Horizon Family Medicine, PA

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, MI, Last):_____ID #, DL # or SS #: _____

Relationship to Patient:_____Date of Birth:_____Employer: _____

INSURANCE –

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

PRIVACY INFORMATION (HIPAA)

I authorize Horizon Family Medicine to contact me and/or to 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 named persons listed below:

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

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

READ & 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**

HFM-PR 042513

Health History Questionnaire:

☐ Initial ☐ Annual

Horizon Family Medicine, PA
Serving Johnston County Since 1980

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative 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
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removed	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	
☐ Emphysema/chronic bronchitis	☐ Cancer (Please list type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal 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)	☐ Other (please describe)	
☐ Bowel/digestive problem			
☐ No Change Since Previous year			

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 that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other
☐ No new specialist visits since previous year	

Please list any new medications prescribed by specialists or providers other than your PCP. Please include name, 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 prescriptions 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	Condition	Relative
☐ Mental illness		☐ Chemical dependency	

Social History: Initial
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:
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	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	☐ Arms ☐ Hips	☐ Back	Miscarriages___
☐ Vomiting blood	☐ Legs ☐ Neck	☐ Shoulders	Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet		

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____

Preventive Health Screening

☐ **Initial** ☐ **Annual**

Name_____ Date Completed _____

Address_____

Local phone number_____ Alternative phone number_____

Preferred Pharmacy_____ Pharmacy phone number_____

Please describe what problem or concern brought you to our office today:

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; 1 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	**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	**1 2 3 4 5 6 7 8 9 10**
I feel that I have a strong understanding of medical language	**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**			**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**	
				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: ☐ **No** ☐ **Yes** **If yes how many drinks/how often_____**				
Illicit drug use (including marijuana, cocaine, steroids): ☐ **Never** ☐ **Past** ☐ **Current**				
If Past or Current drug use describe:				
Exposure to secondhand smoke	☐ **Yes**	☐ **No**	**Wear a seatbelt**	☐ **Yes** ☐ **No**
Eat a diet high in fruits and vegetables	☐ **Yes**	☐ **No**	**See a dentist at least once a year**	☐ **Yes** ☐ **No**
Get 30 minutes of exercise 5 times a week	☐ **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 task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going 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 areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

Mood Screening: Requires Updating Annually for age 11 and up	
A person's mood can have a strong influence on their health status and overall wellbeing. 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 days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Social History: Requires Updating Annually

Please circle appropriate answers below and provide explanations where appropriate

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

How stressful would you rate your job situation: (Circle number)

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Have you had change in Marital Status: ☐ No ☐ Yes If yes, describe below:

How stressful would you rate your current living situation?

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:

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____

MR #

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

410 Canterbury Road	236 Butternut Lane	864 Black Creek Road	213 Barden Street	100 Cunningham Lane, Ste 103
Smithfield, NC 27577	Clayton, NC 27520	Four Oaks, NC 27524	Princeton, NC 27569	Clayton, NC 27527
Phone: (919) 934-5149	Phone: (919) 359-1011	Phone: (919) 963-3148	Phone: (919) 936-5171	Phone: (919) 359-6016
Fax: (919) 934-5632	Fax: (919) 359-9122	Fax: (919) 963-2900	Fax: (919) 936-2328	Fax: (919) 936-2328

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

IF MORE THAN 10 PAGES, PLEASE MAIL RECORDS. DO NOT FAX.

- ❑ 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

Horizon Family Medicine, PA

www.horizonfamilymed.com

PROMISSORY NOTE

PLEASE CHOOSE YOUR PAYMENT SOURCE

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

PRIVATE PAY

I, _____am acknowledging that I am a self paying patient seeking medical attention. I agree to pay my balance in full at the time of service or to pay 50% of my balance now and the remainder in full within 30 days or I will agree to a payment arrangement with the Billing Office before leaving the building and satisfying my agreement before my next scheduled visit.

INSURANCE

I, _____acknowledge that my claim will be sent to my insurance carrier for reimbursement. I will be responsible for the remaining balance (if any) in accordance with my insurance plan. Such payments will be paid within 30 days of receipt of statement or I will contact the Billing Office to make payment arrangements.

WORKMANS COMPENSATION

I, _____acknowledge that a claim will be filed with my workman compensation carrier. If my claim is denied, I will be responsible for all charges on the account. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply Horizon Family Medicine with the information needed to process any and all claims.

PERSONAL INJURY

I, _____acknowledge that a claim will be filed with my attorney, private insurance and/or claim adjustor. I 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 my responsibility to supply Horizon Family Medicine with the information needed to process any and all claims.

_____ _____

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

Horizon Family Medicine, PA
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FINANCIAL & 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 will be reimbursed by Horizon Family Medicine, PA within 15 business days.
  - **Medicare** – Medicare deductibles & 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 dependants 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 cancelled at least 24 hours in advance, a charge of **$30 for missed appointments** may be applied. This fee is NOT covered by your insurance plan and is your responsibility.

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 your 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 with a fee of $15 due upon receipt. 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 & SIGN BELOW

I have read, understand and agree to the above Financial & 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**