# 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**<br>975 West Faris Road<br>Greenville, SC 29605<br>Phone: (864) 729-8330<br>8:00 AM- 9:00 PM Monday- Saturday<br>**PHARMACY HOURS:**<br>8:00 AM- 9:00 PM Monday- Saturday |
| **Mallard**<br>130 Mallard St., PO Box 287<br>Greenville, SC 29601<br>Phone: (864)233-1534<br>8:00 AM- 8:00 PM Monday- Thursday<br>8:00 AM- 5:00 PM Friday<br>**PHARMACY HOURS:**<br>8:00 AM- 6:00 PM Monday- Thursday<br>8:00 AM- 5:00 PM Friday |
| **Travelers Rest**<br>1588 Geer Hwy., PO Box 1370<br>Travelers Rest, SC 29690<br>Phone: (864) 836-1109<br>8:00 AM- 8:00 PM Monday, Wednesday<br>8:00 AM- 5:00 PM Tues, Thurs, Friday<br>**PHARMACY HOURS:**<br>8:00 AM- 12:00 PM , 1:30 PM- 5:00 PM<br>M-F but closed daily for lunch 12-1:30 PM |
| **Greer**<br>111-A Berry Avenue<br>Greer, SC 29651<br>Phone: (864) 801-2035<br>8:00 AM- 5:00 PM Mon, Wed, Friday<br>8:00 AM- 8:00 PM Tuesday, Thursday<br>**PHARMACY HOURS:**<br>8:00 AM- 12:00 PM, 1:30- 5:00 PM<br>M-F but closed daily for lunch 12-1:30 PM |
| **New Horizon Family Dental Care**<br>1 Memorial Medical Drive<br>Greenville, SC 29605<br>Phone: (864) 351-2400<br>8:00 AM- 5:00 PM Mon, Wed, Friday<br>8:00 AM- 7:00 PM Tuesday, Thursday |
| **Health Care for the Homeless**<br>Mobile Unit<br>130 Mallard St., PO Box 287<br>Greenville, SC 29601<br>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 identification** 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). Charges depend 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 show a picture ID and alert us immediately of any **changes** (address, family status, or income). Failure to update information will result in **having to pay full fee**. Please have your **social security number** as well.

**New Horizon Family Dental Care**
**1 Memorial Medical Drive**
**Greenville, SC 29605**

## Patient Rights and Responsibilities

***PURPOSE*:** To outline the basic rights and responsibilities of patients at New Horizon Family Dental Care (NHFDC).

***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***:
NHFDC 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's Signature: Date:

**New Horizon Family Dental Care**
**Patient Rights and Responsibilities**

## You have the right to:

- Respect and dignity
- Privacy and confidentiality
- Know rules and regulations
- Consult a specialist
- Refuse treatment
- Know patient charges
- Obtain information
- Assistance
- Staff Identity
- Informed Consent

## Your responsibilities are:

- Respect and consideration
- Be a partner in your care
- Follow rules and regulations
- Follow treatment instructions
- Results of refusing treatment
- Pay bills promptly
- Give us accurate information

## THREE STEPS TO SAFER HEALTH CARE

1. **SPEAK UP IF YOU HAVE QUESTIONS OR CONCERNS**. Choose a dentist who you feel comfortable talking to about your oral health and treatment. Take a relative or friend with you if this will help you ask questions andunderstand the answers. It's okay to ask questions and to expect answers you can understand.

2. **KEEP A LIST OF ALL THE MEDICINES YOU TAKE**. Tell your dentist and hygienist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. If you are given a prescription, read the label when you receive it, including warnings.Make sure it is what your dentist ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. **MAKE SURE YOU UNDERSTAND WHAT WILL HAPPEN IF YOU NEED SURGERY**. Ask your dentist and surgeon: Who will take charge of my care? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the dentist and dental assistants if you have allergies or have ever had a bad reaction to anesthesia. Make sure you and your dentist agree on exactly what will be done during the operation.

NEW HORIZON
FAMILY HEALTH SERVICES, INC.

**IMPORTANT**
**New Horizon Family Health Services**
**No Show Policy**

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 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 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.

_____ _____
Signature Date

_____ _____
Print Name Date of Birth

**New Horizon Family Dental Care**
**1 Memorial Medical Drive**
**Greenville, SC 29605**

**To complete registrations, you must bring the following:**

1. Proof of Identity
   Adults: Driver's license or other picture identification
   Children: Birth Certificate
   School Record or School ID Card
   Nursery or Daycare Record
2. Social Security Card
3. Proof of Coverage
   a. Current Medicaid Card (if Applicable)
   b. Current Insurance Card (if Applicable)
4. If Applying for Sliding Fee Discount:
   a. Tax Return (from last year)
   b. Proof of Household Income: Three Most Recent Paycheck Stubs
   ***PLEASE NOTE:***
   c. You must provide Proof of Identity and Proof of income to be certified for Sliding Fee.
   d. Annual Recertification is required.

**YOUR VISIT MAY BE DELYED UNTIL THE REQUIRED INFORMATION IS PROVIDED.**

**YOU WILL BE FINANCIALLY RESPONSIBLE FOR FULL CHARGES.**

**NO FREE SERVICES. NO EXCEPTIONS**


# NEW HORIZON FAMILY HEALTH SERVICES, INC

## Patient Registration Form

Date: _____ Social Security No.: _____

Name: _____
FIRST MIDDLE LAST SUFFIX PREFERRED NAME

Date of Birth: _____ Married Status: _____ Former Last Name: _____

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

[ ] Chose not to disclose

Language: _____

Please check all that apply:

[ ] Employed
[ ] Unemployed
[ ] Self-employed
[ ] Veteran
[ ] Migrant
[ ] Full-time student

[ ] Homebound
[ ] Part-time student
[ ] Retired
[ ] Public housing
[ ] Live on Street
[ ] Disabled

[ ] School based health center
[ ] Live with parents/friends
[ ] Live in homeless shelter
[ ] Agricultural worker
[ ] Choose not to disclose

Gender Identity: (Check one)

[ ] Male
[ ] Female
[ ] Transgender Male/ Female-to-Male
[ ] Transgender Female/ Male-to-Female
[ ] Choose not to disclose
[ ] Gender queer
[ ] Other

Sexual Orientation: (Check one)

[ ] Straight or heterosexual
[ ] Lesbian, gay or homosexual
[ ] Bisexual
[ ] Don't know
[ ] Something else
[ ] Choose not to disclose

# NEW HORIZON FAMILY DENTAL CARE

**Patient Registration Form**

Reason for today's visit: _____ Date: _____ Time: _____

Name: _____
FIRST MIDDLE LAST SUFFIX PREFERRED NAME

Date of Birth: _____ Sex: Male Female Marital Status: _____ Former last name: _____

Social Security Number: _____

Race/Ethnicity: (Check one) ☐ Black/African American ☐ Caucasian/White ☐ Asian ☐ Native American ☐ Latino/Hispanic
☐ More than one ☐ Other ☐ Refuse Language: _____

Please check all that apply: ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Veteran ☐ Part-time Student
☐ Full-Time Student ☐ School based health center ☐ Homebound ☐ Public Housing ☐ Live in Homeless Shelter ☐ Live on street
☐ Live with Parents/Friends ☐ Agricultural worker ☐ Migrant ☐ Refuse

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

Phone: _____ _____ _____ Age: _____
HOME MOBILE WORK

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Estimated Monthly Household Income: _____ Household Size: _____

**GUARANTOR INFORMATION (If different from patient):**

Social Security No.:_____

Name: _____
FIRST MIDDLE LAST SUFFIX

Date of Birth: _____ Race: _____ Marital Status: _____ Sex: Male Female

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

Phone: _____ _____ _____
HOME MOBILE WORK

**INSURANCE INFORMATION (*Please provide a copy of all insurance cards):***

Insurance Company: _____ Name of Insured: _____

Insured's Date of Birth: _____ Social Security No: _____ Relationship to Patient: _____

Address: _____
STREET/ PO BOX CITY STATE ZIP CODE

Employer Name: _____ Phone: _____

Address: _____
STREET/PO BOX CITY STATE ZIP CODE

****This is for reporting purposes only. To apply for Sliding Fee Discount you will need to complete the sliding fee application form****

NEW HORIZON
FAMILY DENTAL CARE

**NAME**_____
**CHART #** _____
**DOB** _____
**DATE** _____

## DENTAL HEALTH HISTORY PART I

Date of last visit to a Dentist _____

Have you ever had difficulties associated with dental treatment? Yes ____ No ____

Have you ever been hospitalized in the last three years? Yes ____ No ____

If so, list date and reason: _____

_____

_____

Date of last physical examination _____

Are you presently under the care of a physician? Yes ____ No____

Are you taking any medications? Yes ____ No____

| Medications: | How often do you take the medications? |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

*List any additional medications on the back

| | | |
|---|---|---|
| Are you allergic to: | Dental Anesthetics | Yes ____ No ____ |
| | Penicillin or other Antibiotics | Yes ____ No ____ |
| | Aspirin | Yes ____ No ____ |
| | Other Drugs (List) _____ | |
| | _____ | |
| | Do you smoke or chew Tobacco? | Yes ____ No ____ |
| | Are you on blood thinners and/or aspirin? | Yes ____ No ____ |
| | Have you been tested for HIV/AIDS? | Yes ____ No ____ |
| | If yes, would you like the test redone? | Yes ____ No ____ |
| | If no, would you like to be tested? | Yes ____ No ____ |

NEW HORIZON FAMILY DENTAL CARE

Name_____

Chart #_____

DOB_____

DATE_____

Women: Are you pregnant? _____Yes _____No

**DENTAL HEALTH HISTORY PART II**

| ILLNESS | YES | NO | ILLNESS | YES | NO |
|---|---|---|---|---|---|
| Rheumatic Fever or Rheumatic Heart Disease | | | Shortness of Breath | | |
| Stroke or Circulative Problems | | | Arthritis | | |
| Heart Valve Problems/Surgery | | | Artificial Joints/Artificial Heart Valves | | |
| Angina (Chest Pain upon Exertion) | | | Diabetes | | |
| Heart Trouble/Congestive Heart Failure | | | Hepatitis | | |
| Mitral Valve Prolapse | | | Swelling Ankles | | |
| High Blood Pressure | | | Lupus | | |
| Heart Murmur | | | Allergies | | |
| Stomach Ulcers | | | Seizures/Epilepsy | | |
| Gland Problems | | | AIDS/HIV Positive | | |
| Kidney Problems/Renal Failure | | | Liver Disease | | |
| Glaucoma | | | Tuberculosis | | |
| Venereal Disease | | | Cancer or Tumors | | |
| Fever Blisters or Cold Sores | | | Sinus Trouble | | |
| Blood Disorders (i.e. Anemia, Prolonged bleeding, Hemophilia, Leukemia) | | | Yellow Jaundice | | |
| Fainting or Dizziness | | | Blood Transfusion in past 5 years | | |
| Pain or Noise in Jaw | | | Gout | | |
| Thyroid Problems | | | Alcoholism | | |
| Any teeth loose, sensitive | | | Emotional Disorders | | |
| Substance Abuse | | | Asthma/Emphysema | | |
| Frequent Headaches | | | Sickle Cell Anemia | | |

INDICATE ANY DISEASE CONDITION, OR PROBLEMS NOT LISTED ABOVE THAT YOU THINK THE DENTIST SHOULD KNOW ABOUT:_____

_____

To the best of my knowledge, the provided medical and dental history is correct. I consent to such examinations, x-rays, and diagnostic procedures and tests that may be prescribed. In addition, I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of oral sedatives or local anesthetic and indicated photos, and releasing information to my insurance company.

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Dentist Signature Date

# SLIDING FEE DISCOUNT PROGRAM

## Acceptable documents for sliding fee application:

- Three most recent consecutive paycheck stubs
  - No older than 30 days
    Use **GROSS** pay
  - If it is someone that receives tips, combine hourly pay and tips
    **GOOD FOR 12 MONTHS**
- Social Security determination letter or bank statement, if it is direct deposit (the deposit will say US Treasury)
  **GOOD FOR 12 MONTHS**
- Unemployment determination letter
  - Pay code will only be valid for 3 months
  - **DO NOT** use the one that has "potential" benefit amount
- Letter from Employer
  - On letterhead, notarized and DATED
  - Must state gross income
    **GOOD FOR 12 MONTHS**
- Proof of **court ordered** child support and/or alimony or;
  **GOOD FOR 12 MONTHS**
- Filed income taxes (previous) year, if they are self-employed us the gross amount on Schedule C forms or;
- Gross amount on 1040 or;
- W2's
  **GOOD FOR 12 MONTHS**

'B-I' Point of Service payment is only for the office visit. It doesn't include labs or tests performed.

| Designation | % Poverty | Discount % | Nominal Fee | Point of Service Payment |
|---|---|---|---|---|
| A | 0-100% | 100% | $20.00 | |
| B | 101-120% | 80% | | $30.00 |
| C | 121-130% | 70% | | $39.00 |
| D | 131-140% | 60% | | $40.00 |
| E | 141-150% | 50% | | $59.00 |
| F | 151-160% | 40% | | $69.00 |
| G | 161-170% | 30% | | $80.00 |
| H | 171-180% | 20% | | $88.00 |
| I | 181-200% | 10% | | $90.00 |
| | 200% & Above | 0% | | $97.50 visit could cost up to $150.00 |


**New Horizon Family Dental Care**
**1 Memorial Medical Drive**
**Greenville, SC 29605**

## Sliding Fee Application/Recertification

**Name** _____ **Date of Birth** _____
**Address** _____
**City** _____**State** _____ **Zip**_____
**Phone** _____
**Marital Status: Married** _____ **Single** _____ **Separated** _____**Divorced** _____ **Widow**_____
**Social Security Number** _____

| **Family Members** | **Relationship** | **Date of Birth** |
|---|---|---|
| **1.** _____ | _____ | _____ |
| **2.** _____ | _____ | _____ |
| **3.** _____ | _____ | _____ |
| **4.** _____ | _____ | _____ |
| **5.** _____ | _____ | _____ |
| **6.** _____ | _____ | _____ |

**Income Information:**

**Employer**_____ **Work Phone** _____
**Head Of Household** _____ **Week/Month**
**Spouse** _____ **Week/ Month**
**Other** _____ **Week/Month**
**Total Monthly Household Income** _____

**I certify that the above information is correct to the best of my knowledge. I hereby give permission to New Horizon Family Health Services, Inc. to verify all the above information. If I have a change in my financial status, I will notify the center.**

**Signature:** _____ **Date:** _____

**Verified by:** _____ **Date:** _____

**NEW HORIZON FAMILY DENTAL CARE**
1 Memorial Medical Drive
Greenville, SC 29605
Phone (864) 351- 2400

# AUTHORIZATION TO RELEASE INFORMATION TO OTHER PARTIES

Patient Name: _____
LAST FIRST MIDDLE

Social Security No: _____ Male: _____ Female: _____ Date of Birth: _____

Address: _____

_____ Phone: ( ) _____
CITY STATE ZIP CODE

I, _____ hereby give my written permission for the following person/persons to receive any medical information about me, or my treatment, by New Horizon Family Health Services, Inc.:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

**(CIRCLE ONE) I DO / DO NOT** authorize my medical information to be left on any answering machine or voicemails at home, work, or cell phone.

**Signature**: _____ **Date**: _____

**NEW HORIZON FAMILY DENTAL CARE**

1 Memorial Medical Drive

Greenville, SC 29605

Phone (864) 351- 2400

AUTHORIZATION FOR PEDIATRIC PATIENT TO BE BROUGHT IN FOR TREATMENT BY DESIGNEE (APPLIES TO ALL PEDIATRIC PATIENTAGES 0-16)

Patient Name: _____
LAST FIRST MIDDLE

Social Security No: _____ Male: _____ Female: _____ Date of Birth: _____

Address: _____

_____ Phone: ( ) _____
CITY STATE ZIP CODE

In your absence, is there anyone authorized to seek medical treatment for your child? **(CIRCLE ONE)**

**YES** **NO**

**If yes**, please complete the following:

_____ _____
Print Name Relationship to Patient

_____ _____
Address Phone

_____ _____
Print Name Relationship to Patient

_____ _____
Address Phone

_____ _____
**PARENT / GUARDIAN'S SIGNATURE** **DATE**

_____ _____
**WITNESS** **DATE**


Name_____

Chart #_____

DOB_____

DATE_____

## CONSENT FOR TREATMENT

I hereby authorize New Horizon Family Dental Care to provide dental treatment including, but not limited to, x-ray, examinations and injections as may be ordained as advisable or necessary by the attending professional staff.

_____ _____

Signature Relationship to Patient
(Self, Spouse, Parent/Guardian, Other)

## GENERAL RELEASE/ASSIGNMENT OF BENEFITS

I hereby guarantee payments of all charges incurred for the amount of this patient including transportation and care at any hospital or other facility by a physician and assign any benefits for that patient to New Horizon Family Dental Care.

I hereby authorize New Horizon Family Dental Care to furnish from its records any information requested by insurance of liable third parties in connection with the above assignments.

_____ _____

Signature Relationship to Patient
(Self, Spouse, Parent/Guardian, Other)

## TREATMENT/PAYMENT AGREEMENT

I request New Horizon Family Dental Care to provide me and/or my family with dental care. I acknowledge my responsibility to pay for that care according to the fees established. Furthermore, I authorize assignment of benefits for denial services paid to New Horizon Family Dental Care.

_____ _____

Signature Relationship to Patient
(Self, Spouse, Parent/Guardian, Other)

**Please Answer the Following Questions:**

1. Did you receive a Notice of Privacy ____Yes ____ No
2. Did you receive your Patient's Rights and Responsibilities? ____Yes ____ No

_____ _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

DEN-05
Revised. 08/07