INTERNAL MEDICINE HORIZON

138-B Dublin Sq Rd, Asheboro, NC 27203

*Dr. Imran Haque - Robert George NP - Emily Harless NP*

HORIZON Med-Spa and Vein Center

1380 Eastchester Dr, High Point, NC 27265

*Dr. Imran Haque - Mindy Parks NP - Jacklyn Haplin DNP*

*** ALL OF THE INFORMATION ON THIS FORM MUST BE FILLED OUT , UNLESS MARKED OPTIONAL!**

# PATIENT REGISTRATION

**TODAY'S DATE:** ____ / ____ / ____

**PATIENT NAME:** _____ **DOB:** ____ / ____ / ____ **AGE:** ____
(First, Middle, Last)

**MAILING ADDRESS:** _____

**PHYSICAL ADDRESS:** _____

**HOME PHONE:** _____ **CELL PHONE:** _____ **SS#:** _____

**SEX:** M O F O T O **RACE:** BLACK O WHITE O ASIAN O HISPANIC O NATIVE AMERICAN O BIRACIAL O OTHER O

**STATUS:** SINGLE O MARRIED O WIDOWED O DIVORCED O SEPERATED O

**PREFERRED LANGUAGE:** _____ **EMAIL ADDRESS:** _____
(OPTIONAL)

**HOW DID YOU HEAR OF US:** _____

**EMERGENCY CONTACT:** _____ **RELATIONSHIP:** _____ **PHONE:** _____

**PHARMACY:** _____

## PRIMARY INSURANCE INFORMATION

**PRIMARY INSURANCE COMPANY:** _____ **PHONE:** _____

**INSURANCE ADDRESS:** _____

**MEMBER/SUBSCRIBER ID #:** _____ **PHONE:** _____

**SUBSCRIBER SS#:** _____ **SUBSCRIBERS RELATIONSHIP:** _____

## EMPLOYMENT INFORMATION

**EMPLOYER'S NAME:** _____ **OCCUPATION:** _____
(Optional)

**PHONE:** _____ **EMPLOYER'S ADDRESS:** _____

## OFFICE NOTIFICATIONS

**PREFERRED METHOD OF CONTACT FOR:**

**APPOINTMENT REMINDERS:** O PHONE O TEXT O EMAIL **OTHER:** _____

**OTHER GENERAL NOTIFICATIONS:** O PHONE O OK TO LEAVE MESSAGE? **OTHER:** _____

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# INSURANCE WAIVER

- **INDIVIDUALS RESPONSIBILITY FOR NON-COVERED SERVICES:**
  In consideration of services rendered but Horizon Internal Medicine Asheboro, Horizon internal Medicine High Point or Horizon Med-Spa and Vein Center to the undersigned patient, the undersigned promise(s) to pay and Copayments, Deductibles, Coinsurance or other charges required to be paid by your health insurance coverage.

- **ASSIGNMENT OF BENEFITS PROCEEDS:**
  I request that payment of authorized HMO/Third party Payer/Government Agencies (Medicare or Medicaid) benefits to be made either to me or on my behalf to Horizon Internal Medicine for services furnished to me by the provider.

- **AUTHORIZATION TO RELEASE MEDICAL RECORDS:**
  I hereby authorize Horizon Internal Medicine to release to my Insurer/HMO/Third Party Payer/ Government Agencies, or to whomever is financially responsible for my medical care, ALL information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

- **REFERRALS/CO-PAYMENTS:**
  HMO plans: for plans requiring referrals from the primary care physician, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF THE VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, you will be billed according to the regular fee schedule.

- **PRIVATE INSURANCE or NO INSURANCE:**
  Payments are do at the TIME of VISIT!

_____ _____

*(Print Patient Name or Authorized Representative)* *(Date)*

_____ _____

*(Signature of Patient or Authorized Representative)* *(Relationship if **NOT** patient)*

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# APPOINTMENT CANCELLATION/NO-SHOW POLICY

Thank you for trusting medical care to Horizon Internal Medicine. When you schedule an appointment with Horizon Internal Medicine, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than **24 hours** prior to your scheduled appointment. This gives us time to schedule other patient's who may be waiting for an appointment.

- Effective **November 1st 2017**, any established patient who fails to show or cancel/reschedules an appointment and has not contacted our office with at lest **24 hours** notice, will be considered a No Show and charged a **$25.00 fee**.
- Any established patient why fails to show or cancel/reschedule an appointment with no **24 hour** notice a **second** time, will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no **24 hours** notice should occur, the patient will be at risk of being dismissed from Horizon Internal Medicine. If you do call to reschedule, **please** document the time and the name of the person that you spoke with.
- Any **NEW** patient who fails to show for their initial visit, will not be rescheduled.
- The fee is charged to the patient, **NOT** the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
- If you, the patient has a previous no show fee, you cannot be worked in or have a tele-visit appointment with our providers until the fee(s) is paid in **FULL**.

_____ _____

*(Print Patient Name or Authorized Representative)* *(Date)*

_____ _____

*(Signature of Patient or Authorized Representative)* *(Relationship if **NOT** patient)*

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# HEALTH & HISTORY FORM

***PLEASE READ THOROUGHLY - ALL SECTIONS ARE MANDATORY***

**TODAY'S DATE** ____/____/____

**PATIENT NAME** _____ **DOB** ____/____/____ **AGE** _____

**List of Complaints:** _____
(Reason for Establishing)

**PRESENT HEALTH**

**List Current/Active Medical Conditions:** _____

_____

**List Current Medication (Include over the counter):** _____

_____

**List of Current & Past Medical Specialists:** _____

**List Allergies/Intolerance to Medications, Food or Environment:** _____

_____

**Blood Type (if known):** _____

**PATIENT MEDICAL HISTORY**

**(Have you ever been treated or Diagnosed for the following)**

| | | |
|---|---|---|
| _____ Kidney Disease | _____ Heart Disease | _____ Hepatitis |
| _____ Back or Neck Pain | _____ High or Low BP | _____ Diabetes |
| _____ Stroke or TIA | _____ Tuberculosis | _____ Seizures |
| _____ Blood Transfusion | _____ Thyroid Disease | _____ Hemorrhoids |
| _____ HIV or AIDS | _____ Mono | _____ Anemia |
| _____ Clotting Disorder | _____ Migraines | _____ Meningitis |
| _____ Cataracts or Glaucoma | _____ Substance Abuse | _____ Ulcers |
| _____ Heartburn or Reflux | _____ Diverticulitis | _____ Cancer |
| _____ Mental Disorder | _____ Heart Valve Dysfunction | _____ Cerebral Palsy |
| _____ Asthma or COPD | _____ Auto-Immune Disorder | _____ Urinary Problems |
| _____ Bronchitis or Pneumonia | _____ Gastrointestinal Bleeding | _____ Irregular Bleeding |
| _____ Depression or Anxiety | _____ Arthritis or Joint Disorder | _____ Other: _____ |

**Date of Last Colonoscopy:** _____ **Date of Last Mammogram:** _____

**COMPLETE SURGICAL HISTORY:** _____
(List Type of surgery and Year)
_____

## SOCIAL HISTORY

**MARITAL STATUS: SINGLE** O **MARRIED** O **WIDOWED** O **DIVORCED** O **SEPERATED** O **ALCOHOL USE: Never** O **Rarely** O **Moderate** O **Daily** O

**TOBACCO USE: Never** O **Previously** O **Currently** O **Chew/Snuff** O **ILLICIT DRUG USE: Never** O **Previously** O **Type/Frequency:** _____

## FAMILY MEDICAL HISTORY

| | | | | |
|---|---|---|---|---|
| **Father:** | **ALIVE** | **DECEASED** | **Age:** _____ | **Health Problems:** _____ |
| **Mother:** | **ALIVE** | **DECEASED** | **Age:** _____ | **Health Problems:** _____ |
| **Siblings:** | **ALIVE** | **DECEASED** | **Age:** _____ | **Health Problems:** _____ |
| **Children:** | **ALIVE** | **DECEASED** | **Age(s):** _____ | **Health Problems:** _____ |

**Other Known History:** _____

## REVIEW OF SYSTEMS

**CONSTITUTIONAL SYSTEMS:** O Good general health lately O Recent weight changes O Fever O Fatigue

**EYES:** O Eye disease or Injury O Wear glasses or Contacts O Blurred or Double vision

**EAR/NOSE/MOUTH/THROAT:** O Earaches or Discharge O Chronic sinus problems or Rhinitis O Nose bleeds O Mouth sores
O Bleed gums O Bad breath or Bad taste O Sore throat or Voice changes O Swollen glands in neck

**CARDIOVASCLUAR:** O Heart trouble O Chest Pain or Angina O Palpitations O Swelling of extremities

**RESPIRATORY:** O Chronic or frequent coughing O Spitting up blood O Shortness of breath O Wheezing

**GASTROINTESTINAL:** O Loss of appetite O Change in bowel movements O Nausea or Vomiting O Frequent Diarrhea
O Painful bowel movements O Constipation O Rectal bleeding/bloody stools O Abdominal pain

**GENITOURINARY:** O Frequent urination O Burning/painful urination O Changes in flow of urine O Incontinence or dribble
O Kidney stones ) Sexual difficulty O Testicular pain O Menstrual pain O Irregular periods
O Vaginal discharge # of Pregnancies ____ # or Miscarriages ____ Date of Last Pap Smear _____

**MUSCULOSKELETAL:** O Joint pain O Joint stiffness/swelling O Muscle/joint weakness O Back pain O Cold extremities
O Difficulty walking O Amputee

**INTEEGUMENTARY:** O Rash or itching O Changes in skin color O Changes in hair or nails O Varicose veins O Breast Pain
O Breast Lump O Breast discharge

**PSYCHATIC:** O Memory loss O Nervousness O Depression O Insomnia

**NEUROLOGICAL:** O Frequent headaches O Light headed/dizzy O Seizures O Tremors O Paralysis O Hearing loss/ringing

**ENDOCRINE:** O Glandular or Hormonal problem O Heat or Cold intolerance O Changes in Hat or Glove size

**HEMATOLOGIC/LYMPHATIC:** O Slow to heal after cuts O Anemia O Enlarged glands

***To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.***

_____ _____
*(Signature of Patient or Authorized Representative)* *(Date)*

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# ACKNOWLEDGEMENT OF RECEIPT OR PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OR HEALTH INFORMATION

**Notice of Private Practices:** You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available **upon request**. Out Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we make of your protected health information.

**Purpose of Consent**: By signing this form, you will consent to our use and disclosures of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Private Practices and have full opportunity to read and consider its contents. I understand that signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ _____

*(Print Patient Name or Authorized Representative)* *(Date)*

_____

*(Signature of Patient or Authorized Representative)*

***If this content is signed by a personal representative on behalf of the patient, complete the following:***

Clients Name: _____

Representative/Parent/Legal Guardian name: _____

Signature: _____ Date: _____

Relationship to client: _____

***For Office Use Only***

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ other (please specify): _____

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# CONSENT TO RELEASE MEDICAL INFORMATION

(This form is used to retrieve records)

**Please disclose the following:**

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Lab/Diagnostic Records
- ☐ Other: _____

**To be used for the following purpose(s):**

- ☐ Per Patient Request
- ☐ Continuing Health
- ☐ Weight Management Program
- ☐ Other: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during my care. These may or may not include treatment of substance abuse, other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc. unless herein excepted.

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**(336) 660-6338 (P) (336) 307-3226 (F)**

_____ _____

*(Print Patient Name or Authorized Representative)* *(Date of Birth)*

_____ _____

*(Signature of Patient or Authorized Representative)* *(Date)*

_____

*(Disclosures Expiration Date)*