

PATIENT INFORMATION

Horizons Medical Care

(Please Print Clearly)

Patient Social Security Number: _____ Date of Birth: _____

Name: _____ Sex: M _____ F _____
First Middle Last

Home Phone #: _____ Driver's License #: _____ E-mail Address: _____

Street Address: _____ Employer: _____

City: _____ State: _____ Zip: _____ Work Phone #: _____

Mailing Address: _____ Marital Status: S _____ M _____ Other _____
(If different from street address)

Were You Referred? Yes: _____ No: _____ If Yes, By Whom? _____

Responsible Party / Spouse Information

Please Check Here If Same As Above

Responsible Party / Spouse Social Security #: _____ Date of Birth: _____

Name: _____ Sex: M _____ F _____
First Middle Last

Home Phone #: _____ Driver's License #: _____ Relationship to Patient: _____

Address Line 1: _____ Employer: _____

Address Line 2: _____ Work Phone #: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Primary Insurance Information

Primary Insurance Company Name: _____ SSN: _____

Subscribers Name as it Appears on Card: _____ Date of Birth: _____

Insured's Policy Number or ID: _____ Group Number: _____

Primary Insurance Company Address (On Back Of card): _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information

Secondary Insurance Company Name: _____ SSN: _____

Subscribers Name as it Appears on Card: _____ Date of Birth: _____

Insured's Policy Number or ID: _____ Group Number: _____

Secondary Insurance Company Address (On Back Of card): _____

City: _____ State: _____ Zip: _____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for you co-pay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient’s responsibility to obtain referrals for your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time for the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature

Date

Witness

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release to Medigap Insurer _____ any information needed to determine these benefits payable for related services

Signature

Date

MEDICARE LIFETIME AUTHORIZATION

HIC Number _____

Medicare Certification for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits by made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services such physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance.

Signed: _____

Date: _____

Print Name: _____

Title or Relationship: _____

Witnessed By: _____

Address: _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

Trifold Notice of Privacy Practices

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

Introduction

At Horizons Medical Care, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective [04/14/2003], and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Horizons Medical Care, P.C., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Horizons Medical Care, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Horizons Medical Care, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Kim Vanterpool, at 256.837.2271.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with you regional Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: We will share your relevant health information with other providers involved in your care, to assist in the coordination of your care. This may include specialists, hospitals, clinics, and other individuals or organizations prior to or after us who have provided you with health care.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the hospital, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Release Form for individuals involved in care of patient

I, _____, give Horizons Medical Care, P.C., permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from Horizons Medical Care, P.C..

This consent is valid until such time as I provide Horizons Medical Care, P.C. written revocation of it.

Horizons Medical Care, P.C. may speak with:

Name: _____
Relationship _____

Name: _____
Relationship _____

Name: _____
Relationship _____

Name: _____
Relationship _____

Name: _____
Relationship _____

Name: _____
Relationship _____

Name: _____
Relationship _____

Patient Signature: _____
Date: _____

*This form is to be filed in the patient's medical record

Restriction Request Form

I, _____, patient of Horizons Medical Care, P.C., request that the following restrictions be placed upon how my protected healthcare information PHI may be used or disclosed by the practice.

Restrictions:

Signature _____

Date: _____

Signature Privacy Officer or appointed
designee _____

Restriction accepted by Horizons Medical Care, P.C. - **Yes**

No

Date: _____

RESTRICTION REQUEST FORM

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Horizons Medical Care, P.C.'s **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnesses by:** _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[] Patient refused to sign this Acknowledgement.

Date: _____

Time: _____

Employee Name:

ACKNOWLEDGE FORM

**HORIZONS MEDICAL CARE, P.C.
FINANCIAL POLICY**

We are committed to providing you with the best possible medical care. You can help by eliminating the need for us to bill for co-pays. Due to increased co-pays, participating insurance requirements and compliance issues we find it necessary to update our financial policy.

PAYMENTS:

1. All co-payments, co-insurance and deductibles are due and payable at the time of service, regardless of who brings the patient in for the appointment. Babysitters Grandparents, divorced parents, etc... must be prepared to pay at the time of service. Horizons Medical Care accepts cash, checks and credit cards. We reserve the right to assess a service charge to accounts that require multiple billing for co-pays.
2. There is a \$28 service charge for returned checks. After receiving two returned checks, Horizons Medical Care will only accept cash or credit cards as payment from you.
3. If you need financial assistance or have questions, please contact Horizons Billing Department.
4. If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with Horizons Medical Care, your outstanding balance will be sent to a collection agency and you will be required to pay the entire amount before receiving any further treatment.
5. Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your verbal or written request.

INSURANCE:

1. Our office participates with a variety of insurance plans. It is your responsibility to:
 - Bring your insurance card each visit.
 - Know your co-pay and be prepared to pay your co-pay at each visit.
 - Know your insurance company benefits (physical coverage, lab co-pays, etc...).
 - Specific coverage issues should be directed to your insurance company's Member Service Department.
 - If you are enrolled in a Managed Care Insurance Plan (HMO), you must receive a referral from your PCP before payment can be made to our physicians.
2. If you have insurance that we do not participate with, our office is happy to file the claim for you upon request, however if payment is denied by the insurance company, it will then be your responsibility to make payment in full.
3. Horizons Medical Care files secondary insurance as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the billing department.

I have read and understand "Horizons Medical Care Financial Policy". I agree to assign insurance benefits to Horizons whenever necessary. In the event of nonpayment or default, I am responsible for all costs and reasonable attorney fees. Horizons Medical Care reserves the right to change or amend this financial policy at any time and at its discretion.

Signature of Patient/Responsible Party

Printed Name of Signer

Print Name of Patient

Date of Birth

Date