Horizons Diagnostics, L.L.C.

Date: ______________________ Account #:_______________________

Patient Information:

Name: ____
Last First Middle Initial

Address: ____
Street City State Zip

Home Phone: (_____) ________________________ Cell Phone: (_____) ________________________

Work Phone: (_______) ______________________ E-Mail: ___________________________________

Referring Physician: _________________________ Primary Provider: __________________________

Sex: M F Marital Status: __________________ Date of Birth: ___________________

Race: ______________________________________ Social Security #: __________________________

Ethnicity: ___________________________________ Language: _________________________________

Employer Name: ____________________________ Phone: (_____) ____________________________

Address: ____
Street City State Zip

Emergency Contact: ____
Name Phone # Relationship

Responsible Party (If Patient is a Minor)

Name: ____
Last First Middle Initial

Address: ____
Street City State Zip

Home Phone: (_____) ________________________ Cell Phone: (_____) ________________________

Work Phone: (_______) ______________________ Date of Birth: _____________________________

Employer Name: ____

Address: ____
Street City State Zip

Continued on Back

Health Insurance

Primary Insurance Company: ____

Coverage Date: _________________________ Copay/Coinsurance amount: ____________

Policy #: _______________________________ Group #: _____________________________

Group Name: ____

Policy Holder's Name: _________________________________ Date of Birth: ____________

Social Security #: ________________________ Relationship to Patient: ________________

Secondary Insurance Company: ____

Coverage Date: _________________________ Copay/Coinsurance amount: ____________

Policy #: _______________________________ Group #: _____________________________

Group Name: ____

Policy Holder's Name: _________________________________ Date of Birth: ____________

Social Security #: ________________________ Relationship to Patient: ________________

Pharmacy Information:

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone: ____

I authorize assignment of insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non covered services. I also authorize the physician to release any information necessary to process an insurance claim. I hereby consent to such diagnostic procedures and treatment deemed necessary or advisable while a patient at Horizons Diagnostics, L.L.C.

Signature: ____ Date:____________________

Horizons Diagnostics, L.L.C.

Request for Confidential Communication
Protected Health Information

Patient Name: ____________________________ **MR#:** ____________________

has requested confidential communication of protected health information.

Designated Method of Contacting Patient/Resident/Client

Communications with the patient/resident/client named above should be directed to:

Name:	Relationship to Patient:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Alternative Arrangements for Payment

Payment for services provided to the patient/resident/client will be made as follows (describe payment arrangement):

____

____

____

____

______________________________ ______________________

Patient Signature Date

Maintenance History

Date	Author	Description of Change	Reason for Change
05/28/03	Beth Merritt	Added name and Relationship	Ease of Use of Form

Horizons Diagnostics, L.L.C.

Patient Health History

Date: ________________

Name: ______________________ Age: __________ Date of Birth: ________________

Occupation: ______________________ Education: ☐ High School ☐ College Graduate

Personal History: Have you every had any of the following? (CIRCLE YES OR NO)

High Blood Pressure	YES	NO	Kidney Infection	YES	NO
Low Blood Pressure	YES	NO	Bladder Infection	YES	NO
Heart Disease	YES	NO	Cirrhosis	YES	NO
Heart Attack	YES	NO	Tuberculosis	YES	NO
Blood Clot(s)	YES	NO	Cancer	YES	NO
Phlebitis	YES	NO	Type: ______________________		
Stroke	YES	NO	Goiter	YES	NO
Diabetes	YES	NO	Epilepsy	YES	NO
Gout	YES	NO	Nervous Breakdown	YES	NO
Sinusitis	YES	NO	Gonorrhea	YES	NO
Asthma	YES	NO	Syphilis	YES	NO
Emphysema	YES	NO	Polio	YES	NO
Bronchitis	YES	NO	Anemia	YES	NO
Stomach Ulcer(s)	YES	NO	Mumps	YES	NO
Duodenal Ulcer(s)	YES	NO	Rheumatic Fever	YES	NO
Colitis	YES	NO	German Measles	YES	NO
Gall Bladder Disease	YES	NO	Chicken Pox	YES	NO
Kidney Stone(s)	YES	NO	Any other Disease ______________________		

Injuries:

Concussion/Head Injury	YES	NO	Ever been Knocked Unconscious	YES	NO
Car Accident	YES	NO			

Allergies:

Aspirin	YES	NO	Penicillin	YES	NO
Codeine	YES	NO	Sulfa	YES	NO
Latex	YES	NO			

Surgical History:

Surgery ______________________ Date __________ Physician ________________

Surgery ______________________ Date __________ Physician ________________

Surgery ______________________ Date __________ Physician ________________

Surgery ______________________ Date __________ Physician ________________

Systems: Do you have or have you ever had LONG STANDING? (CIRCLE YES OR NO)

Cough	YES	NO	Heartburn	YES	NO
Sputum (phlegm)	YES	NO	Blood in Stool	YES	NO
Chest Pain	YES	NO	Headache	YES	NO
Ankle Swelling	YES	NO	Dizziness	YES	NO
Palpitation	YES	NO	Fainting Spells	YES	NO
Angina	YES	NO	Seizures	YES	NO
Cramps in Legs	YES	NO	Muscle Weakness	YES	NO
Increase in appetite	YES	NO	Numbness/Tingling	YES	NO
Decrease in appetite	YES	NO	Impaired Hearing	YES	NO
Nausea	YES	NO	Wear Glass/Contacts	YES	NO
Vomiting	YES	NO	Frequent Urination	YES	NO
Diarrhea	YES	NO	Burning Urination	YES	NO
Constipation	YES	NO	Difficulty Urinating	YES	NO
Abdominal Pain	YES	NO	Foul Smelling Urine	YES	NO
Gas pain	YES	NO	Color Change in Urine	YES	NO
Do You Bleed Easily	YES	NO	Bruise Easily	YES	NO

Systems: Continued

Fever YES NO
Weight Loss YES NO
Weight Gain YES NO
Lack of Energy YES NO
Do you Sleep Well? YES NO

WOMEN ONLY

Vaginal Bleeding YES NO
Vaginal Discharge YES NO
Vaginal Itching YES NO

Do you take Birth Control
How Long? ________ years

Menstrual History

Age of Onset ________
Regular YES NO
Cycle ________ days (from start to start)
Usual Duration ________ days
Heavy Medium Light
Pain/Cramps YES NO
Date of Last Period ________________
Date of Last Pap Smear ________________

Pregnancies

How Many? _______
Any Complications? YES NO

Menopause

Age and Year in which periods stopped ____________________________

Family History: Have any your family members been diagnosed with the following conditions?

Diabetes YES NO If so, who? ____________________________
Cancer YES NO ____________________________
Stroke YES NO ____________________________
High Blood Pressure YES NO ____________________________
Heart Disease YES NO ____________________________

Mother: alive deceased Year of birth __________ Age at death ________
Father: alive deceased Year of birth __________ Age at death ________
Total Brothers/Sisters ________ How Many are still living? ________

Social History

Alcoholic Beverages (Circle One)

Never Rarely Moderate Heavy

Tobacco Use

Never Quit _____________(When?)
Current User
_______ Packs per day

Medications Taken Regularly:

____
____
____

Names of Physicians or Specialists Treating You:

____
____
____

______________________________ ______________
Patient/Guardian Signature **Date**

HORIZONS DIAGNOSTICS, L.L.C.

Please carefully read each of the following sections and initial indicating your understanding.

NOTICE OF PRIVACY

_________ Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you. This includes disclosure for the purpose of diagnosing or providing treatment to you, obtaining payment for your health care bills, or to conduct health care operations.

By initialing, you acknowledge that you have been informed that there is a privacy notice in our office and consent to use of medical information or disclosure as outlined above. You are also acknowledging that you have received a full copy of our Notice of Privacy Practices.

NO SHOW POLICY

_________ If you are unable to keep your scheduled appointment, we ask that you call and cancel at least 24 hours prior to the appointment time. If notice of cancellation is not received, there will be a fee billed to the patient's account. This fee is not reimbursable by insurance.

Regular office visits or lab visits - $25.00
New Patient visits and Annual Physicals - $50.00
Procedures (to include ultrasounds, dexa scans, etc.) - $100.00

Missed appointments could result in being discharged from our practice due to non compliance.

PHONE CALL POLICY

_________ If treatment is rendered through telephone evaluation and management, you may be billed for services rendered. These calls could be in reference to medical advice and/or treatment given over the phone. The fee for this service can range from $20.00-$45.00. This fee is not reimbursable by insurance.

ROUTINE TESTING POLICY AND PROCEDURE

_________ The Physicians of Horizons Diagnostics, L.L.C. will make age appropriate recommendations regarding routine screenings for prevention and early detection. This is to include routine screening for colon, cervical, breast, and prostate cancer. Routine screenings may also include diagnostic tests, lab work, and exams performed outside the treatment of your primary care physician. Patient's are encouraged and expected to notify their physician if these screenings have not been performed. If you prefer not to have the recommended screenings, please discuss this with your physician.

NARCOTIC MEDICATION POLICY

_________ By initialing, you acknowledge our Narcotic Medication Policy:

- Narcotic medications will not be called to the pharmacy and will require a written prescription.
- Refills will not be given to patients that have not been seen recently. This will be determined by the physician.
- Refills will not be given because of LOST or STOLEN prescriptions.
- Only one physician should prescribe narcotic medications
- Narcotic Medication requests require a 24 to 48 hour notice.
- Patients must present a photo ID before a prescription is released.

E-PRESCRIBING CONSENT

_________ E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors and enhances patient safety. By initialing, you are agreeing and authorizing that Horizons Diagnostics, L.L.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

ASSIGNMENT OF INSURANCE BENEFITS

_________ I hereby assign all applicable insurance benefits to Horizons Diagnostics, L.L.C. I understand that I am financially responsible for any remaining balances in accordance with my insurance contract.

____ ____________________
Printed Name of Person Completing Form/Relation to patient Date

____
Signature