Horizon Family Medicine, PA

Multiple Locations With One Purpose...Your Health

NEW Patient Registration Form

Patient Information – *Please Print*

Legal Name: _____ **Suffix:** _____

SSN: _____ **Date of Birth:** _____ **Email:** _____

Home Address: _____ **City, State, Zip:** _____

Mailing Address: _____ **City, State, Zip:** _____

Home Number: _____ **Cell Number:** _____ **Work Number:** _____

☐ By checking this box, I consent to receive SMS messages from Horizon Family Medicine related to medical appointments from us. The SMS frequency may vary. Data rates may apply. For assistance, reply HELP. Reply STOP to opt out of receiving text messages. Please review our Privacy Policy and Terms & Conditions.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female

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

First Language: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Emergency Contact – *Who may we contact in case of an emergency?*

Name: _____ **Relationship to Patient:** _____

Home Number: _____ **Cell Number:** _____ **Work Number:** _____

Privacy Information – *HIPAA – Communicating with your Family, Friends, or Caregivers*

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

☐ Home Phone: _____ ☐ Work Phone: _____

☐ Cell Phone: _____ ☐ Email: _____

I authorize Horizon Family Medicine to release my medical information to the following people:

☐ Spouse: _____ Phone Number: _____

☐ Relative: _____ Phone Number: _____

☐ Other: _____ Phone Number: _____

☐ I DO NOT wish to release my health information to anyone besides myself.

Insurance Information

	Primary Insurance	**Secondary Insurance**
Company		
Policy #		
Group #		
Medical Claims Address		
Policy Holder's Name		
Policy Holder's DOB		
Relationship to Patient		

Read and Sign Below

I certify that the information provided is correct and complete to the best of my knowledge.

Signature of Patient (or Legal Guardian): _____ **Date:** _____

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Vaccination Policy

At Horizon Family Medicine, we are committed to providing the highest standard of care to all our patients. Based on evidence-based guidelines and recommendations from the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and other public health authorities, we require that all patients follow the routine childhood immunization schedule.

Our Policy

We **do not accept patients who are unvaccinated** or whose parents/guardians choose to decline routine childhood immunizations without a valid medical contraindication.

This policy is in place to:

- Protect the health and safety of all children and families who visit our practice.
- Prevent the spread of vaccine-preventable diseases.
- Support community immunity, especially for those who are too young or medically unable to be vaccinated.

We recognize that parents and guardians have the right to make medical decisions for their children. However, we believe that not vaccinating poses a risk to other patients and staff in our practice and contradicts our commitment to public health and safety.

Exemptions

Only **documented medical exemptions** signed by a licensed medical provider will be considered on a case-by-case basis. We do not accept philosophical or religious exemptions.

Agreement

By signing below, you acknowledge that you have read, understand, and agree to comply with our practice's vaccination policy. You also understand that failure to comply may result in discharge from the practice.

Parent/Guardian Name: _____

Child's Name(s): _____

Signature: _____ **Date:** _____

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Financial and Office Policy

Financial Policy

Legal Name (First, Middle, Last): _____ Date of Birth: _____

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.

Office Policy

- **LATE** – If you arrive more than 10 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 $15 fee. 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.

Read and Sign Below

I have read, understand and agree to the above Financial and Office Policy. I authorize Horizon Family Medicine to furnish medical information regarding my examinations and treatments to my insurance carriers, and assign all benefits payable to Horizon Family Medicine to be used towards the payment of my account.

Signature of Patient (or Legal Guardian): _____ Date: _____