Horizon Family Medicine, PA
Multiple Locations With One Purpose...Your Health
www.horizonfamilymed.com

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION – *Please Print*

Legal Name (First, Middle, Last): _____ Suffix: _____

SSN: _____ Date of Birth: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Address: _____ City, ST, Zip: _____

Mailing Address: _____ City, ST, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ *(This is part of your protected health record and will not be sold or spammed)*

Employer: _____ Occupation: _____

Gender: □ Male □ Female

Race: □ White/Caucasian □ Other □ Black/African American

First Language: □ English □ Other □ Spanish

Ethnicity: □ Hispanic □ Non-Hispanic

EMERGENCY CONTACT – *Who may we contact in case of an emergency?*

Name: _____ Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY – *Custodial parent, if patient is under 18 years old*

Legal Name (First, Middle, Last): _____ ID#, DL#, SS#: _____

Relationship to Patient: _____ Date of Birth: _____ Employer: _____

If Patient is a MINOR: Please complete this section

Parent 1 Name: _____	Parent 2 Name: _____
Parent 1 Birthdate: _____	Parent 2 Birthdate: _____
Parent 1 Phone: _____	Parent 2 Phone: _____
Is Parent 1 the Guarantor? □ Yes □ No	Is Parent 2 the Guarantor? □ Yes □ No

PRIVACY INFORMATION (HIPAA) Communicating with your Family, Friends, or Caregivers

I authorize Horizon Family Medicine to contact me and/or to leave messages for me in the following ways:

□ Home Phone: _____ □ Work Phone: _____

□ Cell Phone: _____ □ Email: _____

I authorize Horizon Family Medicine to release my medical information to the named persons listed below:

□ Spouse/Parents/Children (Print Name): _____

□ Other (Print Names and Relationship to the Patient): _____

Continued ➡

INSURANCE -

	Primary Insurance	Secondary Insurance
Company		
Policy #		
Group #		
Policy Holder's Name		
Relationship to Patient		

FINANCIAL POLICY

Thank you for choosing Horizon Family Medicine, PA for your family's medical care. We are committed to providing you with quality health care. We appreciate your commitment to adhere to this agreement.

- **INSURANCE** – Your medical insurance is a contract between you and your insurance company. Horizon Family Medicine is not a party to that contract. We will file insurance claims on your behalf, as a courtesy. In order for your claims to be processed timely and accurately **you must present a current insurance card and state issued photo ID at each visit**. If you arrive without your card, you will be responsible for all charges until the billing office has received complete, current and accurate insurance information. Horizon Family Medicine policy is to have **Social Security numbers on all patients** to file insurance claims – this helps protect the patient and Horizon Family Medicine from insurance fraud. All information provided to us is part of your confidential health record and is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
  - **Claim Submission** – If your insurance company requires you to supply information to them for processing of a claim you must comply with their request in a timely manner. **If your insurance company has not processed a claim on your behalf within 90 days of submission due to information that you have not provided, the balance will be transferred to your responsibility.** If a payment is received for that claim, you may request reimbursement from **Raleigh Durham Medical Group Billing Department at 866-557-2612** or choose to leave the amount as a credit on your account.
  - **Medicare –** Medicare deductibles and co-insurances are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier. Please notify the front desk staff if you have recently changed Medicare plans. Third-party claims are the responsibility of the patient.
  - **Non-Contracted Insurance Plans** – Payment is required at time of service.
- **CO-PAYMENTS/DEDUCTIBLES/PAYMENTS** – **Payment is required at the time of service**. We currently accept Cash, Personal Checks, Visa, MasterCard, and Discover. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office **PRIOR** to your appointment to discuss payment arrangements. **There will be a $35.00 service charge for all returned checks.**
  - **Self-Pay** – Uninsured patients are classified as Self-Pay. We can provide an estimate of our fees prior to services in the office. This is only an estimate actual charges may be higher or lower. Self-Pay patients may be given a 30% "Prompt Pay" savings when their balance is paid at the time of service. You may also contact the Billing Office for payment arrangements.
- **MINORS** – Parents and guardians are responsible for payments for their dependents at the time of service. Patients between the ages of 16 and 18 can be seen without a parent or guardian present as long as parent or guardian is reachable by phone.
- **MISSED APPOINTMENTS** – Unless canceled at least 24 hours in advance, a charge will be accessed for missed appointments. This fee is NOT covered by your insurance plan and is your responsibility. New Patients who missed their New Patient scheduled appointment may not be eligible to reschedule with our practice.

OFFICE POLICY

- **LATE** – If you arrive more than 15 minutes late for your appointment you will be asked to reschedule.
- **PRESCRIPTION REFILLS** – Call your pharmacy and ask them to fax a refill request to our office. DO NOT wait until you are out of medicine. Refill requests take 24-48 business hours.
- **FORMS** – Forms requiring medical review and physician signature – including school, day care, and camp physicals, prior authorizations, FMLA, disability or other paperwork – will be completed within 7-10 business days which may be subject to a $35 fee. This fee is not billed to the insurance company and is the financial responsibility of the patient. Please make sure to allow plenty of time for completion. Emergencies will be handled on a case by case basis.
- **PATIENT CONFIDENTIALITY** – In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Horizon Family Medicine Notice of Privacy Practices is available to all patients in the office or online at www.horizonfamilymed.com.

Continued 

PAYMENT SOURCES

If you are ***PRIVATE PAY***, you are acknowledging that you are a self paying patient seeking medical attention. You agree to pay your balance in full at the time of service or to pay 50% of your balance now and the remainder in full within 30 days or you agree to a payment arrangement with the Billing Office before leaving the building and satisfying your agreement before your next scheduled visit.

If you are ***INSURED***, you are acknowledging that your claim will be sent to your insurance carrier for reimbursement. You will be responsible for the remaining balance (if any) in accordance with your insurance plan. Such payments will be paid within 30 days of receipt of statement or you will contact the Billing Office to make payment arrangements.

If your visit with our practice is for ***Workmans Compensation***, you are acknowledging that a claim will be filed with your workman compensation carrier. If your claim is denied, you will be responsible for all charges on the account. Such payments will be paid within 30 days of receipt of statement. It is your responsibility to supply Horizon Family Medicine, PA with the information needed to process any and all claims.

If your visit with our practice is for ***PERSONAL INJURY***, you are acknowledging that a claim will be filed with your attorney, private insurance and/or claim adjuster. You will be responsible for all claims if payment is not received within 30 days. Such payments will be paid upon receipt of statement. It is your responsibility to supply Horizon Family Medicine, PA with the information needed to process any and all claims.

ACKNOWLEDGMENT AND SIGNATURE

In signing this Patient Registration Form, you are acknowledging the following…

- You certify that you have read and completed this form to it's entirety and that it is correct and complete to the best of your knowledge.
- You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before our practice received your written notice to stop the communications.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.
- You authorize Horizon Family Medicine to furnish medical information regarding your examinations and treatments to your insurance carriers, and assign all benefits payable to Horizon Family Medicine to be used towards the payment of your account.
- You acknowledge that information related to a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse might be included in a communication you authorize on this form. Information that has been shared as permitted by this form may be redisclosed and no longer protected by state or federal privacy laws.
- An Authorization to Release Health Information or Patient Access Request must be completed for this practice to provide copies of or transmit your health information/records to anyone other than you.

_____ _____

Signature of Patient (or Legal Guardian) Date

Description of Personal Representative's Authority (attach necessary documentation if not previously provided)

_____

FOR OFFICE USE & REFERENCE ONLY

□ This authorization has been revoked: _____ (date)
This revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received: _____ (date)

□ Copy provided to patient/personal representative

Notes: _____

_____

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Patient Name: _____ Date of Birth: _____

ATTENTION: There may be two (2) billing codes at the time of an Annual Preventive Exam.

Insurance billing guidelines require separate billing for such services and/or tests when performed during the Preventive Exam.

- Preventive Exam itself
- Medical Management of current conditions or the diagnosis of new conditions. (See "Things NOT included in a Preventative Medical Exam" below) _____
  Initials

★If you prefer, we can often do both at one visit, if time allows, or you may choose to do this at two separate visits. In such instances, the patient is responsible for any co-pays or deductibles associated with such tests or service, in addition to the normal charge for the Preventive Exam. _____
Initials

A Preventive Exam is a checkup to assess your overall health and includes the following:

- Preventive Exams are also referred to as "physicals," "wellness exams," or "annual exams."
- An age and gender appropriate history and examination
- Prevention and health maintenance issues related to age, sex, and family history
- A review of risk factors and strategies to reduce those risk factors
- Preventive tests, routine labs, age appropriate cancer screening, mood screening, appropriate screenings for diabetes, cholesterol, anemia, kidney and liver diseases.
- Administration of age appropriate immunizations/vaccines
- Guidance about diet, exercise, and other advice/strategies to improve health

Things NOT included in a Preventive Exam appointment:

- Management of your current health conditions (example: high blood pressure, diabetes, high cholesterol, depression, anxiety, insomnia, arthritis, etc.)
- Issuing new or refill of prescriptions
- The diagnosis of any new problem that requires testing, referrals, diagnostic test, medications, etc.
- If we see any questionable indicators, we will usually ask that you schedule a return visit to allow time for proper time and treatment of new problems or chronic conditions.

Your health is our priority and your time matters. We appreciate you helping us maintain our appointment schedule as closely as possible.

Patient Signature: _____ Date: _____

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Health History Questionnaire / Preventive Health Screening

Name: _____ Date of Birth: _____
Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Please describe what problem or concern brought you to our office today:
☐ Primarily to establish care ☐ Other - please briefly describe:_____

Special Communication Needs: Requires Updating Annually					
Language preference:					
If 'yes' to any of the questions below, how can we assist?					
Visual impairment	☐ Yes	☐ No	Cognitive impairment	☐ Yes	☐ No
Hearing impairment	☐ Yes	☐ No	Sensory impairment	☐ Yes	☐ No
Speech impairment	☐ Yes	☐ No	Other:		

Personal Health History		**Previous Surgical Procedures**	
Please check past or current problems or conditions		Please check if you have had any of the following...	
Condition	Condition	Procedure	Year
	☐ Seizures		
☐ Hypertension	☐ Headaches	☐ Heart surgery	
☐ High Cholesterol	☐ Stroke	☐ Carotid artery surgery	
☐ Diabetes	☐ Prostate problem	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Breast problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Urinary tract infections	☐ Hysterectomy	
☐ Congestive heart failure	☐ Osteoarthritis	☐ Gallbladder removed	
☐ Asthma	☐ Cancer *(Please list type below)*	☐ Appendix removed	
☐ Emphysema/chronic bronchitis	_____	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesphageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental illness	☐ Pacemaker	
☐ Colon cancer	☐ Other *(Please describe below)*	☐ Other *(Please describe below)*	
	_____	_____	

Specialty Providers: Requires Updating Annually	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year you last saw them.	
☐ No new specialist visits since previous year	
	☐ Nephrologist
☐ Eye doctor	☐ Psychiatrist
☐ Cardiologist	☐ Allergist
☐ Oncologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other: _____

MEDICATIONS: Please list any medications you take, including over-the-counter, herbs and supplements. Also, include any medications prescribed by specialists or providers other than your PCP. Include dose and frequency.

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below…

Are you unable to fill your prescription(s) because of the cost? ☐ Yes ☐ No

Are you unable to fill your prescription(s) because of lack of transportation? ☐ Yes ☐ No

Have you ever applied for any pharmacy assistance? ☐ Yes ☐ No

Allergies

Please list any allergies to medications or foods

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative
☐ Mental Illness	
☐ Chemical Dependency	
☐ Opioid Dependency	

Opioid History and Current Usage: Requires Updating Annually

It is very important that you take the medication(s) your health care professional has given you.
Please check any of the below...

- Have you ever taken drugs called Opioids (ex: Morphine, Oxycontin, Dilaudid, Fentanyl)? ☐ Yes ☐ No
- Are you currently taking any Opioid for chronic pain? ☐ Yes ☐ No
- Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy) ☐ Yes ☐ No

Social History: Initial / Requires Updating Annually

Please circle appropriate answers below and provide explanations where appropriate

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your current living situation: (Circle number)
Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:
_____

Are there financial concerns that affect your ability:
1) to go to the doctor ☐ No ☐ Yes If yes, describe: _____
2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:_____

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?
☐ No ☐ Yes If yes, describe:_____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other *(please describe below)*
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	Females – Please complete
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow: ☐ Reg ☐ Irreg ☐ Pain/cramps
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow__ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfullness	1st day of last period _____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies _____
☐ Vomiting	☐ Arm ☐ Hips ☐ Back		Miscarriages_____
☐ Vomiting blood	☐ Legs ☐ Neck ☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet		

Health Literacy Questionnaire:	
It is really important to your provider that you understand the information related to your health. Please rate the following questions on a scale of 1 to 10; being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health.	0 1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home.	0 1 2 3 4 5 6 7 8 9 10
I feel that I have strong understanding of medical language.	0 1 2 3 4 5 6 7 8 9 10

Health Maintenance:						
Please check whether you have had the following preventive services and enter the year of the service						
Immunizations		Year	Tests		Location	Year
Tetanus vaccine / Tdap	☐ Yes ☐ No		Pap smear / pelvic	☐ Yes ☐ No		
Pneumonia vaccine	☐ Yes ☐ No		Mammogram	☐ Yes ☐ No		
Influenza vaccine	☐ Yes ☐ No		Bone dexascan	☐ Yes ☐ No		
Shingles vaccine	☐ Yes ☐ No		Colonoscopy	☐ Yes ☐ No		
Covid vaccine	☐ Yes ☐ No		Prostate test	☐ Yes ☐ No		
Additional Vaccines taken since previous year ☐ Yes ☐ No If yes, list vaccine name and date:						

Health Behaviors: Requires Updating Annually for 11 years and older	
Tobacco Use: ☐ Never ☐ Quit/when _____ ☐ Current Smoker If current smoker, how many packs per day/for how many years _____	
Alcohol Intake: ☐ Yes ☐ No If yes how many drinks/how often _____	
Illicit Drug Use (marijuana, cocaine, steroids) ☐ Never ☐ Past ☐ Current If past or current drug use describe: _____	
Exposure to secondhand smoke	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No
Wear a Seatbelt	☐ Yes ☐ No
See a dentist at least once a year	☐ Yes ☐ No
Wear sunscreen	☐ Yes ☐ No

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older				
Do you experience leaking in the following situations:	Not at all	A little	Sometimes	A Lot
During daily activities (work, household tasks)				
During physical activities (walking, exercising)				
During recreational activities (movies, hobbies)				
During social activities (out with friends, family visits)				
During car trips				

Fall Risk Screening: Requires Updating Annually for 65 years and older	
In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Functional Assessment: Requires Updating Annually for 65 years and older				
Do you need assistance in the following situations:	Not at all	A little	Sometimes	A Lot
Bathing, dressing and grooming				
Daily activities (cooking, cleaning)				
Walking or driving				
Communicating needs and feelings				
Understanding directions				
Keeping appointments				
Taking medications				
Performing other medical treatments				
If yes to any of these questions, who helps with these activities? _____				

Mood Screening: Requires Updating Annually for 11 years and older	
A person's mood can have a strong influence on their health status and overall well being. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	**Feeling down, depressed or hopeless**
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the day	☐ More than half the day
☐ Nearly every day	☐ Nearly every day

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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864 Black Creek Road
Four Oaks, NC 27520
Phone: 919-963-3148
Fax: 919-963-2900

236 Butternut Lane
Clayton, NC 27520
Phone: 919-359-1011
Fax: 919-359-9122

100 Cunningham Lane
Clayton, NC 27527
Phone: 919-359-6016
Fax: 919-359-6017

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Other Name: _____

Street:_____ City, ST Zip: _____

Date of Birth: _____/_____/_____ Phone: _____ Cell: _____

I authorize the release of medical information as indicated below:

FROM

Practice: _____
Attn: _____
Street: _____
City, ST Zip: _____
Phone: _____
Fax: _____

TO

Horizon Family Medicine, PA
Attn: Medical Records Department

☐ 864 Black Creek Road	☐ 236 Butternut Lane	☐ 100 Cunningham Lane
Four Oaks, NC 27524	Clayton, NC 27520	Clayton, NC 27527
Phone: 919-963-3148	Phone: 919-359-1011	Phone: 919-359-6016
Fax: 919-963-2900	Fax: 919-359-9122	Fax: 919-359-6017

IF THERE ARE MORE THAN 10 PAGES, PLEASE MAIL RECORDS. DO NOT FAX.
*****Please DO NOT send a CD*****

❑ I would like to pick up my records, please call me at the number above.
❑ I would like the records mailed (please indicate the address above).

What to Release: Please choose the records you would like released:

❑ Outpatient note(s)
❑ X-Ray report(s)/film(s)
❑ Laboratory reports(s)
❑ Immunization record
❑ Pathology reports(s)
❑ ALL Medical records
❑ Other, please specify:_____

NOTE: The records listed below have special protection by law. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests ❑ Yes ❑ No/NA
The diagnosis or treatment of drug and/or alcohol abuse ❑ Yes ❑ No/NA
The treatment and/or consultation for mental health or psychiatric disorders ❑ Yes ❑ No/NA

Purpose of the release: Please indicate the reason for this release:

❑ Transfer care
❑ For use in a lawsuit
❑ Follow-up related to an injury
❑ Personal use
❑ To obtain disability
❑ Worker's compensation
❑ Armed Forces requirement
❑ For another doctor
❑ Other, please specify:_____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

❑ Please change the expiration date to last for _____days.

I understand this Authorization can be revoked at any time according to Horizon Family Medicine's privacy practices. This request must be made in writing. Once these records are released, the information is not protected by Horizon Family Medicine and may potentially be re-disclosed by the party who received these records. Horizon Family Medicine, its employees and officers, and attending physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form, and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative AND Relationship to Patient Date

_____ _____
Signature of Witness Date

***If you have any questions about transferring your records, please contact the Office Coordinator at the Horizon location where you are a patient. Contact information for all Horizon Family Medicine locations is found at the top of this page.*