Horizon Family Medicine PLLC
1335 E. CENTER STREET, #1
Kingsport, TN 37664

Telephone (423) 247-2263 Fax: (423) 246-1943

NEW PATIENT INFORMATION FORM

DATE: _____

NAME: _____

DATE OF BIRTH: _____

PHONE NUMBERS: HOME: _____ **WORK:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SOCIAL SECURITY NUMBER: _____

HEALTH INSURANCE: _____

PREVIOUS PHYSICIAN: _____

REASON FOR THE CHANGE: _____

HOW DID YOU KNOW ABOUT US: _____

PAST MEDICAL HISTORY: _____

CURRENT MEDICAL PROBLEMS: _____

CURRENT MEDICATIONS: _____

_____

ACCEPTED: _____ **NOT ACCEPTED:** _____

NEW PATIENT DEMOGRAPHICS

In order to serve you properly, we will need the following information. All information will be confidential. Please contact the receptionist or nurse if you have any questions.

Please present your Driver's License and Insurance Card to the receptionist

Patient Name: _____ (first) _____ (middle) _____ (last) _____ (goes by)

Gender: _____ DOB: _____ Race: _____ Ethnicity: _____ Language: _____

SS#: _____

Primary Address: _____ (line one) _____ (line two)
(no "PO Box")

City: _____ State: _____ Zip: _____

Secondary Address: _____ (line one) _____ (line two)

City: _____ State: _____ Zip: _____

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

Preferred contact method: _____ email address: _____

Name and Phone number of someone who does not live with you who we may notify in case of emergency:

_____

Name and Phone number of your Pharmacy: _____

Primary Insurance: _____ Secondary Insurance: _____

If insurance is through your spouse please provide their name: _____

DOB: _____ SS#: _____

I authorize release of any information that I have provided or related to my treatment or the treatment of my child, for the purpose of evaluating and administering claims for insurance benefits.

I also assign any payment of insurance benefits to be paid to the treating physician and understand that any costs incurred on my behalf or that of my child that are not paid by insurance are my responsibility.

I hereby authorize Horizon Family Medicine, LLC to access/download patient's medical/medication history from any available resource.

I acknowledge that the HIPAA policies of Horizon Family Medicine, PLLC have been made available to me and that I have been given the opportunity to ask questions concerning these policies and been offered a personal copy.

_____ _____
signature of patient or parent if patient is a minor date

please complete both sides of this document and return to the receptionist

Horizon Family Medicine

Name: _____ Gender: M F Age:____ DOB:_____

Please list all physicians and specialists who have treated you in the recent past:

_____

_____

_____

Habits: (check all that apply)

( ) Currently smoke cigarettes. How many years? ___ How many packs per day? ___

( ) Currently uses smokeless tobacco. How many years? ____

( ) Previously smoked cigarettes. How many years? ____ Quit Date: _____

( ) Previously used smokeless tobacco. How many years? ____ Quit Date: _____

( ) Currently drinks alcohol. How many drinks per day? ____ Per Week? ____

( ) Uses or takes illegal drugs. Please list along with current or quit date:

How much caffeine do you consume in a normal day (tea, coffee, soda etc.) _____

( ) Exercises regularly. How many times per week? ____

How many hours of sleep do you average per night? _____

Advanced Directives

Do you have a living will? ____ Do you have a durable power of attorney? ____

(If not, please let us know and we will provide this for you. If you have one, please bring a copy with you.)

Allergies (please describe reactions)

Medication allergies: _____

Food allergies: _____

Environmental Allergies: _____

Immunizations (If possible, please bring a copy of your shot record with you.)

Last pneumonia shot? _____ Last Flu shot? _____ Last TB skin test? _____ negative or positive

Last tetanus shot? _____ Did it include pertussis?

Women's Health

Last pap smear? _____ normal or abnormal

Last mammogram? _____ normal or abnormal

Number of pregnancies? _____ Number of children born? _____ Last menstrual period? _____

please complete both sides of this document

Method of birth control? _____ Age of menopause? _____

Have you had a hysterectomy? _____ If yes, was it partial or complete? _____

Health Maintenance:

Have you had a colonoscopy? ____ If yes, year _____ and physician _____ Date scheduled to repeat _____

Have you had a bone density scan? ____ If yes, year _____

When was your last eye exam? _____ Physician/Clinic? _____

When was your dental exam? _____ Physician/Clinic? _____

Surgical History

Surgery	Date	Physician

Medications (Please list all medications you are taking including over the counter medications)

Medication	Dosage/Strength	Directions

Family History (please list any cancers, health conditions, and diseases.)

Relation:	Healthy?	Deceased?	Age
Mother:			
Father:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			
Sibling #1 B or S:			
Sibling #2 B or S:			
Sibling #3 B or S:			
Sibling #4 B or S			

please complete both sides of this document

General Consent for Treatment and Test: I consent to treatment by the physician and staff for my illness and/or health evaluations, including but not limited to x-rays, blood test, laboratory procedures, medications and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

Independently Practicing Doctor: I understand and agree that most of the radiologists, pathologists, and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations and do not practice as employees of our office. I hereby authorize payment directly to these physicians the insurance benefits otherwise payable to me but not to exceed the total charges due to the physicians. I also authorize the release of any medical information necessary to process these insurance claims.

Release from Liability for Leaving Against Medical Advice: I agree that if I leave the physician's office against the advice of my physician or the staff, then the physician and the staff are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

Authorization to Release Medical Information: I authorize the office staff and all physicians involved in my care to disclose and release my medical information to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

Assignment of Insurance Benefits/Promise to Pay: For and in consideration of services rendered and to be rendered, I hereby guarantee payment for all charges incurred for the service. I authorize and direct any person, firm, or corporation, including but not limited to, insurance companies or attorneys representing the patient or any other party, for such services, to assign proceeds of any payment for services rendered to said patient directly to my physician. I understand that by accepting assignment of said benefits, the provider does not relinquish its right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in the hands of a collector or attorney for collection, I will pay reasonable collection fees and attorney fees, interest, court costs and other collection

I acknowledge I have read and understand the above policies, the Horizon Family Medicine, PLLC "Practice Information Sheet", and the Horizon Family Medicine, PLLC financial policy.

_____ _____

signature of patient or parent if patient is a minor date

I authorize the office of Horizon Family Medicine, PLLC to leave messages regarding appointment information in the event I cannot be reached by phone. Voicemail: Yes __ No __

I, give Horizon Family Medicine, PLLC and office staff permission to discuss my medical condition with the family or friends listed below.

Name: _____ Relationship:_____ Phone#:_____

Name: _____ Relationship:_____ Phone#:_____

Name: _____ Relationship:_____ Phone#:_____

please complete both sides of this document and return to the receptionist

1335 E. Center St
Suite 1
Kingsport, Tennessee 37664
423-247-2263 (fax) 246-1943

Medical Records Release

Patient's Name _____ Date of Birth ____/____/____

I hereby authorize my medical records to be *(please check applicable box)*:

☐ **RELEASED TO** ☐ **OBTAINED FROM**

Name / Facility _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Description of the information to be disclosed:

_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke the authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research related treatment, in which case you may refuse to provide that research related treatment)

☐ If this box is checked, I understand that my full and complete medical records may include information regarding drug and alcohol use, mental health information and/or a history of acquired immune deficiency syndrome (AIDS) or related conditions.

☐ If this box is checked, I understand that you will receive compensation from a third party for the use of disclosure of my information.

Signature _____ Date ____/____/____

Person or entity requesting the information if other than patient _____

This authorization shall expire one year from date of signature

PRACTICE INFORMATION

OFFICE HOURS:
Our office hours are Monday through Thursday 8:00 a.m. to 5:00 p.m., Friday 8:00 a.m. to 1 :00 p.m. Our office is closed for lunch from 12:30 pm - 1 :30 pm Monday through Thursday. Please go to your nearest emergency room with an after-hours emergency.

APPOINTMENTS:
Appointments may be made by calling 423-247-2263 during office hours. Every effort will be made to provide the earliest possible appointment for our patients. Due to the unscheduled nature of emergencies, occasional delays do occur.

Please arrive 15 minutes before you scheduled appointment to allow us time for check in.

LATE ARRIVALS:
Please call our office as soon as you can if you are going to be late for an appointment so that an appropriate solution can be developed. A late arrival will be registered and worked into the schedule as soon as possible. If a patient is more than 30 minutes late, the appointment may be rescheduled.

NO SHOWS:
Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A patient who is a no-show three times may be dismissed from the Practice.

EMERGENCIES:
If you have a true emergency please call 911 or go to the nearest emergency room.

REFERRALS:
If you are referred to the practice by a doctor who is not a member of our office, please make this fact known so that we may share our findings with your personal physician.

PRESCRIPTION REFILLS:
We always attempt to process refill request quickly however, it is not always possible. Please allow 2 business days for refill requests to be processed.

HOSPITALIZATION:
If you require hospitalization your doctor will make arrangements for your admission. Any business matters regarding the payment on hospital accounts are customarily discussed with the hospital admitting office at the time of admission. The hospital's and our practice bill will include medical care administered by your doctor during your hospital stay. You will receive 2 separate bills.

COMPLAINTS:
It is our sincerest desire that you will have no occasion to register a concern, but if a concern should arise, please call the office manager. Your constructive criticism is encouraged at all times.

please review both sides of this document

FINANCIAL POLICY

As a courtesy, Horizon Family Medicine, PLLC verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Horizon Family Medicine, PLLC that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance, we will be happy to submit a bill to your insurance company. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion you will be liable for. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for medical care. Do not assume that you will not owe anything if you have more than one insurance policy.

If you render a check for payment and it is returned for any reason you will be charged a $30.00 returned check fee.

Payment of your account is expected within a reasonable time period. Horizon Family Medicine, PLLC accepts cash, checks, Visa, Mastercard, and Discover.

If you have a billing question call (423) 434-0818.

please review both sides of this document