIV is a virus, which is the cause of Acquired Immunodeficiency Syndrome (AIDS). If you have been exposed to the HIV virus, your body produces an antibody. That means if the antibody is present in your blood, you have the HIV virus. To do the HIV antibody test, my blood will be tested by a method called ELISA. If this test shows no antibody, the result will be reported back to me as "negative". If the test shows that a certain antibodies are in the blood, the test is considered "positive". Positive blood will be retested by the same method to see if a second positive test occurs. If both ELISA tests are positive, my blood will be retested by a method called Western Blot. The Western Blot is used to confirm the ELISA test results. The result of the Western Blot may be positive, negative, or uncertain. I will only be informed of a positive HIV test if the Western Blot has confirmed it or by some other test that permits accurate diagnosis.

_____2. I understand that the HIV blood test alone does not show that I have AIDS. The test result should be considered along with my medical exam and other tests, plus any history of high-risk behavior, to include if I have AIDS or any of the other HIV-related illnesses.

_____3. I further understand that the HIV test cannot be used to diagnose AIDS, nor can it totally exclude the chance that I may be infected with the HIV virus. A person who has been infected with the HIV virus may not test positive for weeks or months.

_____4. It has been explained to me that a direct physical effect from having the HIV antibody test is a mild discomfort that occurs when the blood is drawn. Other effects depend on the results of the test. Because there is no cure for HIV at this time, the effect for persons who are infected with the HIV virus are unknown. Thus, a positive test result can have a major psychological impact on the person tested and those who are close to him or her. A positive test could have a financial impact. I may also have a hard time getting health insurance in the future. My HIV test result will become a part of my medical record. That means that health care personnel caring for me will know about the results of the test. To the best of its ability, Five Horizons Health Services l will not give the results of my HIV test to others except as required by law.

_____5. I have read this information sheet carefully and I have discussed the HIV test with my doctor. I have had a chance to ask questions and my doctor has answered them to my satisfaction. I realize that the results of the test may affect my mental and financial well-being. I realize that knowing my HIV antibody status may help my doctor advise me about my care and help me make choices about my behavior and about other health issues.

_____6. I understand that my test results will remain private except when law or regulation requires revealing the results. The results may also be revealed to protect the well being of office staff personnel involved in my care.

_____7. By my signature below, I consent to having a blood sample collected from me, or from a person for who I am authorized to give consent, for the purpose of testing for the presence of the HIV antibody.

_____	_____	_____	_____
Print Name	Patient's Signature	Date	Time

_____
Witness

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Name:_____DOB:_____Date:_____

Sexual Lifestyle Assessment

The follow questions are to be answered honestly and as accurate as possible. Five Horizons Health Services is dedicated to keeping you healthy in providing the best possible care. Our goal is to help prevent you from getting STI's including HIV. Please take a moment to answers the follow questions.

Please circle or check answers that apply:

1. I have sex with condoms.

   Always Sometimes Never

2. Approximately, how many sexual partners have you had in the past 6 months?

   ☐ 0 ☐ 4
   ☐ 1 ☐ 5
   ☐ 2 ☐ 6-10
   ☐ 3 ☐ >10

3. I have sex with ___

   Men Women Both men and women

4. I have_____sex.

   Anal Vaginal Oral Other: _ _ _ _ _

5. Have you ever had a sexually transmitted infection (STI)?
   (STI examples: Syphilis, Gonorrhea, Chlamydia, Herpes, HPV, HIV)

   Yes No

6. I know the_____status of my past/ present sexual partner(s).

   HIV STI Both I don't know the STI or HIV status.

7. Are you having sex with or considering having sex with some who is lilV positive?

   Yes No

8. Have you ever injected drugs that were not prescribed to you by a medical provider?

   Yes No

9. In the past six months, have you been treated in a methadone or other medication based drug treatment program?

   Yes No

10. I identify my gender as_____
    (fill in the blank)

11. Other questions or concerns I have about my sexual health .

_____