WELCOME TO NEW HORIZON FAMILY HEALTH SERVICES!

Thank you for choosing NHFHS as your medical home!
Please take a few minutes to read this new patient information before your visit.

SERVICE LOCATIONS

Faris
975 West Faris Road
Greenville, SC 29605
Phone: (864) 729-8330
8:00 AM- 9:00 PM Monday- Saturday

PHARMACY HOURS:
8:00 AM- 9:00 PM Monday- Saturday

Travelers Rest
1588 Geer Hwy., PO Box 1370
Travelers Rest, SC 29690
Phone: (864) 836-1109
8:00 AM- 8:00 PM Monday
8:00 AM- 5:00 PM Tues, Wed, Thurs, Friday

PHARMACY HOURS:
8:00 AM- 12:00 PM , 1:30 PM- 5:00 PM
M-F but closed daily for lunch 12-1:30 PM

Greer
111-A Berry Avenue
Greer, SC 29651
Phone: (864) 801-2035
8:00 AM- 5:00 PM Mon, Wed, Friday
8:00 AM- 8:00 PM Tuesday, Thursday

PHARMACY HOURS:
8:00 AM- 12:00 PM, 1:30- 5:00 PM
M-F but closed daily for lunch 12-1:30 PM

New Horizon Family Dental Care
1 Memorial Medical Drive
Greenville, SC 29605
Phone: (864) 351-2400
8:00 AM - 5:00 PM Monday, Wednesday
8:00 AM - 7:00 PM Tuesday, Thursday
8:00AM - 12:00 PM Friday

Health Care for the Homeless
Mobile Unit
111-A Berry Avenue
Greer, SC 29651
Monday- Friday

REGULAR BUSINESS HOURS:
New Horizon Family Health Services operates on an appointment basis but provide services for sudden or acute illness **(same day appointments for established patients only).**

Regular business hours vary by location as listed in the service location column.
All locations are **closed on New Year's Day, Martin Luther King, Jr.'s Birthday, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day (2 days), and Christmas (2 days).

APPOINTMENTS:
For appointments, call directly to most convenient location. Press 1 for English or 2 for Spanish, and then follow the prompts.

Should you have an emergency after regular business hours, please call New Horizon Family Health Services and speak to the on-call nurse.

CANCELLATIONS/RESCHEDULING APPOINTMENTS:
WE ASK THAT YOU CALL THE OFFICE AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TO CANCEL/RESCHEDULE YOUR APPOINTMENT. This allows us to better serve you and our other patients.

MEDICATIONS:
Please bring **all** your medications with you to your appointment.

PHARMACY HOURS:
Press 3 for Pharmacy; on the last Thursday of each month, call for afternoon hours. Regular business hours vary by location as listed in the service location column.

FEES/PAYMENTS:
New Horizon Family Health Services accepts private insurance, Medicare, Medicaid, and offers sliding scale fee discount for those without insurance and who qualify.

- Patients who receive Medicare or Medicaid benefits must **bring their insurance** card each time they visit.
- **If you are on a sliding fee scale, the federal government requires that we have your financial status on file** (recent income tax statement, 3 most recent paycheck stubs showing regular hours worked/gross income, or **notarized** document from employer stating salary per hour/week and number of hours worked). The amount you pay depends on number of family members living in your home and family income before taxes.
- **Your copay is for the OFFICE VISIT ONLY; you are responsible for the charges for injections, procedures, labs, etc.**
- You must alert us immediately of any **changes** (address, family status, or income). Failure to update information will result in **having to pay full fee**.

Revised 6/20

NEW HORIZON FAMILY HEALTH SERVICES, INC
Patient Registration Form

Date: _______________________ Social Security No.:___________________________

Patient Name: ____
FIRST MIDDLE LAST SUFFIX PREFERRED NAME

Date of Birth: _______________________ Marital Status: ________________________ Former last name: _____________________

Address: ____
STREET/PO BOX CITY STATE ZIP CODE COUNTY

Age: ________________ Sex: (Check one) ☐ Male ☐ Female

Phone: (____)_____-_________ (____)_____-_________ (____)_____-_________
HOME MOBILE WORK

Contact preferences: (Circle one) **Home Phone** **Work Phone** **Mobile Phone** **Mail** **Portal**

(Circle One) **I DO / I DO NOT** authorize my medical information to be left on any answering machine or voice mails at home, work, or cell phone.

How would you prefer your patient care summary? (Circle one) **Paper** **Portal** **Decline**

Email: ____ Are you interested in using the Patient Portal? (Circle one) YES NO
(Email will be used for Patient Portal Access)

ADDITIONAL DEMOGRAPHIC DATA

The data gathered below will only be used to obtain information about you and your household so that we can better meet your medical, behavioral health, and/or dental needs. **This information will not be used to withhold or deny services.**

Household Size:	**Estimated Monthly Household Income:**	**Primary Language (Spoken in Home):**
__________________	________________________	__________________________________

Race: (Check one)
☐ Black/African American
☐ Caucasian/White
☐ Asian
☐ Native American
☐ Other race
☐ Choose not to disclose

Ethnicity: (Check one)
☐ Latino/ Hispanic
☐ Non-Latino/Non-Hispanic
☐ Choose not to disclose

Homeless Status: (Check one)
☐ Street
☐ Doubling Up - Live with Parents/Friends
☐ Homeless Shelter
☐ Transitional
☐ Other
☐ N/A

Employment Status: (Check one)
☐ Employed
☐ Unemployed
☐ Self-employed
☐ Retired
☐ Part-time student
☐ Full-time student
☐ Choose not to disclose

Sexual Orientation:(Check one)
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Don't know
☐ Straight or heterosexual
☐ Something else
☐ Choose not to disclose

Gender Identity: (Check one)
☐ Male
☐ Female
☐ Gender queer
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Choose not to disclose

Please check all that apply:
☐ Disabled
☐ Veteran
☐ Public housing
☐ Agricultural worker and/or Migrant
☐ Homebound
☐ School based health center
☐ N/A

NEW HORIZON FAMILY HEALTH SERVICES, INC

Patient Registration Form

GUARANTOR (Responsible Party) INFORMATION

(If different from patient):

Social Security No.:______________________ Date of Birth: _______________________ Relationship to Patient: _________________

Name: ____
FIRST MIDDLE LAST SUFFIX

Address: ____
STREET/PO BOX CITY STATE ZIP CODE COUNTY

Phone: _______________________ _______________________ ____________
HOME MOBILE WORK

INSURANCE INFORMATION

(MEDICAID, MEDICARE, PRIVATE, or other 3rd Party Coverage, please provide a copy of all insurance cards.)

Insurance Company	Name of Insured	Insured's Date of Birth	Insured's Social Security No.	Relationship to Patient

If you have private insurance, what is your annual deductible, per family member?	$_________________

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices or New Horizon Family Health Services and that I have been given the opportunity to ask questions about the notice.

Patient Signature (or responsible party): __________________________________ Date: _________________
Relationship to Patient: ________________________

Emergency Contact

Individuals listed as Emergency Contact could be called after 2 unsuccessful attempts at patient contact in the case of an urgent need. I authorize release of the minimum amount of information necessary to the individuals listed below. Authorization expires upon my written request.

Primary Emergency Contact:

Name: __________________________________ Relationship: ___________________ Phone: ________________________

Secondary Emergency Contact:

Name: __________________________________ Relationship: ___________________ Phone: ________________________

How did you hear about us? (Circle one) **Online** **Community Events** **Friend/Family** **Referral** **Other ______**

ADMIN-06
Rev 5.18 KLB
Rev 5.19 KLB
Rev 6.20 KW

NEW HORIZON FAMILY HEALTH SERVICES, INC.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Name: ____ Date of Birth: _________________________

PURPOSE: To outline the basic rights and responsibilities of patients at New Horizon Family Health Services, Inc. (NHFHS).

POLICY: It is the policy of NHFHS to provide services that are sensitive to the basic rights of human beings for independence of expression, decision and action.

NHFHS recognizes that during illness, the concern for the personal dignity and human relationships are always of great importance.

NHFHS further recognizes that patients have a right to expect the following characteristics when receiving services:

RIGHTS:

Respect and Dignity - The patient has the right to considerate, respectful care at all times and under all circumstances with recognition of their personal dignity.

Privacy and Confidentiality - The patient has the right, within the law, to personal and informational privacy.

Personal Safety - The patient has the right to expect reasonable safety insofar as the center practices and environment are concerned.

Identity - The patient has the right to know the identity and professional status of individuals providing service and to know which physician or other practitioner is primarily responsible for his/her care.

Information - The patient has the right to obtain, from the practitioner responsible for coordinating his/her care, complete and current information concerning his/her diagnosis (if known), treatment and any known prognosis.

Assistance - The patient has the right to ask questions and discuss problems that arise during an office visit. NHFHS provides any individual to handle patient complaints.

Consent - The patient has the right to reasonable informed participation in decisions involving his/her health care.

Consultation - The patient, at his/her own request and expense, has the right to consult with a specialist.

Refusal of Treatment - The patient may refuse treatment to the extent permitted by law.

Patient Charges - Regardless of the source of payment for care, the patient has the right to request and receive an itemized and detailed explanation of the total bill for services rendered.

Patient Rules and Regulations - The patient should be informed of the rules and regulations applicable to conduct as a patient.

RESPONSIBILITIES:

NHFHS as a provider of health services has a right to expect reasonable, responsible behavior on the part of patients. Characteristics of such behavior are as follows:

Provision of Information - The patient has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications and other matters relating to their health.

Compliance with Instructions - The patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care.

Refusal of Treatment - The patient is responsible for his/her actions if treatment is refused or if the practitioner's instructions are not followed.

Patient Charges - The patient is responsible for assuring that the financial obligations incurred in providing his/her health care are fulfilled as promptly as possible.

Rules and Regulations - The patient is responsible for following center rules and regulations affecting patient care and conduct.

Respect and Consideration - The patient is responsible for being considerate of the rights of other patients and center personnel and for assisting in the control of noise, smoking and eating in the center.

Patient Signature (or responsible party): ____________________________________ Date: ______________________________

Relationship to patient: ____________________________

IMPORTANT

New Horizon Family Health Services

No Show Policy

Patient Name: _________________________________ **Date of Birth:** ____________________

It is very important to keep all appointments and "no shows" should be avoided. Please arrive on time for your appointment. If you are more than 15 minutes late for your appointment, you may be asked to wait until your Provider is available, or to reschedule.

If you must cancel an appointment, you will need to call at least 24 hours in advance or it will be considered a no show. This notice is necessary to allow the availability of the time slot for other patients needing an appointment.

If you have problems keeping your appointments, please contact us as soon as possible. We will be happy to help you in any way possible with keeping your appointments.

A fee of $3.00 will be charged for each no show for an office visit. A fee of $10.00 will be charged for each no show for a scheduled procedure. After three no shows, you may be removed from any future scheduled appointments. You will need to call the morning of the day that you wish to be seen. We will let you know what may be available at that time.

Thank you for your cooperation.

I acknowledge that I have received and understand the information about New Horizon Family Health Services' No Show policy.

Patient signature (or responsible party):________________________________ **Date:** ______________

Relationship to patient: _______________________________