HORIZONS DIAGNOSTICS
Caring for Our Community

NEW PATIENT LETTER

Welcome to Horizons Diagnostics!

Thank you for entrusting us with your healthcare needs. At Horizons, we strive to provide the best comprehensive care for most age groups with an array of additional services, including ultrasound, x-ray, in-house labs for faster results, DEXA scans, physical therapy & EMGs, EKGs, and remote patient monitoring.

We look forward to caring for you and your family's needs in the years ahead.

Healow App

With Healow, you can securely access your health records, view your lab results, manage your medications, and send messages to our health care team.
Scan the QR code with your Apple or Android phone to download the app. Open the camera, hover over the QR code, and click the link.
Practice Code: FDJDBA

What to bring to your Appointment

- ✓ ID & Insurance Cards
- ✓ List of current medications
- ✓ Completed New Patient Packet:
  - ☐ New Patient Welcome Letter
  - ☐ Patient Registration
  - ☐ Patient Health History
  - ☐ Patient Financial Agreement
  - ☐ Notice of Privacy Practices
  - ☐ HIPPA Authorization Form

Arrival Time

Please arrive 30 minutes early to your scheduled appointment time. Otherwise, your appointment may be rescheduled. This will allow our staff adequate time to enter or update your information. A no-show fee will be assessed for any appointments not canceled within 24 hours of the scheduled appointment date.

Co-Pay and Billing

Co-pay is due at the time of service.

Name (Last, First):

Appointment Date:

Date of Birth:

Appointment Time:

Primary Care Provider:

Appointment Location:

- ☐ Woodruff Road
- ☐ Enterprise Court
- ☐ Whittlesey Blvd.

By signing below, I acknowledge that I have received and completed all documents in the New Patient Packet.

Patient Signature

Date

Family & Internal Medicine Enterprise
106 Enterprise Court
Suite A (1st Floor)
Columbus, GA 31904
(706) 321-2585 or (706) 321-2555

Family & Internal Medicine Woodruff
3934 Woodruff Road
Columbus, GA 31904
(706) 322-0304

Central Administration
106 Enterprise Court
Suite C (2nd Floor)
Columbus, GA 31904
(706) 321-0476

Center for Vein Care
6600 Whittlesey Boulevard
Suite A (2nd Floor)
Columbus, GA 31909
(706) 321-9486

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PATIENT INFORMATION

Patient Information

Patient Last Name	First Name	Middle Initial	Birthdate
Address	City	State	Zip
Primary Phone	Other phone #	Email	
Sex (check one) ☐ Male ☐ Female	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Security Number	
Race	Ethnicity	Preferred Language	Primary Care Provider
Employer Name	Status (Check one) ☐ Full Time ☐ Part Time ☐ Retired	Employer Phone	
Employer Address	City	State	Zip
Preferred Pharmacy	Pharmacy Address	Pharmacy Phone	
Emergency Contact	Phone Number	Relationship	

Complete section below only if patient is a minor

Responsible Party

Responsible Party Last Name	First Name	Middle Initial	Birthdate
Address	City	State	Zip
Primary Phone	Other phone #	Relationship to Patient	
Sex (check one) ☐ Male ☐ Female	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Security Number	

Insurance & Subscriber Information

Primary Insurance Company		Effective Date	
Claims Mailing Address (Street or PO Box)	City	State	Zip
Policy ID Number	Group Number	Policy Holder's Full Name	
Policy Holder's Date of Birth	Policy Holder's Social Security Number	Relationship to Patient	
Secondary Insurance Company		Effective Date	
Claims Mailing Address (Street or PO Box)	City	State	Zip
Policy ID Number	Group Number	Policy Holder's Full Name	
Policy Holder's Date of Birth	Policy Holder's Social Security Number	Relationship to Patient	

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 herby consent to such diagnostic procedures and treatment deemed necessary or advisable while a patient at Horizons Diagnostics, L.L.C.

Signature	Date

Name:_____ DOB:_____

PERSONAL HISTORY: Do you have (current) or have you had (past) any of the following conditions?

- ☐ Alcohol/Drug Abuse
- ☐ Allergy (Hay Fever)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Rheumatoid)
- ☐ Arthritis (Osteoarthritis)
- ☐ Asthma
- ☐ Bladder/Kidney Problems
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Breast Lump (benign)
- ☐ Cancer: Breast
- ☐ Cancer: Colon
- ☐ Cancer: Other Type
- ☐ Cancer: Ovarian
- ☐ Cancer: Prostate
- ☐ Chicken Pox
- ☐ Colon Polyp
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Emphysema
- ☐ Fractures (broken bones)
- ☐ Gallblader Disease
- ☐ Gastroesophageal Reflux (Heartburn)
- ☐ Glaucoma
- ☐ Gout
- ☐ Gynecological Conditions
- ☐ Heart Attack
- ☐ Hepatitis (Specify Type)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate Conditions
- ☐ Seizures/Epilepsy
- ☐ Skin Conditions (Specify Type)
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other:

Comments: _____

SURGICAL HISTORY: Please list any procedures or surgeries. List any abnormal finding or complications.

Procedure	*Year*	*Performed by:*	*Comments*

PRIOR HOSPITALIZATIONS: Please list all past hospitalizations.

Procedure	*Year*	*Comments*

FAMILY HISTORY: Indicate which relative has had the following diseases. If relative is deceased, indicate cause and year in the comments section. IF YOU ARE ADOPTED AND DO NOT KNOW YOUR FAMILY HISTORY, CHECK HERE: ☐

Disease	Mother	Father	Sister(s)	Brother(s)	Maternal Mother	Maternal Father	Paternal Mother	Paternal Father			Comments
No significant history known											
Alzheimers											
Asthma											
Autoimmune Disease											
Bleeding or clotting disorder											
Cancer											Type:
Colon Polyp											
Coroanry Artery Disease											
Depression/Suicide/Anxiety											
Diabetes											
Emphysema/COPD											
Glaucoma											
Heart Disease											
Hepatitis B or C											
High Blood Pressure/Hypertension											
High Cholesterol											
Hypothyroidism/Thyroid Disease											
Kidney Disease											
Macular Degeneration											
Migraine Headaches											
Osteoporosis											
Other:											

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HIPPA AUTHORIZATION FORM

Horizons Diagnostics has taken measures to protect our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These are people other than what is covered in our Notice of Privacy Practices. HIPAA (Health Insurance Privacy & Accountability Act) does allow Horizons Diagnostics to release information to outside entities on your behalf.

Patient Name (Last, First):	Patient DOB:	Primary Care Physician Name:

I authorize the person/people listed below to obtain medical information about myself.

I understand that Horizons Diagnostics is not responsible for the information provided if it is given to a person that I have listed below. Please Complete and check the options that apply.

Name (Last, First):	Phone Number:	Relationship to Patient:
☐ - All of my health information ☐ - My health information relating to the following treatment or condition:		

Name (Last, First):	Phone Number:	Relationship to Patient:
☐ - All of my health information ☐ - My health information relating to the following treatment or condition:		

Name (Last, First):	Phone Number:	Relationship to Patient:
☐ - All of my health information ☐ - My health information relating to the following treatment or condition:		

Name (Last, First):	Phone Number:	Relationship to Patient:
☐ - All of my health information ☐ - My health information relating to the following treatment or condition:		

Consent to Use & Disclosure of Protected Health Information (HIPAA)

Your protected health information will be used by Horizons Diagnostics or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. Horizons Diagnostics reserves the right to modify the Privacy Practices outlined in the notice.

I have reviewed the consent form and give my permission to Horizons Diagnostics to Use and Disclose my health information in accordance with the Federal Privacy Standards

Patient/ Legal Guardian Signature Date

Signature of Witness Date

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PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. We ask all patients to review and sign the policy as outlined below. We are happy to answer any questions you may have. A copy will be provided to each patient as requested.

Insurance. As a courtesy to our patients, Horizons Diagnostics will file insurance on behalf of the patient. Our office participates in most insurance plans. It is the patient or guarantor's responsibility to ensure the practice has correct insurance information on file. If you are insured in a plan we participate in, but do not have updated insurance information on file, payment in full for each visit is required until we can verify your coverage. If your insurance is a plan we do not participate in, payment in full is expected at each visit.

Patient Payment. As a part of the contract with your insurance carrier, copayments, deductibles, and coinsurance are the patient's responsibility and will be collected at the time of each visit.

Claims. We will submit claims to the most current insurance on file and assist you in any way we reasonably can to get these claims paid. Your insurance company may not accept all information from our office and require information from you. It is your responsibility to comply with their request. If the claim cannot be processed by the insurance company within 30 days due to incorrect information, the bill for services will become the responsibility of the patient or guarantor.

Uninsured Patients. Our office does offer a discount for those who are uninsured. Please be advised this offer is only good if payment for services rendered is received upfront. If not paid on the date of service, the self-pay discount will be removed from the account.

Assignment of Insurance Benefits.
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 proceduresand treatment deemed necessary or advisable while a patient at Horizons Diagnostics.

Nonpayment. Statements will be mailed for any balances greater than $8.88 on a monthly basis. A finance charge of 1.5% will be assessed on any balance greater than 30 days in age**.** If your account is more than 90 days past due, you will receive a notice in the mail informing you that your account is now eligible to move forward into the collections process. We understand extenuating circumstances therefore payment plan options are available to patients upon request. Please contact your provider's billing office at **(706) 321-0476** to set up payment arrangements or with any questions. Any patients with balances in collections will be required to pay for any future services rendered in full at the time of service.

Missed Appointments. A no-show fee will be assessed for any appointments not canceled within 24 hours of the scheduled appointment date. Regular office and/or lab visits will have a $25 no-show fee. New patient and Annual Physical Appointments have a $50 no-show fee. Procedural visits range from a $50 to $200 no-show fee depending on the type of procedure scheduled.

Televisits/Phone Management Fee. If treatment is rendered as a result of 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 fees for these services range from $25 to $40 per occurrence and are not all reimbursable by your insurance company.

I have read and understand the financial policy and agree to abide by its guidelines.

_____ _____
Signature of Patient or Responsible Party Date

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MEDICAL RECORDS
Release/Request Form

PH: 706-321-0476, Option 4
Enterprise **FAX:** 706-323-0245
Woodruff **FAX:**706-327-0870

Patient Name (Last, First):		Date of Birth:
Address:		
Are you a current patient at Horizons Diagnostics?	❑ YES ❑ NO	If **YES**, please list your provider:

Please circle and complete the boxes below for either A or B.

A. Request Medical Records **FROM Horizons Diagnostics.**

I authorize Horizons Diagnostics to release health care information to the following recipient(s):

Physician / Name:	Phone:
Address:	Fax:

Delivery Method:
❑ FAX ❑ MAIL ❑ PICK UP

B. Release Medical Records **TO Horizons Diagnostics.**

I authorize the following healthcare provider to release my medical records to Horizons Diagnostics:

Physician / Name:	Phone:
Address: 106 Enterprise Court, Suite C Columbus, GA 31904	Fax:

Delivery Method:
❑ FAX ❑ MAIL ❑ PICK UP

Document Type: If you selected **MAIL** or **PICK UP** for the delivery method, check the box below to determine the document type. NOTE: There may be an additional fee to have records printed.

❑ Printed (Paper Copy)
❑ Disk/CD

Information to be released or disclosed: I authorize the release/disclosure of the following health information:

❑ All
❑ Medical History
❑ Progress Notes
❑ Operative Reports
❑ Imaging Reports
❑ Laboratory Results
❑ Other: _____

Term: I understand that this Authorization will remain in effect:

❑ 90 days from the date of this Authorization.
❑ Until the Provider fulfills this request.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, behavioral health, AIDS/HIV, or alcohol and drug abuse. I authorize the release or disclosure of this type of information. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above could be redisclosed and no longer protected by those regulations. I understand Horizons Diagnostics may receive compensation for its use/disclosure of the information.
I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment of my eligible benefits. I voluntarily consent to authorize my health care provider to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified above. I may inspect or copy any information used/disclosed under this authorization. I understand this consent is revocable by me, in writing, at any time except to the extent that action has been in reliance on it.

Patient Signature Date Signature of Witness Date

Signature of Guardian/Representative Date Legal Relationship to Patient Signature of Witness Date

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NOTICE OF PRIVACY PRACTICES

An individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by Horizons Diagnostics, and of the individual's rights and Horizons Diagnostics' legal duties with respect to protected health information.

Content of Notice

I. Required Elements.
Horizons Diagnostics will provide a notice that is written in plain language and that contains the following elements.

A. Header: The notice contains the following statement as a header or otherwise prominently displayed "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."

B. Uses and disclosures: The notice contains the following information.
1. A description, including at least one example of the types of uses and disclosures that Horizons Diagnostics is permitted to make for each of the following purposes: treatment, payment, and health care operations.
2. A description of each of the other purposes for which Horizons Diagnostics is permitted or required to use or disclose protected health information without the individual's written authorization.
3. If a use or disclosure for any purpose described in paragraphs (1) or (2) of this section is prohibited or materially limited by other applicable law, the description of such use or disclosure will reflect the more stringent law as defined.
4. For each purpose described in paragraph (1) or (2) of this section, the description will include sufficient detail to place the individual on notice of the uses and disclosures that are permitted or required by law.
5. A statement that other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization.

C. Separate statements for certain uses or disclosures: Horizons Diagnostics intends to engage in the following activities, and will provide a separate statement in the notice that:

1. Horizons Diagnostics may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.
2. Horizons Diagnostics may contact the individual to raise funds for the Horizons Diagnostic

D. Individual rights: The notice contains a statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, as follows.

1. The right to request restrictions on certain uses and disclosures of protected health including a statement that Horizons Diagnostics is not required to agree to a requested restriction.
2. The right to receive confidential communications of protected health information.
3. The right to inspect and copy protected health information as per the law.
4. The right to request to amend protected health information as provided by the law.
5. The right to receive an accounting of disclosures of protected health information.
6. The right of an individual, including an individual who has agreed to receive the notice electronically, to obtain a paper copy of the notice from Horizons Diagnostics upon request.

E. Horizons Diagnostics duties. The notice contains:

1. A statement that Horizons Diagnostics, is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
2. A statement that Horizons Diagnostics is required to abide by the terms of the notice currently in effect.
3. For Horizons Diagnostics to apply a change in a privacy practice that is described in the notice to protected health information that Horizons Diagnostics created or received prior to issuing a revised notice, a statement that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. The statement also describes how it will provide individuals with a revised notice.

F. Complaints: The notice contains a statement that individuals may complain to Horizons Diagnostics and to the Secretary of the Department of Health and Human Services if they believe their privacy rights have been violated, and a brief description of how the individual may file a complaint with the Privacy Officer of Horizons Diagnostics, and a statement that the individual will not be retaliated against for filing a complaint.

G. Contact: The notice will contain the name, or title, and telephone number of the Privacy Officer to contact for further information.

H. Effective date: The notice contains the date on which the notice is first in effect which may not be earlier than the date on which the notice is printed or otherwise published.

II. Revisions to the notice.

Horizons Diagnostics will promptly revise and distribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, Horizons Diagnostics legal duties, or other privacy practices stated in the notice. Except when required by law, a material change to any term of the notice may not be implemented prior to the effective date of the notice in which such material change is reflected.

III. Provision of notice.

Horizons Diagnostics will make the notice available on request to any person and to individuals as specified.

IV. Specific requirements for certain covered health care providers.

If Horizons Diagnostics has a direct treatment relationship with an individual, it will:

A. Provide the notice no later than the date of the first service delivery, including service delivered electronically, to such individual after the compliance date.
B. In an emergency treatment situation as soon as reasonably practicable, Horizons Diagnostics must make a good faith effort to obtain written acknowledgement of receipt of the notice and document the good faith and effort, and reason if unable to obtain.
C. Horizons Diagnostics will:
   1. Have the notice available at the service delivery site for individuals to request to take with them.
   2. Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from Horizons Diagnostics to be able to read the notice.
D. Whenever the notice is revised, make the notice available upon request on or after the effective date of the revision and promptly comply with the requirements.

V. Specific requirements for electronic notice.

A. Horizons Diagnostics' web site provides information about customer services and/or benefits and will prominently post its notice on the web site and make the notice available electronically through the web site.

B. If capable, Horizons Diagnostics may provide the notice required by this section to an individual by e-mail, if the individual agrees to electronic notice and such agreement has not been withdrawn. If Horizons Diagnostics knows that the e-mail transmission has failed, a paper copy of the notice will be provided to the individual. Provision of electronic notice by Horizons Diagnostics will satisfy the provision requirements when made timely.
C. If the first service delivery to an individual is delivered electronically, Horizons Diagnostics will provide electronic notice automatically and contemporaneously in response to the individual's first request for service.
D. The individual who is the recipient of electronic notice retains the right to obtain a paper copy of the notice from Horizons Diagnostics upon request.

VI. Joint notice by separate covered entities.

If Horizons Diagnostics and another organization participate in organized health care arrangements, it may comply with this section by a joint notice, provided that:

A. The covered entities participating in the organized health care arrangement agree to abide by the terms of the notice with respect to protected health information created or received by Horizons Diagnostics as part of its participation in the organized health care arrangement.
B. The joint notice meets the implementation specifications, except that the statements required by this section may be altered to reflect the fact that the notice covers more than Horizons Diagnostics; and
   1. Describes with reasonable specificity the covered entities, or class of entities to which the joint notice applies.
   2. Describes with reasonable specificity the service delivery sites, or classes of service delivery sites, to which the joint notice applies.
   3. If applicable, states that the covered entities participating in the organized health care arrangement will share protected health information with each other, as necessary to carry out treatment payment or health care operations relating to the organized health care arrangement.
C. The covered entities included in the joint notice will provide the notice to individuals in accordance with the applicable implementation specifications. Provision of the joint notice to an individual by any one of the covered entities included in the joint notice will satisfy the provision requirements of this section with respect to all others covered by the joint notice.

VII. Documentation.

Horizons Diagnostics will document compliance with the· notice requirements by retaining copies of the notices issued by Horizons Diagnostics and, if applicable, any written acknowledgements of receipt of the notice of documentation of good faith efforts to obtain such written acknowledgement.