Welcome to New Horizons Healthcare

New Patient Information Packet

Please **read** the entire packet, **complete** the applications, and **bring** all necessary documentation to your appointment with our Eligibility Coordinator.

*Your appointment will be rescheduled with the Eligibility Coordinator if packet is incomplete or requested documentation is not available.*
Welcome to New Horizons Healthcare!

Please **read** the entire packet, **complete** the applications, and **bring** all necessary documentation to your appointment with our Eligibility Coordinator or your appointment will be rescheduled.

**ALL APPOINTMENTS**

Because of the demand for our services, it is very important to keep your scheduled appointment.

If unforeseen circumstances require you to cancel or reschedule, please give us at least a 24 hours’ notice by calling our office at (540) 362-0360. Your courtesy will allow us to schedule another patient.

**Notification less than 24 hours is considered a no show.**

More than three “no-show” appointments in a 12 month period will jeopardize your ability to make future scheduled appointments and we would like to avoid that situation.

**INITIAL APPOINTMENT WITH ELIGIBILITY COORDINATOR**

The following information is required for **ALL** patients:

- Your **driver’s license** or other photo ID. We need to make a copy of your license for our file.
- Your completed **Patient Health History Form**
- Your completed **Sliding Fee Discount Application** with requested documentation (See information regarding this program below)
- Your **insurance card** if you have insurance. *If you are covered by insurance, complete the Insurance Declaration Page.*

**SLIDING FEE DISCOUNT PROGRAM**

Available for Medical Office Charges and for Medication Assistance Program (MAP)

All patients may apply (insured and uninsured) for the **Sliding Fee Discount Program**. If you have insurance, you may qualify for additional discounts on charges under our Sliding Fee Program based on your annual income and the size of your family. This discount may be applied to your deductible or co-insurance. If you have insurance, but do not have coverage for drugs, you may also qualify for help with your medications through the MAP.

The **sliding fee discount is good for one year and you will need to reapply annually**.

An application to apply for this program is enclosed. Eligibility cannot be determined until we receive all requested information from you. *If it is determined you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due.*

**ESTABLISHING ELIGIBILITY IS REQUIRED BY BRINGING APPLICATION AND ALL DOCUMENTATION BELOW:**

- Wages from employment (30 days)
- Copy of your **MOST RECENT** Federal Income Tax Return or a completed Federal Form 4506T (Verification of Non-Filing). Our office will provide this form, if needed.
- Check stubs or statements showing **INCOME** from Social Security; Disability; Retirement or Veteran’s Benefits; Temporary Assistance to Needy Families; Rental Assistance; Child Support and/or Rental Income.
- If you do not have an income from any of the sources above, please complete the enclosed **Housing and Support Verification Form** to help us verify your current living circumstances to establish eligibility.

If you have questions about your Sliding Fee Guidelines or the Pharmacy Assistance Program, you may call our Eligibility Coordinator at 540-283-2556.

**MEDICAL RECORDS FROM ANOTHER PHYSICIAN**

A form for you to sign to allow us to request your medical records from another doctor or clinic if needed will be provided at your eligibility appointment.

I acknowledge by my signature below, that I have read and agree with the provisions of the Sliding Fee Program. I acknowledge and understand that I will be considered responsible for all charges until the Sliding Fee Determination is complete and I am deemed eligible. *If I am not eligible, I understand I will be responsible for all charges.*

Applicant or Responsible Party’s Signature

Date

Thank you for choosing New Horizons Healthcare for your healthcare needs.
Instructions for Sliding Scale Application

1. **Fill in every blank field.** If fields are left blank, your application will be considered incomplete. It will be returned to you.

2. **Fill out income information.** If any individual in the household is over 18 and is considered a dependent (i.e. full time student or disabled), proof of dependence is required. Independent individuals over 18 in the household must apply separately.

   **IMPORTANT:**
   
   Documentation/Proof of All Income is required to process Sliding Scale application

   The following types of documentation are required, as applicable, to document your income:

   - **EMPLOYED:**
     - If employed during total of previous tax year, then the prior year’s IRS 1040 Income Tax Return OR
     - One month’s worth of CURRENT pay stubs showing gross income OR
     - A letter from your employer stating one (1) month gross salary
   - **SELF EMPLOYED:** Prior year’s Federal Income Tax return (IRS 1040), along with Schedule C.
   - **UNEMPLOYED – NO INCOME:** Letter from family or a friend confirming your need of Financial Assistance, or a Notarized Letter verifying your lack of income.
   - **UNEMPLOYMENT/WORKER’S COMPENSATION:** Forms verifying weekly benefit amount or Denial of benefits
   - **SICK LEAVE:**
     - Statement from your doctor stating dates you are unable to work
     - Statement from employer indicating paid sick leave
     - If you are on leave without pay, letter from employer providing your year-to-date gross income and your hire date.
   - **GOVERNMENT BENEFITS:** Social Security, SSI, VA, Disability, or other government benefits
     - Letter confirming or denying, OR
     - Photocopy of check(s), OR
     - Bank statement showing automatic deposit
     - The Current Benefit Statement may be obtained from Social Security by calling 800-772-1213
   - **SOCIAL SERVICES:**
     - “Notice of Action” : Food Stamps, General Relief, Aid to Dependent Children, TANF
     - Letter confirming receipt of housing
   - **OTHER RESOURCES:** Provide legal proof, bank statement, or official award letter
     - Retirement benefits
     - Trust fund allotments
     - Child Support and/or Alimony received (not paid).
   - **HOMELESS:** If homeless, a letter from current shelter is required.
   - **LIQUID ASSETS:** Provide statement(s) from Bank or Credit Union
     - Savings
     - Investments
     - CD’S
     - Interest, Dividends
   - **OTHER:** Copy of custody papers for “other” dependents in your home.

3. How did you hear about us? ________________________________

4. **Medicare** – Do you have Medicare Part-D prescription drug coverage: Yes / No
   Did you qualify for extra help to assist with the cost of your premium and co-pays: Yes / No
   Would you like additional info about Medicare Part D prescription drug coverage: Yes / No

**Comments:** use this area to explain any unusual circumstances which you feel may be helpful.
APPLICATION FOR FINANCIAL ASSISTANCE
SLIDING SCALE PROGRAM

Applicant's Information

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Date of Birth:</th>
<th>Gender:</th>
<th>Mailing Address:</th>
<th>City, ST, Zip:</th>
<th>Marital Status:</th>
<th>Race:</th>
<th>Ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Employment Began:</th>
<th>Employer Phone Number:</th>
<th>How often are you paid?</th>
<th>Amount you are paid:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If unemployed, date employment ended:</th>
<th>If unemployed, has anyone applied for Disability?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

| List of family members: | Social Security #: | Date of birth: | Relation: | Monthly Gross Income*: | Employer name: | Full-time?
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(include yourself)</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid?</th>
<th>Yes / No</th>
<th>Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Stamps?</td>
<td>Yes / No</td>
<td>Amount:</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>Do you/spouse or any of your children under the age of 18 receive Social Security Benefits?</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Medicaid?</td>
<td>Yes / No</td>
<td>Who?</td>
</tr>
<tr>
<td>Food Stamps?</td>
<td>Yes / No</td>
<td>Amount:</td>
</tr>
<tr>
<td>Do you/spouse or any of your children under the age of 18 receive Social Security Benefits?</td>
<td>Yes / No</td>
<td></td>
</tr>
</tbody>
</table>

| Medicaid? | Yes / No | Who? |
| Food Stamps? | Yes / No | Amount: |
| Do you/spouse or any of your children under the age of 18 receive Social Security Benefits? | Yes / No |

<table>
<thead>
<tr>
<th>Did you file income taxes for last year:</th>
<th>Yes / No</th>
<th>IRA's:</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your filing:</td>
<td>Joint or Single</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you or others in the family have insurance?</th>
<th>Yes / No</th>
<th>Name(s):</th>
<th>Insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(please bring card)</td>
</tr>
</tbody>
</table>

| Child Support Received (not paid): | Yes / No | Amount: |
| Alimony Received (not paid): | Yes / No | Amount: |
| Checking Account: | Yes / No | Amount: |
| Saving Account: | Yes / No | Amount: |
| Do you receive rental income? | Yes / No | Amount: |
| Stocks, Bonds, CD's: | Yes / No |        |

<table>
<thead>
<tr>
<th>Do you receive services from one of the following facilities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Ridge Behavioral Health</td>
</tr>
</tbody>
</table>

The information provided above is, to the best of my knowledge and belief, complete, accurate and true. I authorize the release of all information which New Horizons Healthcare may need to determine whether I qualify for financial assistance through the Sliding Scale Program.

Applicant's Signature: ___________________________ Date _____________ Spouse's Signature: ___________________________ Date _____________
**INSURANCE DECLARATION PAGE**

Please present **ALL** insurance cards to Eligibility Coordinator at time of appointment.

### NO INSURANCE COVERAGE

I currently do not have any medical insurance or pharmacy prescription coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage or pharmacy prescription coverage, I will notify New Horizons Healthcare within 30 days of the start date of the new insurance and will provide a copy of my card. Initial here: ______

### PRIMARY INSURANCE COVERAGE

<table>
<thead>
<tr>
<th>INSURANCE COMPANY INFORMATION</th>
<th>SUBSCRIBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company name:</td>
<td>Policy Holders Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Policy Holders DOB:</td>
</tr>
<tr>
<td>City, St, Zip:</td>
<td>Policy Holders Employer:</td>
</tr>
<tr>
<td>Subscriber/Policy/Medicaid/Medicare #:</td>
<td>Relationship to the patient:</td>
</tr>
<tr>
<td>Group #:</td>
<td></td>
</tr>
</tbody>
</table>

Does your *primary* insurance offer prescription drug coverage?  Y / N

### SECONDARY INSURANCE COVERAGE

<table>
<thead>
<tr>
<th>INSURANCE COMPANY INFORMATION</th>
<th>SUBSCRIBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company name:</td>
<td>Policy Holders Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Policy Holders DOB:</td>
</tr>
<tr>
<td>City, St, Zip:</td>
<td>Policy Holders Employer:</td>
</tr>
<tr>
<td>Subscriber/Policy/Medicaid/Medicare #:</td>
<td>Relationship to the patient:</td>
</tr>
<tr>
<td>Group #:</td>
<td></td>
</tr>
</tbody>
</table>

Does your *secondary* insurance offer prescription drug coverage?  Y / N

### PREFERRED PHARMACY INFORMATION

<table>
<thead>
<tr>
<th>Pharmacy name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City, St, Zip:</td>
<td></td>
</tr>
<tr>
<td>Phone #:</td>
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</tbody>
</table>

### DECLARATION

By signing below I am acknowledging that the above information it true and accurate to the best of my knowledge. I also attest that if it is found that I am knowingly withholding insurance information and the time frame to file previous claims has been exceed I will be held responsible for any past due amounts.

Applicant’s Signature: ___________________________  Date: __________  Witness Signature: ___________________________  Date: __________
New Horizons Healthcare employs a Medication Assistance Program (MAP) team to organize applications for free medications for those who qualify for indigent programs offered by pharmaceutical companies.

By signing below, you are agreeing to abide by the following terms:

- You must have a medical appointment with your New Horizons Healthcare (NHH) Primary Care Provider every three months unless otherwise instructed by your Primary Care Provider. You will obtain lab work pertinent to the medical management of your diagnosis as instructed by your NHH Primary Care Provider. If you do not comply with your medical management plan as instructed by our staff, your participation will be terminated with this program.

- It will be your responsibility to give notice to our MAP staff in a timely manner that you need more medication to be ordered through the MAP sponsored by the various drug manufacturers. You must call the MAP staff to reorder additional medication after you have completed a one-month supply of medication. Failure to give enough notice to provide an uninterrupted supply may result in you having to pay for your prescription at the regular retail pharmacy price until medications may be obtained from the manufacturer. Sliding fee discounts will not be applied toward a medication that could otherwise be obtained through this program.

- You must notify the MAP staff immediately in the event of any changes regarding your household, such as change of address, household status (e.g. marriage, divorce, birth, adoption), change of income, new insurance, Medicare, or Medicaid coverage, etc.

- You must notify the MAP staff in the event that your provider discontinues any of your medications, changes a dose or the number of times that you take your medication each day immediately. Failure to provide notification of a medication change may result in an interruption of your medication.

- You must complete the annual re-enrollment process and provide specific income documentation upon request. Failure to comply with this request will terminate your participation in this program.

- It is your responsibility to pick up your medications once you are notified. You will receive a letter stating medication(s) is available for pick up. All medications must be picked up within 30 days after being notified by our office. Please contact our office immediately to request an extension of time. If you fail to pick up within 30 days, your medications will be returned to the drug manufacturer.

- It will be your responsibility to replace medications that are lost or stolen after you have signed for them.

- New Horizons Healthcare cannot guarantee the provision of medications obtained through MAP sponsored by various drug manufacturers. You have the option of purchasing the medications at the retail pharmacy of your choice.

- New Horizons Healthcare may obtain some medications on your behalf through various medication assistance programs, outside of New Horizons Healthcare. Each medication is charged a $10.00 fee and is due at time of pick-up. The fee is not to cover the medication, but the administrative costs associated with processing applications for medications received through this program. No refunds are given for medication obtained through our program.

- I hereby authorize New Horizons Healthcare’s MAP staff as designated Patient Assistance Advocates to sign my name on the necessary pharmaceutical form(s) that may be required for ordering my needed medications.

I, the undersigned, certify that I have read and agree to the Policy for New Horizons Healthcare’s MAP benefits. I understand that violation of any part of the policy may make me ineligible for future MAP services.

Applicant’s Signature: __________________________________________ Date: __________________
# HOUSING AND SUPPORT VERIFICATION FORM

To determine eligibility for discounted services, please complete **ONE** of the following that apply to your situation as of the date of this form. We appreciate your cooperation and wish to assure you that any information provided will be considered confidential.

## PATIENT STATEMENT

Check All That Apply:

- I do not receive any form of public assistance for housing or living expenses
- I do not have anyone to vouch for my living arrangements
- Other - Explain: ____________________________________________

Initial Here

### ARE YOU HOMELESS OR LIVE IN A SAFETY SHELTER? (RAM, TRUST, SALVATION ARMY, ETC.)

If yes, please have a representative of the shelter fill out this section and sign. Thank you.

To New Horizons Healthcare:

- __________________________________ has been a resident at ______________________________________
  ( Applicant’s Name) (Facility Name)
  from ______________ to ______________ (Phone Number for Verification)

  (Signature) _____________________________________________ (Title) ______________ (Date)

### DO YOU RECEIVE SUBSIDIZED HOUSING?

If yes, please have a representative of the Housing Authority fill out this section and sign. Thank you.

To New Horizons Healthcare:

- __________________________________ is a current resident of __________________________________
  ( Applicant’s Name) (Address)
  All rental fees are subsidized by __________________________________
  (Locality Name) (Phone Number)

  (Signature) _____________________________________________ (Title) ______________ (Date)

### IS YOUR FOOD AND SHELTER PROVIDED BY FRIENDS/FAMILY OR MEMBER/ORGANIZATION?

If yes, please have this section filled out and signed by the person providing assistance. Thank you.

To New Horizons Healthcare:

- I __________________________________ am providing __________________________ with food and shelter.

  (Print Name) (Applicant’s Name)

  This individual has no other means of support to the best of my knowledge. I am providing this support until ________________.

  (Signature) _____________________________________________ (Date)

  Address ___________________________________ Phone ______________________

## AUTHORIZATION TO RELEASE INFORMATION

I authorize any above named organization or person to release information for verification of housing and support (living expenses) as requested.

Patient or Responsible Party Signature: ___________________________ Date: ___________________________
### CURRENT MEDICATIONS (INCLUDE NON-PRESCRIPTION PRODUCTS)

<table>
<thead>
<tr>
<th>Medication/Strength</th>
<th>Dosage</th>
<th>Medication/Strength</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Aspirin? Yes / No If yes, circle one: 81mg or 325mg

### LIST ALL MEDICATION ALLERGIES:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Onset Date</th>
<th>Condition</th>
<th>Onset Date</th>
<th>Condition</th>
<th>Onset Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Reflux</td>
<td></td>
<td>Emphysema/COPD</td>
<td></td>
<td>Neck/Back Problems</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td>Erectile Dysfunction</td>
<td></td>
<td>Paralysis</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td>Fractures</td>
<td></td>
<td>Psoriasis</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Glaucoma</td>
<td></td>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Heart Attack</td>
<td></td>
<td>STD’s</td>
<td></td>
</tr>
<tr>
<td>Cataracts</td>
<td></td>
<td>Heart Catheterization</td>
<td></td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Heart Murmur</td>
<td></td>
<td>Thyroid Disorder</td>
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<tr>
<td>Diabetes/Sugar</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Diabetic Neuropathy</td>
<td></td>
<td>High Cholesterol</td>
<td></td>
<td>Ulcer Disease</td>
<td></td>
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<tr>
<td>Diverticulosis</td>
<td></td>
<td>HIV</td>
<td></td>
<td>Urinary Tract Infections</td>
<td></td>
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<tr>
<td>DVT/Clotting Disorder</td>
<td></td>
<td>Kidney Stones</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td>Liver Disease</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL ILLNESSES OR CONDITIONS

- Acid Reflux
- Anxiety
- Arthritis
- Asthma
- Cancer
- Cataracts
- Depression
- Diabetes/Sugar
- Diabetic Neuropathy
- Diverticulosis
- DVT/Clotting Disorder
- Eczema
- Acid Reflux
- Anxiety
- Arthritis
- Asthma
- Cancer
- Cataracts
- Depression
- Diabetes/Sugar
- Diabetic Neuropathy
- Diverticulosis
- DVT/Clotting Disorder
- Eczema
- Asthma
- COPD
- Depression
- Diabetes/Sugar
- Drug or Alcohol Abuse
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Seizures
- Strokes
- Cancer
- Heart Attack
- COPD
- Depression
- Diabetes/Sugar
- Asthma
- COPD
- Depression
- Diabetes/Sugar
- Drug or Alcohol Abuse
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Seizures
- Strokes
- Cancer
- COPD
- Depression
- Diabetes/Sugar
- Drug or Alcohol Abuse
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Cancer
- COPD
- Depression
- Diabetes/Sugar
- Asthma
- COPD
- Depression
- Diabetes/Sugar
- Drug or Alcohol Abuse
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Cancer
- COPD
- Depression
- Diabetes/Sugar
- Asthma
- COPD
- Depression
- Diabetes/Sugar
- Drug or Alcohol Abuse
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Cancer
- COPD
- Depression
- Diabetes/Sugar
- Asthma
- COPD
- Depression
- Diabetes/Sugar
- Drug or Alcohol Abuse
- Heart Attack
- High Blood Pressure
- High Cholesterol

### SURGICAL HISTORY

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Year</th>
<th>Surgery</th>
<th>Year</th>
<th>Surgery</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendectomy</td>
<td></td>
<td>Gall Bladder Removal</td>
<td></td>
<td>Joint Replacement</td>
<td></td>
</tr>
<tr>
<td>Back Surgery</td>
<td></td>
<td>Hernia Repair</td>
<td></td>
<td>Major Car Accident</td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Bypass</td>
<td></td>
<td>Hysterectomy</td>
<td></td>
<td>Tonsillectomy</td>
<td></td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td></td>
<td>C-Section</td>
<td></td>
<td>Other</td>
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</tr>
</tbody>
</table>

### FAMILY MEDICAL HISTORY: (BLOOD RELATIVES)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Brothers: #</th>
<th>Sisters: #</th>
<th>Sons: #</th>
<th>Daughters: #</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Alive / Deceased</td>
<td>Alive / Deceased</td>
<td>Healthy: Y/N</td>
<td>Healthy: Y/N</td>
<td>Healthy: Y/N</td>
<td>Healthy: Y/N</td>
</tr>
<tr>
<td>If deceased, give age:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>COPD</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Depression</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Diabetes/Sugar</td>
<td>Yes</td>
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<tr>
<td>Drug or Alcohol Abuse</td>
<td>Yes</td>
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<tr>
<td>Heart Attack</td>
<td>Yes</td>
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<tr>
<td>High Blood Pressure</td>
<td>Yes</td>
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<tr>
<td>High Cholesterol</td>
<td>Yes</td>
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<tr>
<td>Seizures</td>
<td>Yes</td>
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<tr>
<td>Strokes</td>
<td>Yes</td>
<td></td>
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</tr>
</tbody>
</table>

Family History of Cancer - List relation, type, & age

### SOCIAL HISTORY

<table>
<thead>
<tr>
<th>Tobacco Usage</th>
<th>Alcohol Usage</th>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you smoke?</td>
<td>Do you drink alcohol?</td>
<td>Do you regularly exercise?</td>
</tr>
<tr>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td># packs per day</td>
<td>Enter # of drinks per day below:</td>
<td>If yes, describe below:</td>
</tr>
</tbody>
</table>
### MISCELLANEOUS

- Working smoke detector in your home? [ ]
- Do you drink beverages with caffeine? [ ]
- Are you sexually active? [ ]
- Do you use drugs other than your prescribed medications? [ ]
- Do you travel outside the US? [ ]
- Pets? [ ]
- Do you practice a particular religion? [ ]
- If so, what denomination? ____________________________
- Education Level: ____________________________
- What type of work do you or did you do? ____________________________
- Are you disabled? [ ]
- If yes, describe your disability: ____________________________

### GYNECOLOGY HISTORY (FEMALES ONLY)

#### PAP SMEAR

- Date of last PAP Smear: ____________________________
- Location of last PAP Smear: ____________________________
- History of Abnormal PAP Smear results: Yes / No

#### MAMMOGRAM

- Date of last Mammogram: ____________________________
- Location of last Mammogram: ____________________________
- Do you conduct Monthly breast exams? Yes / No

### MENSTRUAL CYCLE

- Age began menstruating: ____________________________
- Date of last menstrual period: ____________________________
- How long are your periods? ____________________________
- Are they irregular? ____________________________

### OB HISTORY (FEMALES ONLY)

#### PREGNANCY

- Number of Living Children
  - #1: ____________________________
  - #2: ____________________________
  - #3: ____________________________
  - #4: ____________________________
  - #5: ____________________________
  - #6: ____________________________
  - #7: ____________________________
  - #8: ____________________________
  - #9: ____________________________
  - #10: ____________________________

- Full-term Delivery: [ ]
- Natural or Cesarean: [ ]
  - N / C: ____________________________
  - N / C: ____________________________
  - N / C: ____________________________
  - N / C: ____________________________
  - N / C: ____________________________
  - N / C: ____________________________
  - N / C: ____________________________
  - N / C: ____________________________
- Gestational Diabetes? [ ]
- Birth Weight over 9 lbs? [ ]
- Miscarriage/Stillborn/Abortion: [ ]
  - M / S / A: ____________________________
  - M / S / A: ____________________________
  - M / S / A: ____________________________
  - M / S / A: ____________________________
  - M / S / A: ____________________________
  - M / S / A: ____________________________
  - M / S / A: ____________________________
  - M / S / A: ____________________________

### VACCINES / DIAGNOSTIC TESTS

#### VACCINES

- Flu Shot: [ ]
  - Date: ____________
- Tetanus/TDAP: [ ]
  - Date: ____________

#### DIAGNOSTIC TESTS

- Cardio Stress Test: [ ]
  - Date: ____________
- Colonoscopy: [ ]
  - Date: ____________
- EKG: [ ]
  - Date: ____________
- EGD Upper Endoscopy: [ ]
  - Date: ____________

### MEN ONLY:

- PSA Testing: Yes / No
- Prostate Exam: Yes / No
- Date: ____________

### MISCELLANEOUS INFORMATION

**NEW HORIZONS HEALTHCARE**

3716 Melrose Ave NW Roanoke, VA 24017

Patient Name ____________________________  Social Security # ____________________________  DOB: ____________
Sign your initials next to each section:

_____ CONSENT FOR TREATMENT: I authorize the employees, agents and staff of New Horizons Healthcare to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations and treatment, as may in the opinion of the patient’s physician be necessary.

_____ NO GUARANTEE: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examinations.

_____ FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges, whether or not paid by insurance. New Horizons Healthcare does not participate in every insurance plan. I understand that I am responsible for verifying that my NHH provider is a participating provider in my insurance plan. Payment is expected at time of service.

_____ RELEASE OF INFORMATION: I authorize the clinic to release my and all of my patient medical and billing information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by New Horizons Healthcare. I consent to use and disclosure of my protected health information to carry out treatment, payment or health care operations by New Horizons Healthcare.

_____ 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 healthcare provider, Is directly exposed to bodily fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patients will be deemed to have consented to 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.

_____ SLIDING FEE SCALE: Qualifying for our sliding fee scale based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information from you. If it is determined you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due. We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the sliding fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of the determination. If you do not pay for the services at the time they are rendered, your balance must be paid in full within sixty (60) days.

_____ MEDICARE LIFE-TIME/MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare/Medicaid benefits be made on my/the patients behalf for any services furnished by or in the clinic; including physician services. I authorize any holder of medical or other information about me, to release to New Horizons Healthcare for Medicare and Medicaid Services, the Virginia Department of Medical Assistance Services and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or organization to submit claim to Medicare and/or Medicaid for payment. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

_____ CERTIFICATION AND ACKNOWLEDGMENT: I certify that all foregoing information and all information supplied by me, as part of the registration process is correct. I also acknowledge receipt of New Horizons Healthcare’s Notice of Privacy Practices (HIPAA).
NEW HORIZONS HEALTHCARE

PATIENT RIGHTS & RESPONSIBILITIES

You have the RIGHT...

• To choose New Horizons Healthcare as your family health care home;
• To be treated with respect and dignity;
• To expect quality care which takes into consideration your personal, spiritual, and cultural values;
• To receive confidential treatment;
• To access any information contained in your medical records;
• To expect that our health care providers and staff will listen to your needs;
• To receive helpful and understandable information about your diagnosis, treatment, and prognosis;
• To give informed consent before the start of a procedure or treatment;
• To refuse treatment to the extent allowed by law and to be informed of the medical consequences;
• To expect an appointment within a reasonable time frame;
• To know the costs of all procedures or services;
• To receive and understand the statement of fees for services provided.

You have the RESPONSIBILITY...

• To keep your appointments or notify the Center to promptly cancel so that others may be seen in your place;
• To tell the health care provider accurate and complete information concerning your present complaints/symptoms, past illnesses / ailments, medications, and any other matters relating to your health;
• For following the treatment plan recommended by your health care provider;
• To tell the provider if you do not understand the treatment plan and what is expected of you;
• To notify the Center of any changes in your personal information (address, phone numbers, insurance, employment, etc.);
• To pay for services provided or to make arrangements to pay (only if approved by management);
• The patient is responsible for being considerate of the rights of other patients and facility personnel, which includes refraining from use of foul language and abusive, threatening, or disruptive behavior;
• To be respectful of other patients and staff, and maintain a safe, clean, and comfortable office environment at all times;
• To inform staff of any legal-medical information, such as Powers of Attorney, that might impact decisions about your health care.

I, the patient, have read and understand the above patient rights and responsibilities:

Signature:____________________________________________ Date:________________________
NEW HORIZONS HEALTHCARE
NOTICE OF PRIVACY PRACTICES
Effective Date: November 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). It describes how, when and why we may use and/or disclose protected health information (“PHI”) about you. It also describes your rights to access and control of your PHI. “PHI” means any recorded or oral information about you, including demographic data, that may identify you or that can be used to identify you, that is created or received by New Horizons Healthcare (“the Company”) and that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for the provision of health care to you.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that PHI about you is personal and confidential. We are committed to protecting the privacy of PHI. This Notice applies to all PHI generated or received by the Company. It also applies to all employees of the Company who may have access to or are required to use your PHI for any of the purposes described in this Notice, as well as persons having a business associate agreement with the Company.

WE ARE REQUIRED BY LAW TO:

- make sure that your PHI is kept confidential;
- give you this Notice of our privacy practices with respect to PHI about you;
- abide by the terms of the Notice, as currently in effect; and
- notify you in the event that there is a breach of your unsecured PHI.

1. USES AND DISCLOSURES OF PHI

The following describes ways that we are permitted by HIPAA to use and disclose your PHI. For each category we will explain what we mean and give some examples. Not every use or disclosure is listed and the examples are not exhaustive. This explanation is provided for your general information only. Disclosure of your PHI for the purposes described in this Notice may be in writing, orally, or electronically, by facsimile or by any other means.

A. TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

1. For Treatment. We may use and disclose PHI about you to provide, coordinate, or manage your treatment and related services. This includes the coordination or management of your healthcare with a third party for treatment purposes. We may disclose PHI about you to doctors, nurses, technicians, counselors, medical students, or other personnel who are involved in taking care of you. For example, we may disclose your PHI to any health care provider who has referred you to us for treatment. We may also disclose PHI about you for treatment activities of other health care providers. For example, if your family doctor has determined that you need to be seen by the Company, we may send him a report of our diagnostic findings and our plan of treatment to assist him in providing you with care.

2. For Payment. We may use and disclose PHI about you so that the treatment and services you receive at the Company may be billed to, and payment may be collected from, an insurance company or other third party. For example, we may need to give your health plan information about your health care provider so that your health plan will pay us or reimburse you for that treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose PHI to another provider involved in your care for the other provider’s payment activities. This might include disclosures of demographic information to laboratory or x-ray providers for payment of their services.

3. For Health Care Operations. We may use and disclose PHI about you for our own operations. These uses and disclosures are necessary to run the Company and provide quality care to patients. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine PHI about many of your patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to the Company personnel for training programs. We may combine the PHI we have with PHI from other providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may sometimes remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning who the specific patients are. We may also provide your PHI to our accountants, attorneys, consultants and others in order to operate the Company and to make sure we are complying with the laws that affect us.

We may also disclose PHI to another covered entity for certain health care operations of that entity, if the entity either has or had a relationship with you, such as a treatment relationship, and if the PHI pertains to such relationship. Such disclosure is limited to certain activities of the other entity, including quality assessment and related activities, protocol development, care coordination, contacting health care providers and patients with information about treatment alternatives, and reviewing the competency and qualifications of health care professionals.

We may use or disclose your PHI in order for third party “business associates” to perform various activities involving treatment, payment or operations on behalf of our Company. However, whenever our arrangement between the Company and a business associate involves the use or disclosure of your PHI, we will have a written contract, as and when required by law, that contains terms to protect the privacy of your PHI.

B. USES AND DISCLOSURES BEYOND TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PERMITTED WITHOUT AUTHORIZATION OR OPPORTUNITY TO OBJECT

Federal privacy rules allow us to use or disclose your PHI without your permission or authorization for a number of reasons including the following:

1. Treatment Alternatives. We may use and disclose PHI about you to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
2. **Health-Related Benefits and Services.** We may use and disclose PHI about you to tell you about health-related benefits or services that may be of interest to you. For example, we may send you a packet of information and registration forms prior to your first appointment with one of our doctors.

3. **Appointment and Patient Recall Reminders.** We may use and disclose PHI about you to contact you as a reminder you have an appointment or that you are due to receive periodic care. This contact may be by phone, in writing, automated appointment system, e-mail, or otherwise and may involve leaving an email, message over an answering machine or which could (potentially) be received or intercepted by others.

4. **As Required by Law.** We may disclose PHI about you when required to do so by, and if we limit the disclosure as required by, federal, state or local law.

5. **To Avert a Serious Threat to Health or Safety.** We may use and disclose limited PHI about you when we believe it is necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

6. **Eye, Organ and Tissue Donation.** If you are an organ donor, we may disclose PHI about you to organizations that handle eye organ or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

7. **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI about you as required by military command authorities in certain situations. We may also disclose PHI about foreign military personnel to the appropriate foreign military authority.

8. **Worker’s Compensation.** We may disclose PHI about you for workers’ compensation or similar programs as required by law. These programs provide benefits for work-related injuries or illness without regard to fault.

9. **Public Health Activities.** We may disclose PHI about you to a public health authority for public health activities. These activities generally include the following:

   - to prevent, control, or report disease, injury or disability;
   - to report vital events such as births and deaths;
   - to report child abuse or neglect;
   - to report reactions to medications or problems with products, track FDA regulated products, enable product recalls, repairs or replacements and to conduct post marketing surveillance;
   - to notify people of recalls of products they may be using;
   - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

10. **Schools.** We may disclose PHI about you (or your child) to a school if you (or your child) are a student or a prospective student, and: (i) the PHI is limited to proof of immunization; (ii) the school is required by law to have proof of such immunization prior to admission; and (iii) we obtain and document your agreement to the disclosure.

11. **Emergency Situations.** We may disclose PHI about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family or others can be notified about your general condition and location or death.

12. **Victims of Abuse, Neglect and Domestic Violence.** We may use and disclose PHI about you to notify the appropriate government authorities if we believe you have been a victim of abuse, neglect or domestic violence, but we will only make this disclosure; (i) if you agree; (ii) when required by law; or (iii) when authorized by law and certain other conditions are met.

13. **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws and other activities necessary for oversight of the health care system, government benefit payments and entities subject to government regulation. This does not include disclosure for investigations or other activities in which you are a subject of the investigation and which do not arise out of the receipt of health care, a claim for public health benefits or the qualification for receipt of public health benefits or services.

14. **Lawsuits and Administrative Proceedings.** We may disclose PHI about you in response to a court or administrative order. We may also disclose PHI pursuant to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made by the party requesting the information to tell you about the request or to obtain an order protecting the information requested. We may also use such information to defend ourselves or any personnel of the Company in any actual or threatened action.

15. **Law Enforcement Purposes.** We may disclose PHI if asked to do so by a law enforcement official:

   - In response to a court order, subpoena, warrant, summons, grand jury subpoenas or similar process;
   - To identify or locate a suspect, fugitive, material witness, or a missing person;
   - About the victim of a crime if the individual agrees and, under certain limited circumstances, where we are unable obtain the person’s agreement;
   - About a death we believe may be the result of criminal conduct;
   - About criminal conduct at the Company;
   - In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime;
   - About certain types of wound or physical injuries as required by law.
16. **Victims of a Crime.** We may disclose your PHI if asked by a law enforcement official, if (i) you are suspected to be a victim of a crime, (ii) you agree to the disclosure or (iii) we are unable to obtain your agreement because of incapacity or other emergency circumstances. However, the law enforcement official must represent that the information needed to determine whether a violation of law by a person other than you has occurred, and the information is not intended to be used against you, that immediate law enforcement activity depends on the disclosure and would be materially and adversely affected by waiting until you are able to agree, and we determine that the disclosure is in your best interest in the exercise of professional judgment.

17. **Coroners, Medical Examiners and Funeral Directors.** We may disclose PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI about patients of the Company to funeral directors as necessary to carry out their duties.

18. **National Security and Intelligence Activities.** We may disclose PHI about you to authorized federal officials so they may conduct intelligence, counter-intelligence and other activities authorized by the National Security Act.

19. **Protective Services for the President and Others.** We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

20. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI about you to the correctional institution or law enforcement official. This disclosure may be necessary (i) for the institution to provide you with health care; (ii) to protect your health and safety or the health and safety of others; or (iii) for the safety and security of the correctional institution.

21. **Research.** Under certain circumstances, we may use and disclose PHI about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process by an Institutional Review Board ("IRB") or a Privacy Board. We will obtain an Authorization from you before using or disclosing your individually PHI unless the authorization requirement has been altered or waived by the IRB or Privacy Board. If reasonably possible, we may make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an Authorization for the use or disclosure is not required. If we obtain certain representations from the researcher, we may use and disclose PHI about you for the researcher to prepare protocols preparatory to research.

22. **Incidental Disclosures.** We may use and disclose PHI about you incident to otherwise permitted or required uses and disclosures. For example, we may ask you to sign a sign-in sheet when you arrive for an appointment at the Company as an incident to the treatment process.

23. **To the Secretary of the Department of Health and Human Services.** We are required to disclose PHI about you when requested by the Secretary of the Department of Health and Human Services in order to investigate or determine our compliance with HIPAA.

C. **USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION BUT WITH YOUR OPPORTUNITY TO OBJECT.**

1. **Disclosures to Family, Friends or Others Involved in Your Case.** We may disclose your PHI to your family members, to a close personal friend or other person that you identify if it is directly relevant to the person’s involvement in your care or payment related to your care. We may also disclose PHI concerning your location, condition or death in connection with trying to locate or notify family members or others involved in your care. Generally, we will obtain your verbal agreement before using or disclosing PHI in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your express agreement if we feel, in the exercise of professional judgment, that it is in your best interest.

2. **Objection to Disclosures.** You may object to these disclosures by indicating the names and relationship of individuals that you do not want to receive your medical information on the "Acknowledgement of Receipt of Notice of Privacy Practices" form. If you are present and do not object to these disclosures, or if you are present and we can infer from the circumstances that you do not object, or if you are not present or able to object and we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person’s involvement with your care, we may disclose your PHI for such purpose.

D. **USES AND DISCLOSURES WHICH YOU MAY AUTHORIZE**

1. **Psychotherapy Notes.** We must obtain a valid authorization from you for any use or disclosure of psychotherapy notes, unless such use or disclosure is: (i) necessary to carry out treatment, payment or health care operations; or (ii) otherwise required by law.

2. **Marketing.** We must obtain a valid authorization from you for any use or disclosure of your PHI for marketing purposes unless the marketing communication is in the form of a face-to-face communication; is a promotional gift of nominal value; or is a refill reminder or other communication regarding a drug or biological currently being prescribed.

3. **Sale of PHI.** We must obtain a valid authorization from you for any use or disclosure of your PHI which results in a sale of your PHI for which the Company receives financial remuneration.

Other uses and disclosures of PHI not described in this Notice or in the laws that apply to us will be made only with your written authorization. If you provide us with a written authorization to use or disclose PHI about you, you may revoke that authorization, in writing, at any time to the extent that we haven’t already taken any action relying on the authorization. If you revoke your authorization, we will no longer disclose PHI about you pursuant to that revoked authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided you.
II. PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THE COMPANY REGARDING THE USE AND DISCLOSURE OF YOUR PHI.

You have the following rights regarding PHI we maintain about you:

1. **Right to Inspect and Copy.** You have the right to inspect and copy your PHI that is contained in a “designated record set.” A “designated record set” contains medical and billing records and any other records that the Company uses for making decisions about your care. This does not include information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law that prohibits access to PHI or information which your doctor identifies as potentially harmful to you or others if it is released.

To inspect and copy PHI in your designated record set, you must submit your request in writing to our Privacy Officer, as identified on the last page of this Notice. If you request a copy of the information, we may charge a cost-based fee for the costs of copying, mailing or other supplies (tapes, diskettes, etc.) associated with your request. We will respond to you within 15 days after receiving your written request.

We may deny your request to inspect or copy, in certain limited circumstances. If you are denied access to your PHI because a physician has determined it may be dangerous to you or another person, you may request that the denial be reviewed. Another licensed health care professional chosen by the Company will review your request and the denial. The person conducting the review will not have participated in the first decision to deny your request. In the alternative, you may choose another provider to review the material at your expense. We will comply with the outcome of that review.

2. **Right to Amend.** If you feel that the PHI in your designated record set is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Company.

To request an amendment, your request must be made in writing and submitted to the Company’s Privacy Officer, as identified on the last page of this Notice. In addition, you must provide:

- the reasons for the request;
- a description of the problem – how the information is incorrect or incomplete;
- a description of the administrative information to be corrected; and/or medical information to be amended including the source if known, date and provider of service;
- the specific wording to make the entry correct/complete;
- identification of person(s) who need to be advised of the amendment, including contact information and authorization to advise them if necessary.

The request must be dated and signed by you. We will act on your request within 60 days of receiving your request. If we are unable to act on the request within the 60-day period, we may extend the time for action by no more than 30 days by providing you, within the initial 60 days, with a written statement of the reasons for the delay and the date by which we will complete our action on your request.

We may deny your request for an amendment if it is not made in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the designated record set kept by or for the Company;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is accurate and complete.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don’t file one, you have the right to ask that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you we have done it, and tell others whom you identify and authorize us to tell that need to know about the change to your PHI.

3. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice. We are also not required to account for disclosures made to you, disclosures that you agreed to by signing an authorization, disclosures for a facility directory, to friends or family members involved in your care, incidental disclosures, or certain other disclosures we are permitted to make without your authorization.

To request this accounting of disclosures, you must submit your request in writing to our Privacy Officer, as identified on the last page of this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. We will respond within 60 days of receiving your request. If we are unable to respond within the 60 day period, we may extend the period for up to an additional 30 days if we send you a written statement of the reasons for the delay within the initial 60 day period. In certain situations we are required by HIPAA to temporarily suspend your right to receive an accounting of disclosures.

4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care, like a family member or friend or for notification purposes. For example, you could ask that we not use or disclose information about a particular treatment that you had.

We are not required to agree to your request, except for disclosures to a health plan which would have been made in the course of carrying out the Company’s payment or healthcare operations, and pertain solely to a healthcare item or service for which the Company has been paid out-of-pocket in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or unless the information is required to be disclosed by law.

To request such restrictions, you must make your request in writing to our Privacy Officer, as identified on the last page of this Notice. In your request, you must tell us (i) what information you want to limit; (ii) whether you want to limit our use, disclosure or both; and (iii) to whom you want the limits to apply, for example, disclosures to your spouse or children.
We may terminate our agreement to a restriction, except for a restriction relating to disclosures to a health plan which would have been made in the course of carrying out the Company’s payment or healthcare operations, and pertain solely to a healthcare item or service for which the Company has been paid out-of-pocket in full, if:

- you agree to or request the termination in writing;
- you orally agree to the termination and the oral agreement is documented; or
- we inform you that we are terminating the agreement, except that such termination is only effective with respect to protected health information created or received after we have so informed you.

5. **Right to Request Alternative Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or email, or the like.

To request confidential communications, you must make your request in writing to our Privacy Officer, as identified on the last page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests as long as we can easily provide it in the format you requested. Your request must specify how or where you wish to be contacted.

6. **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may also view a copy of this Notice on our web site.

7. **The Right To Get This Notice by E-mail.** You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of this Notice.

To obtain a paper copy of this Notice contact our Privacy Officer, as identified on the last page of this Notice.

III. **CHANGES TO THIS NOTICE**

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for protected health information that we already have about you as well as any such information we receive in the future. We will post a copy of the current Notice in the administrative area at the Company. The Notice will contain on the first page, in the top right-hand corner, and at the end of the Notice, the effective date. In addition, each time you register at, or are admitted to, the Company for treatment or health care services, you may request a copy of the current Notice in effect. You may also view a copy of the current Notice on our web site at www.newhorizonshealthcare.org.

IV. **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Company or the Department of Health and Human Services. To file a complaint with us, please contact our HIPAA Privacy Officer at the address and telephone number noted below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

V. **PRIVACY OFFICER**

The Company’s Privacy Officer is Kimberly Robertson, who may be reached at (540) 362-3718.

VI. **EFFECTIVE DATE**

This Notice is effective as of November 1, 2013.
NEW HORIZONS HEALTHCARE

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that on _________________, 20___, I received a copy of New Horizons Healthcare’s Notice of Privacy Practices, dated _________________.

Signature of patient or patient’s representative: ___________________________  Date: _________________

Printed name of patient or patient’s representative: _________________________________

Relationship of patient’s representative to patient: _________________________________

Evidence of the authority of the patient’s representative (attach evidence to last page of this acknowledgement):