HORIZONS HEALTHCARE

2795 Main Street West, Building #27, Snellville, GA 30078 Ph: 770.985.8001; Fax: 770.985.8028

PATIENT INFORMATION

LAST NAME FIRST NAME MI AGE DOB / /

SSN: _____ SEX: ☐M ☐ F _____

MARITAL STATUS/LIVING SITUATION: □ MARRIED □ WIDOWED □ SINGLE □ DIVORCED
□ SEPARATED □ OTHER: _____

STREET ADDRESS_____

CITY STATE ZIP CODE

CELL PHONE HOME PHONE EMAIL OCCUPATION

PRIMARY INSURANCE ID# PHONE#

IF PRIMARY INS. IS A MEDICARE ADVANTAGE PLAN, WHAT IS YOUR REGULAR MEDICARE ID #?

SECONDARY INSURANCE ID# PHONE#

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR PERSONAL CARE HOME? □ YES □ NO
IF SO, WHICH ONE? _____
LOCATION: _____

RESPONSIBLE PARTY

LAST NAME FIRST NAME RELATIONSHIP TO PATIENT

ARE YOU THE PATIENT'S POA? □ YES □ NO *IF YES, PLEASE PROVIDE A COPY FOR PATIENT'S CHART

ADDRESS:
STREET

CITY STATE ZIP CODE

CELL PHONE HOME PHONE ALT. PHONE

EMAIL ADDRESS

EMERGENCY CONTACT (IF DIFFERENT FROM RESPONSIBLE PARTY)

LAST NAME FIRST NAME RELATIONSHIP TO PATIENT

ARE YOU THE PATIENT'S POA? □ YES □ NO *IF YES, PLEASE PROVIDE A COPY FOR PATIENT'S CHART

ADDRESS:
STREET

CITY STATE ZIP CODE

CELL PHONE HOME PHONE ALT. PHONE

EMAIL ADDRESS

PRE-VISIT/HEALTH HISTORY FORM

LAST NAME FIRST NAME MI AGE DOB / /	
HEIGHT: FEET INCHES	CURRENT WEIGHT: LBS.
REFERRED BY/HOW DID YOU HEAR ABOUT US?	
IF APPLICABLE, SPOUSE'S/PARTNER'S NAME	HOW MANY YEARS MARRIED/TOGETHER?
WHERE WERE YOU BORN & RAISED?	
HOW MANY CHILDREN DO YOU HAVE? WHAT ARE THEIR NAMES (IF ADULTS):	
YOUR HIGHEST LEVEL OF EDUCATION: ☐ PRIMARY SCHOOL ☐ SECONDARY/HIGH SCHOOL ☐ SOME COLLEGE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER:	
OCCUPATION:	RETIRED? ☐ NO ☐ YES WHAT YEAR?
ALLERGIES:	
REASON FOR VISIT:	
DO YOU HAVE A MEMORY PROBLEM? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:	
DO YOU HAVE A PSYCHIATRIC HISTORY? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:	
HAS ANYONE IN YOUR FAMILY HAD MEMORY OR MENTAL HEALTH PROBLEMS? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:	
DO YOU HAVE SPECIAL LIVING NEEDS? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:	
ARE YOU DISABLED? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:	
DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MANY PACKS PER DAY? IF YOU QUIT, WHEN DID YOU STOP?	DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW OFTEN/MANY? IF YOU QUIT, WHEN DID YOU STOP?

PAST MEDICAL HISTORY

- □ Rheumatic Fever
- □ Heart Attack
- □ Congestive Heart Failure
- □ Irregular Heart Beat
- □ Dizziness
- □ Ankle Swelling
- □ Shortness of Breath
- □ Stroke
- □ TIA's
- □ Head Injury
- □ Loss of Consciousness
- □ Diabetes
- □ High Blood Pressure
- □ Cataracts
- □ Glasses
- □ Hearing Difficulty
- □ Ulcer
- □ Anemia
- □ Urinary Tract Infection
- □ Prostate Problems
- □ Cancer
- □ Constipation
- □ Diarrhea
- □ Kidney Disease
- □ Asthma/COPD
- □ Seasonal Allergies
- □ Thyroid Disease
- □ Liver Disease
- □ Arthritis
- □ Other _____

FAMILY HISTORY

Pathology	Relationship	Pathology	Relationship	Pathology	Relationship
Alcoholism		Cancer		Glaucoma	
Asthma		Diabetes		Heart Dz	
Bleeding Dz		Seizures		Hypertension	
Kidney Dz		Mental Illness		Migraine	
Osteoporosis		Stroke		Thyroid Dz	

YEAR OF MOST RECENT:

Tetanus Shot		Cholesterol		Pneumonia Vaccine	
Flu Vaccine		Rectal Exam		TB Test	

HOSPITAL/ER ADMISSIONS

Year	Illness or Operation	Year	Illness or Operation

CURRENT MEDICATION & DOSAGE

INSURANCE PAYMENT AUTHORIZATION FORM

MEDICARE PATIENTS

Medicare Beneficiary Payment Authorization

I, _____, request that payments of authorized Medicare Benefits be made on my behalf to Horizons Healthcare for services furnished to me by its providers. I authorize any holder of medical information about me to be released to the healthcare financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____Date_____

Authorized Signature (if other than patient) _____Date _____

ALL OTHER PATIENTS WITH INSURANCE (NON-MEDICARE)

Insurance Beneficiary Payment Authorization

I, _____, understand that Horizons Healthcare will submit all charges to my insurance carrier and I herby assign benefits to Horizons Healthcare. I authorize the release of all medical information necessary to secure payment of insurance benefits.

I recognize and accept that it is ultimately my responsibility for any balance or fee not covered by my insurance plan.

I also recognize and accept that it is my responsibility, as the insurance policy holder (or as the authorized person acting on behalf of the patient), to verify benefit coverage pertaining to services rendered by Horizons Healthcare, confirm in-network participation, and to understand that while Horizons Healthcare, as a courtesy, may assist in obtaining this information, I ultimately bear responsibility for being familiar with the details and benefits of my insurance plan.

Patient Signature _____Date _____

Authorized Signature (if other than patient) _____Date _____

HORIZONS HEALTHCARE

SELF-PAY PATIENTS

Patient's Name: _____ DOB: _____

Patients who have no insurance coverage, or who wish to pay for healthcare services out of pocket instead of going through their insurance company, may elect to be "self-pay". The fee for the office visit is due at the time of the appointment.

Initial here: _____I accept personal responsibility for any fees associated with services rendered by Horizons Healthcare providers.

Initial here: _____I understand that if I have lab work done, the visit will result in separate charges billed directly by the lab company, for which I am also responsible.

Patient/Responsible Party Signature Date

Name and relationship of responsible party, if not the patient

HORIZONS HEALTHCARE

OUR POLICIES

WE WOULD LIKE TO FAMILIARIZE YOU WITH HOW OUR SERVICES ARE BILLED AND INFORM YOU OF OUR POLICIES. WE ASK THAT YOU PLEASE READ OUR POLICIES THOROUGHLY.

If you have any questions, please ask our staff, who will be happy to discuss them with you.

REGISTRATION:

All new patients must complete provide insurance information, which will be verified by us. Once Insurance has been verified, all new patients must complete the Patient Information Packet and Authorization for Release of Medical Records form.

INSURANCE:

Please note that we participate with Medicare, most Medicare Advantage Plans, Medicaid, and several third party insurance plans. We will be happy to file your insurance claim for your visits with us as a service to you; however, you are ultimately responsible for any balance due. Please see additional important information regarding insurance on our PATIENT/INSURANCE REGISTRATION FORM.

You are expected to notify us of any change in your insurance coverage whenever one occurs. We cannot be held responsible for filing insurance incorrectly when new information has not been made available to us, or if the new policy does not cover our services. Providing the information to the assisted living facility or personal care home where the patient resides, or to other healthcare professionals is not sufficient. We need the information given to us directly.

MISSED APPOINTMENT & CANCELLATION FEE:

Your appointment time is reserved for you. Please give our office at least 24 hours notice if you must cancel an appointment so someone else may be given the time slot. If you miss more than one appointment without prior notification, you will be charged a $25.00 fee.

PRESCRIPTION REFILLS:

Please allow a MINIMUM of 48-72 hours for prescription refills. Do not wait until you are out, or are nearly out, of a prescription before notifying us. We have many patients and we need to time to handle refills properly.

I, _____, have read and accept the above policies presented.

Patient (or Representative) Signature: _____Date_____

HORIZONS HEALTHCARE

-FOR MEDICARE PATIENTS ONLY-

CHRONIC CARE MANAGEMENT CONSENT FORM

Dear *Medicare Patient* and/or Family Member,

We appreciate the opportunity to provide you with comprehensive primary care. In addition to our regular services, Horizons Healthcare provides Chronic Care Management Services.

Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team, caregivers, and the patient in order to maintain the best possible health outcome. Examples include diabetes, high blood pressure, heart disease, depression, and others. Federal regulations enable Medicare to pay for chronic care management.

What are the benefits of signing up for Chronic Care Management Services?

- Coordinate visits with your doctors, facilities, labs, radiology, or others
- Assist with management of medications
- Provide a personalized and comprehensive care plan
- Assist with scheduling preventive care services
- Ongoing communication with caregivers and PCH/ALF staff.

What do you need to know before signing up?

Understand that this care is subject to a Medicare coinsurance amount (approximately $8 to $9) billed by Horizons Healthcare each month that you receive chronic care management. Patients who are dually eligible (Medicare/Medicaid) are exempt from cost-sharing. Additionally, Medigap and supplemental insurance often covers the co-insurance. The service is subject to your annual Medicare deductible.

You have a right to:

Discontinue this service at any time for any reason. Your signature is required to end your chronic care management services; therefore, please notify us in writing if you want to terminate CCM services. The provider will continue providing CCM services until the end of the month and may bill Medicare for those services. After the end of the month, the provider will discontinue CCM services and no longer bill for those services to Medicare.

- Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between caregivers directly involved with your health.

Note: You must sign this agreement to receive chronic care management services. **Only one physician can bill for this service for you.** Please let us know if you have entered into a similar agreement with another physician/practice.

Our goal is to make sure you get the best care possible from everyone that is involved with your health.

Patient's Name_____DOB:_____

I agree to participate in the Chronic Care Management program. Yes ___ No___

Print Name _____Relationship to Patient_____

Signature_____Date_____

Patricia Gray-Smith, NP Paul E. Allen, MD Nicole Moncrieffe, NP Andrea Alexis, NP

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Authorization of Release of Medical Records

PATIENT INFORMATION (Please Print):

Name: _____ DOB: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

I, _____ (Relationship to patient: _____) hereby authorize the use or release of the above named individual's health information as described below for continued medical care:

*Pertinent information (includes history and physical, laboratory, x-rays, pathology reports, consultations, procedure reports, discharge summary, current medications, EKG reports, progress notes, and health maintenance information).

_____

Patient/Representative Signature Date

PLEASE RELEASE RECORDS FROM/TO (circle one):

Name (Provider/Medical Practice): _____
Phone: _____
Address: _____
Fax: _____

FROM/TO (circle one):
Horizons Healthcare, LLC
2795 Main St., W #27
Snellville, GA 30078
Ph: 770.985.8001; Fax; 770.985.8028

HIPAA STATEMENT/NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND REPORT ANY GRIEVANCE TO: HORIZONS HEALTHCARE, 2795 Main Street, W Bldg #27 Snellville, GA 30078 – Phone: (770) 985-8001.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the Patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We have prepared this "Summary Notice of HIPAA Privacy Practices" to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations:

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers.
- PAYMENT means such activities as obtaining payment or reimbursement for services, billing or collection activities and utilization review.
- HEALTH CARE OPERATIONS include managing your Electronic Medical Record to facilitate diagnostic medical consultations with participating physicians, as well as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.
  We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about our services or other health-related services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Horizons Healthcare Privacy Officer:

1. You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operations. You may also request that we limit our disclosures to persons assisting your care. We will consider your request, but are not required to accept it.
2. You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.
3. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.
4. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.
5. You have a right to receive a list of certain instances when we have used or disclosed your medical information. If you ask for this information from us more than once every twelve months, we may charge you a fee.

HORIZONS HEALTHCARE: HIPAA ACKNOWLEDGEMENT

By signing this I am acknowledging that I have read and understand this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of Privacy Practices. I understand that, by signing this acknowledgement and consent form that I am giving my consent for this office's use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Name: _____

Signature: _____

If this acknowledgement is signed by a personal representative on behalf of the patient please complete the following:

Guardian or Personal Representative's Name: _____

Signature: _____ Date: _____