Horizon Medical
Associates, P.C.

Horizon Medical Associates Policy Information
*For **New Patient Consultations:***

Patient Name: _____ Today's date _____

Thank you for choosing our practice as your health care provider. We are committed to providing you with the highest standard of care and will make every effort to ensure that your experience exceeds your expectations.

We have included our office ***New Patient*** forms and ask that you fill out these forms at home and bring them with you at your first visit. Please bring a current **Picture I.D**. along with your **Insurance Card(s)** to all your appointments.

It is our policy to collect **Copay** or **Coinsurance** fees at the time of your visit. We accept cash/check/credit-debit cards. There is a convenience ATM on the main floor of the North Grove main campus. We are located on the 2nd floor, Suite 2100.

You have been scheduled to see _____ on _____ at _____a.m./p.m., as a **New Patient Consult**, with the date and time previously agreed upon by you (or your representative) and our scheduler.

We understand plans change and you may not be able to keep your appointment. We kindly request 3-day's notification of any changes, including cancellation or rescheduling. A **$50 rescheduling fee** will be assigned to patients who do not notify our office within this time frame, which will need to be paid 1 week prior to the next scheduled appointment. A 2nd request to reschedule will not be granted.

We thank you for your understanding and cooperation with our office policies and appreciate the opportunity to participate in your medical treatment.

1330 Boiling Springs Rd., Suite 2100
Spartanburg, SC 29303
864-591-1700 (P) 864-591-0007 (F)

Horizon Medical Associates, P.C.

Patient Information

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Marital Status: S M D W Other_____

City: _____ State: _____ Zip: _____ Social Security #: _____

Phone: Home: _____ Cell: _____ Work: _____

Race: ( ) White ( ) Black/African American ( ) Hispanic ( ) American Indian ( ) Asian ( ) Other _____

Ethnicity: ( ) Hispanic/Latino ( ) Not Hispanic/ Latino ( ) Declined

Emergency Contacts

The person or persons below will only be contacted in the event of an emergency.

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Insurance Information

Primary Insurance Information:

Name of Primary Insurance: _____

Mailing Address for Claims: _____

Group #:_____ ID #_____ Effective Date: _____

Subscriber Information **( ) Check here if same as the patient**

Name: _____ Date of Birth: _____ Social Security #: _____

Mailing address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Relation to Patient: _____

Secondary Insurance Information:

Name of Secondary Insurance: _____

Mailing Address for Claims: _____

Group #: _____ ID #: _____ Effective Date: _____

Subscriber Information **( ) Check here if same as the patient**

Name: _____ Date of Birth: _____ Social Security #: _____

Mailing address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Relation to Patient: _____

Compound Authorization for Information Disclosure(s)

Patient Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

This authorization form permits:

Horizon Medical Associates, P.C.
1330 Boiling Springs Rd
Suite 2100
Spartanburg S.C. 29303

To use or disclose protected health information to the entities or listed below for the above name patient:

Authorization to leave voicemail:

Indicate which voicemail boxes, if any, and type of information we may leave:

Home#: _____ ☐ Appointments /Test Results ☐ Financial information

Cell#: _____ ☐ Appointments /Test Results ☐ Financial information

Work#: _____ ☐ Appointments /Test Results ☐ Financial information

Authorization for Email and Text Messaging:

Email: _____

☐ Appointment ☐ Financial Information ☐ Medical/ Treatment Information

Text Messages: Phone #: _____

☐ Appointment ☐ Financial Information ☐ Medical/Treatment Information

School/Work

Indicate if your School or Work may receive information about your appointment:

School Name: _____ ☐ Appointment Dates

Workplace: _____ ☐ Return to School / Work Dates

Others who may receive your information: (Ex. Spouses, Parents, Children, Sister, Brother, Etc)

Name: _____ Relationship: _____

☐ Appointment ☐ Financial Information ☐ Medical/ Treatment Information

Name: _____ Relationship: _____

☐ Appointment ☐ Financial Information ☐ Medical/ Treatment Information

Name: _____ Relationship: _____

☐ Appointment ☐ Financial Information ☐ Medical/ Treatment Information

****Please read and sign the next page to authorize these disclosures.**

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event:

This authorization shall be enforced until revoked by the patient in writing or the patient leaves the practice.

Verification method or code:

This practice will verify the identity of any entity requesting protected health information. Verification information may include, but is not limited to, driver's license or photo ID.

Rights of the Patient

I understand that I have the right to refuse to sign the authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative (as defined by HIPAA) Date

Description of Personal Representative's Authority (attach necessary documentation)

****

Office Use Only:

Receiving Employee: _____ Date Received: _____

☐ Copy given to patient

Horizon Medical Associates, P.C.

Last Name: _____ **First Name:** _____ **MI** _____

Date of Birth: _____ **Social Security Number:** _____

Height: _____ **Weight:** _____(lbs)

Pharmacy Name: _____ **Location:** _____ **Phone #:** _____

Allergies to Medication: _____

Current Medications: Please list any prescription medications, over the counter medications, and vitamin supplements you take routinely:
Check none if you are not taking any medications **None** ☐

Name of Drug/Supplement:	Strength:	How often (#of times per day):

Surgical History – List all prior surgeries and dates (approximate):

_____
_____
_____

Medical History -Circle all that apply to you:

Anemia	Chronic Kidney Dis	High Blood Pressure	Osteoporosis
Asthma	Deep Vein Thrombosis	Heart Disease	Parkinson's
Arthritis	Depression	Heart Attack	Peripheral Vascular Di
Cancer:	Diabetes	IBS	Rheumatoid Arthritis
Type: _____	GERD	Lupus	Seizures
	Gout	Liver Disease	Thyroid Disease
CVA (Stroke)	Hepatitis C	Migraine Headaches	Kidney Stones
Chronic UTI	High Cholesterol	Anxiety	Valvular Heart Disease
COPD	Hyperlipidemia	Osteoarthritis	Traumatic Brain Injury
Elevated PSA	Low Testosterone	Atrial Fibrillation	Obesity

List any other medical conditions/ diagnosis/disease here:

_____
_____
_____

Family History: Check any illness in your immediate family and include relationship – (Blood Relatives Only)

Diagnosis	Relationship	Diagnosis	Relationship
____Bladder Cancer		____ Kidney Failure	
____ Breast Cancer		____Kidney Stones	
____ Diabetes		____Lung Cancer	
____ High Blood Pressure		____Prostate Cancer	
____ Kidney Cancer		____Stroke	
Other:			

Social History:

1 Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

2. Smoking Status:

☐ Never Smoker ☐ Former Smoker ☐ Current Every day Smoker ☐ Current Some day Smoker

- **If Current or Former smoker:**

How much do/did you smoke per day? _____

How many years did/have you smoked? _____

3. Do you drink alcohol? **Yes** **Not anymore** **Never**

Type of Alcohol: Beer Wine Other

Drinking Habit: Social Light Moderate Excessive

4.How many caffeinated drinks do you have each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 +

5. Have you ever had a blood transfusion? ☐ Yes ☐ No **Any reactions to transfusions?** _____

6. Language:

☐ English ☐ Spanish ☐ French ☐ German ☐ Portuguese ☐ Russian ☐ Chinese ☐ Other: _____

7.Race:

☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ American Indian/Alaska Native

☐ Eskimo ☐ Pacific Islander ☐ Unknown

Review of Systems: (Circle all that apply)

Constitutional:	Fever	Chills	Weight Loss	Other: _____
Eyes:	Blurry Vision	Double Vison	Cataracts	Other: _____
ENT and Mouth:	Hearing Loss	Nasal Stuffiness	Sore Throat	Other: _____
Cardiovascular:	Chest Pain	Swollen Ankles	Irregular Heartbeat	Other: _____
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough	Other: _____
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels	Other: _____
Genitourinary:	Incontinence	Painful Urination	Blood in Urine	Other: _____
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	Other: _____
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History	Other: _____
Neurological:	Numbness	Tingling	Dizziness	Other: _____
Hematologic/Lymphatic	Swollen Glands	Abnormal Bleeding	Transfusion History	Other: _____

Horizon Medical Associates, P.C.

Financial Policy

We are excited that you have chosen to put your trust into our practice for your healthcare needs. We are committed to helping provide the best medical care possible for you. We hope that you will take a moment to familiarize yourself with our financial policies.

Providing our office with the most accurate information at the time of service helps to make sure that your claims are field correctly to your insurance company.

1. We ask you present your insurance cards and picture ID at every visit. It is your responsibility as the patient to provide our office with the correct information to bill your insurance.
2. If you have a change of address or telephone number, or any information that could delay insurance payments, please notify our front office.

Referral and Authorizations

Horizon Medical Associates, P.C. requires a referral from your primary care physician for you to be seen and treated while your insurance may not. Obtaining this referral is your responsibility. Failure to obtain this referral may mean that your insurance company will not pay benefits for your visit. Please remember to check with your insurance to determine their requirements. If your plan requires **you** to have an authorization to see a specialist, **you** will need to obtain that from your Primary Care Physician prior to seeing the specialist. If authorization is not obtained, **you** will be held responsible for the balance for that date of service.

Copays, Deductibles, and Co-Insurance

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Please remember that patient responsibility amounts are determined by your individual insurance plan, not Horizon Medical Associates, P.C. For your convenience we accept cash, personal check, Visa, Master Card, American Express, Discover. There is a $30.00 charge for returned checks.

Past Due Balances

If your insurance company denies our charges, you will be responsible for the entire balance. You are expected to pay your balance within 30 days of the insurance denial. If you need to make arrangements, you may speak with someone in our Insurance Department. Patients with an outstanding balance of 60 days or more must make arrangement for payment prior to scheduling further appointments. Horizon Medical Associates reserves the right to advise you to seek care through an alternate clinic or medical provider if your account becomes delinquent.

Self-Pay Patients

Patients without insurance or patients who waive the right to have their insurance filed are expected to make payment in full at the time of visit. New patients will be responsible for a deposit for $250.00 at check-in. Established patients will be responsible for a deposit of $90.00 at check-in. You will be responsible for the remainder of the balance at check-out.

I acknowledge that I have read and have had the opportunity to ask any questions regarding Horizon Medical Associates P.C. Financial Policy. I agree to assign insurance benefits to the Horizon Medical Associates P.C. for all services provided. I also agree to be responsible for an administrative collections fee and/or any additional fees charged by a collection agency or court fees and costs associated with collections of this debt, along with the original debt.

Signature of patient or

Authorized representative: _____ Date: _____

Horizon Medical Associates, P.C.

General Consent to Treat and

Patient Acknowledgement of Privacy Practices Notice

You have the right, as a patient to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended at our practice. You have the right at any time to discontinue services. The consent will remain fully effective until it is revoked in writing.

You have the right to discuss the treatment plan with your physician about the purpose, potential, risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (nurse Practitioner, Physician Assistant), and other health care providers or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sigh additional consent forms prior to the test(s) or procedure(s).

I certify that I have received a copy of the Notice of Privacy Practices. This notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time.

I certify that I have read any fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Date**

_____ _____

Printed Name of Witness **Date**

_____ _____

Signature of Witness **Date**