10,000 West Colonial Dr, Ocoee. FL 34761 **Phone**: 407-578-6610 **Fax:** 407-578-2247

PATIENT INFORMATION INTAKE FORM

DATE_____/_____ /_____

FIRST NAME_____MIDDLE INITIAL _____ LAST NAME_____

DATE OF BIRTH _____/_____/___ SOCIAL SECURITY NUMBER ____-____-____**GENDER** __ MALE __ FEMALE

MARITAL STATUS __ MARRIED __ SINGLE __ DIVORCED __ SEPARATED __ WIDOW _ WIDOWER

ADDRESS_____ APARTMENT/SUITE_____

CITY _____STATE _____ ZIP CODE _____HOME PHONE _____

CELL PHONE _____ RACE _____ PRIMARY LANGUAGE _____Email _____

EMPLOYMENT STATUS

_ EMPLOYED __ SELF EMPLOYED __ UNEMPLOYED __ DISABLED __ RETIRED __ STUDENT

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATION _____PHONE _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____ PHONE _____ ID/SUBSCRIBER NUMBER _____ GROUP NUMBER _____ SUBSCRIBER NAME _____
RELATIONSHIP TO PATIENT _____SUBSCRIBER SSN _____-_____-_____

SUBSCRIBER DOB _____/_____/_____ SUBSCRIBER GENDER __ M __ F

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

NAME OF INSURANCE COMPANY _____ PHONE _____ ID/SUBSCRIBER NUMBER _____ GROUP NUMBER _____ SUBSCRIBER NAME _____

RELATIONSHIP TO PATIENT _____SUBSCRIBER SSN _____ SUBSCRIBER _____

DOB _____/__/_____ SUBSCRIBER GENDER __ M __ F

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OFFICE AND FINANCIAL POLICIES

Welcome to Horizon Primary Care, MD, PA. We are committed to providing you with the best care possible and would like to inform you of our office's financial policies.

New Patients: All new patients must complete the new patient paperwork before seeing the provider. The information must be updated when changes occur. You are responsible for informing us of changes in address, phone number, email, insurance, pharmacy, etc.

Insurance Billing: We are only responsible for filing claims to contracted insurance companies. We file claims as a courtesy to our patients. Any deductibles, co-insurance, and non-covered services are your responsibility.

Deductibles and Co-pays: Full payment is due when services are rendered. This includes co-payments, deductibles, and services not covered by your insurance. If you are on a high-deductible plan, we collect $150 for new patients and $100 for established patients until the deductible has been met. You may be asked to reschedule your appointment if you cannot pay your co-pay or deductible.

Returned checks: There will be a $45 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. Your account will be flagged for failure to pay, and checks will no longer be accepted as a form of payment for your account.

Prescription refills: We only provide prescription refills during an office visit with a provider. We require office visits regularly for all patients taking prescription medications. Please bring all the prescription bottles and a detailed medication list for your appointment.

Referrals: All referrals must be evaluated in the office. If your insurance requires authorization, please note that the referral process will take 7 to 10 business days. We need the proper documentation and medical records before approving the referral.

Disability and FMLA paperwork: There will be a charge of $35.00 for completing medical forms. FMLA forms require an appointment. Payment is due at the time you pick up these forms. Please allow 10 to 14 days for the completion of these forms. If you want the forms mailed or faxed to you or the insurance, payment will be due before mailing or faxing.

Authorization for Release of Prescription Information:

I hereby authorize Horizon Primary Care to release any prescription information to:

Name of Pharmacy _____ Phone **Number:** _____

Patient Name (Please Print): _____ **DOB:** _____

Patient Signature: _____

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Acknowledgment of Notice of Privacy Practices:

I understand that **Horizon Primary Care** has the right to change its Notice of Privacy Practices, which is available occasionally. I may contact **Horizon Primary Care** anytime to obtain a current copy.

Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

Consent for Treatment: This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you indicate that (1) you intend that this consent continues in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services.

****Signature: _____ Date: _____**

TELEPHONE CONSUMER PROTECTION ACT (TCPA) OPT-IN CONSENT FORM

Authorization Regarding Messages

(Please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical

treatment, care, test results, or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

Authorization to Release Information to Family or Friend Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Horizon Primary Care to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____ Phone Number: _____

2. _____ Relation to Patient: _____ Phone Number: _____

Patient Name: _____ Signature: _____ Date: _____

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Authorization to Release Medical Records

Name of Patient _____ **Date of Birth** _____

I, the undersigned, authorize the release of, or request access to, the information specified below from the

medical record(s) of the patient named above.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

INFORMATION TO BE RELEASED FROM:

Office Name: _____ **Phone #:** _____

Please include a comprehensive compilation of all medical records from the **past three years**. This should encompass detailed documentation of every medical year, including clinical visits, **ALL** laboratory test results, and imaging reports such as X-rays, MRIs, and CT scans. Ensure that all relevant information, including dates, findings, and associated treatment plans, is included for a complete medical history overview.

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released, and the appropriate address):

To: Horizon Primary Care **Phone:** 407-578-6610 **Fax: ADD new fax number**

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS**.**

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon it.

The authorization will expire 12 months from the date of my signature unless I revoke it before that time.

Date: _____ **Signature:** _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship with Patient

_____