FOR INTERNAL USE ONLY
Insurance Cards Received ☐
Date: _____

HORIZON Health Care, Inc.

NEW PEDIATRIC PATIENT REGISTRATION

PATIENT'S PERSONAL INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____

Mailing Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____ Country of Birth:_____

Social Security #:_____ Date of Birth: ____/____/_____ Former name(s):_____

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

E-mail Address:_____

Name of School_____

Mother's Name: _____ Contact Phone Number: _____

Father's Name:_____ Contact Phone Number:_____

RESPONSIBLE PARTY (Who is responsible for payment for services?)

Please note that the responsible party will receive an itemized list of services provided during your visit.

☐ Self ☐ Spouse ☐ Parent ☐ Other (specify relationship) _____

Please complete information below if you did not mark "self" as responsible party:

Responsible Party Name:_____

Mailing Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____

Social Security #:_____ Date of Birth: ____/____/_____

Home Phone:_____ Cell Phone:_____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

HEALTH INSURANCE and PHARMACY INFORMATION

Do you currently have health insurance? ☐ Yes ☐ No

Name of Insurance:_____

What pharmacy do you currently use? _____

City of Pharmacy: _____

HORIZON Health Care, Inc.

INTERPRETIVE SERVICES

Do you need interpretive services? ☐ Yes ☐ No

If so, what language? _____

COMMUNICATION NEEDS

Do you have any communication needs that we should be aware of, such as hearing loss or vision impairment?

☐ Yes, please specify: _____

☐ No

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against applicants seeking to participate in this program. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, we are required to note the race, ethnicity and sex of applicants on the basis of visual observation or surname.

RACE/ETHNICITY (*Mark all that apply*)

☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander ☐ Unknown or refuse to report

Do you consider yourself? (*Please check one*)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

SEX AT BIRTH (*Please check one*)

☐ Male ☐ Female

***** *While Horizon recognizes a number of genders, many insurance companies and legal entities unfortunately do not.*

Horizon realizes that every patient has a unique set of health needs. We feel that it is most important to respect an individual's choice about how to identify. These questions are asked of all patients and are completely voluntary to complete.

WHAT IS YOUR SEXUAL ORIENTATION? (*Please check one*)

☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Lesbian or Gay ☐ Other ☐ Unknown

☐ I would prefer not to disclose

WHAT IS YOUR CURRENT GENDER IDENTITY? (*Please check one*)

☐ Male ☐ Female ☐ Transgender male/female-to-male ☐ Transgender female/male-to-female

☐ Other ☐ I would prefer not to disclose

HORIZON Health Care, Inc.

HOUSEHOLD INCOME

Horizon Health Care is a Federally Qualified Health Center (FQHC) which means we receive Federal Grant funds that allow us to provide discounted fees to patients who qualify based on their household size and income. We are required to collect income information on the patients we serve. We respect that this information is personal and confidential.

How many people live in your household? _____

What is your total annual household income? _____

If your income is less than the income identified on the right for your household size, please ask about our sliding fee program.

Household Size	Annual Income less than or equal to
1	$25,520
2	$34,480
3	$43,440
4	$52,400
5	$61,360
6	$70,320
7	$79,280
8	$88,240
9	$97,200
10	$106,160

HORIZON HEALTH CARE PATIENT PORTAL – MY HORIZON CHART

Horizon Health Care, Inc. is pleased to offer My Horizon Chart – an easy, secure and convenient way to access your or your child's health records 24/7. My Horizon Chart allows you to communicate with your care team online, when it's convenient for you.

Parents or legal guardians can receive access to My Horizon Chart for children ages 0-11. This access will expire automatically when the child turns 12 years of age or becomes legally emancipated. A minor child ages 12-17 may grant their parent or guardian access to My Horizon Chart. Please request that form from the receptionist if needed.

☐ **YES,** I give Horizon Health Care, Inc. permission to set up a My Horizon Chart account for my child aged 0-11.

Please give access to the following parent(s)/guardian(s):

Name: _____ Date of Birth: _____

Email Address: _____

Name: _____ Date of Birth: _____

Email Address: _____

Signature of Responsible Party: _____

Relationship to Patient: _____ Date: _____

☐ **NO,** I am not interested in My Horizon Chart at this time.

HORIZON Health Care, Inc.

CONSENT AND AUTHORIZATION

- Horizon Health Care, Inc. (Horizon) is dedicated to providing primary care, dental, behavioral health and addiction services to patients across our network. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. Horizon patients may be referred to providers from other health care specialties within the Horizon network; members of the team will share health information with each other as clinically necessary.
- The professional staff of Horizon will depend on statements made by the patient, patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. In treating patients, studies including x-rays, labs, laboratory tests, EKGs or psychological tests may be warranted. You are encouraged to ask questions about the benefits and risks of treatment with your healthcare team.
- Some services at Horizon may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, accessible via the internet or saved in any way.
- Procedures may be recommended by your healthcare provider as part of your treatment. I understand that I will be told the reasons for the treatment/procedure(s), the benefits or risks with it, and other treatment options. I further understand that there are risks associated with simple and common procedures and that the healthcare provider cannot guarantee success.
- I understand that if I carry health/dental insurance, all services furnished are charged directly to me and that I am personally responsible for payment of all services whether or not they are covered by insurance. This office will help prepare my insurance forms or assist in making collections from insurance companies and will credit any such collections to my account.
- I hereby give authorization for payment of insurance benefits to be made directly to Horizon for services until I revoke such authorization. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. The information I have given is correct. I agree that a photocopy of this agreement shall be as valid as the original. I have read the above conditions of treatment and payment and agree to their content.
- I understand that if I do not make acceptable payments on my account as defined by Horizon Health Care, Inc. (Horizon) policy, I may be placed on a scheduling restriction until my balance is current or until payment arrangements have been made.
- I understand that Horizon will protect the confidentiality of my protected health information and will release my protected information for the purposes stated in the Horizon Notice of Privacy Practices, and as I have indicated on the "Preferred Communication Form".

I ask, agree and consent to evaluation and treatment for myself and/or my child(ren) or dependent as set forth above, including any studies or procedures that Horizon Health Care, Inc. professional staff determine are necessary or appropriate. I have read and understand the authorizations regarding payment for my care. My signature below indicates consent to the statements above. If signing as a parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient or Responsible Party Signature: _____ Date:_____/_____/_____

HORIZON Health Care, Inc.

PREFERRED COMMUNICATION FORM

Patient Name:_____ Date of Birth:_____/_____/_____

PREFERRED COMMUNICATION METHODS

How would you like to receive information from our practice? (*Check all that apply***)**

- ☐ Phone Call
  - ☐ Cell Phone: _____
  - ☐ Home Phone: _____
  - ☐ Work Phone: _____ During what hours? _____
- ☐ Text Message
- ☐ Mail Reminder
- ☐ Patient Portal Message

PLEASE NOTE: *We may need to contact you by mail for certain purposes. If you have special requests regarding mail, please talk to the receptionist regarding confidential communications.*

EMERGENCY CONTACT INFORMATION

In an emergency, Horizon will contact the individual listed below to inform them of your location and general condition.

Name:_____ Relationship to Patient:_____

Home Phone:_____ Work Phone:_____ Cell Number: _____

ADDITIONAL CONTACTS

Some patients desire for a family member or close friend to have access to their health information. If you would like your emergency contact or another person to have access to your health information, please complete the information below with contact information and indicate what information can be shared.

- ☐ Please do not speak with anyone but me.
- ☐ I give my permission to speak with the emergency contact noted above.
- ☐ I give my permission to speak with:

  Name: _____ Relation: _____ Phone: _____

  Name: _____ Relation: _____ Phone: _____

Please indicate below what we can speak with the above contact(s) about. This applies to HIPAA/Confidentiality Law.

- ☐ To remind me that I am due for a test or appointment.
- ☐ To give details about dates and/or preparations for a test or appointment.
- ☐ To discuss my test results, condition, and/or medical care.

Patient or Responsible Party Signature: _____ Date:_____/_____/_____

HORIZON Health Care, Inc.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law.

The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgment that you have received a copy of this notice.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I,_____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Horizon Health Care, Inc.

Signature: _____

Date: _____/_____/_____

Signature of Parent or Patient's Authorized Representative *(if applicable)*: _____

Date: _____/_____/_____

Description on Legal Authority to Act on Behalf of Patient: _____

_____

HORIZON Health Care, Inc.

PATIENT HEALTH HISTORY (PEDIATRIC)

Patient Name:_____ Date of Birth: ____/____/_____ Date: ____/____/_____

MEDICATIONS *(Please list any medications the child is currently taking, prescribed or over the counter)*

Medication	Dosage	Route	Frequency

ALLERGIES *(Please list any known allergies child has to medication or food)*

Allergen	Reaction

SURGERIES/HOSPITALIZATIONS *(Please list any surgeries or hospitalizations child has had and include the month/year)*

Surgery	Date Completed

OTHER PROVIDERS *(Please list any other providers your child sees for care, include their name and facilities.)*

Provider Name	Facility

BIRTH HISTORY

Type of Delivery: Vaginal C-Section

Single or multiple birth? _____

Was child born prematurely? Y N

Gestational Age: _____ weeks

Birth Weight: _____

Did the child have any complications during birth? Y N
If yes, explain: _____

Did the child have any of the following complications at or after birth?

- Respiratory conditions Y N
- Transient Tachypnea Y N
- Neonatal Jaundice Y N
- Group B strep exposure Y N

MATERNAL HISTORY

Pregnancy Complications Y N
If yes, explain: _____

Gestational Diabetes Y N

Tobacco use during pregnancy Y N

Alcohol or drug use during pregnancy Y N
If yes, explain: _____

Pre-existing maternal conditions Y N
If yes, explain: _____

Prenatal labs normal Y N

Mother HIV positive Y N

HORIZON Health Care, Inc.

FAMILY HISTORY (*If **CHILD** or a **FAMILY MEMBER** has had any of the following, please circle Y (yes) and indicate self or which family member when applicable***)**

ADD/ADHD	Y N	_____	Heart Disease	Y N	_____
Anemia	Y N	_____	Kidney Disease	Y N	_____
Allergies/Hay Fever	Y N	_____	Liver Disease	Y N	_____
Asthma	Y N	_____	Mental Illness	Y N	_____
Arthritis	Y N	_____	Neurological Disease	Y N	_____
Anxiety/Depression	Y N	_____	Osteoporosis	Y N	_____
Blood Clots	Y N	_____	Respiratory Disease	Y N	_____
Cancer	Y N	_____	Skin Disease	Y N	_____
Type(s): _____			Stomach/Colon Disease	Y N	_____
Developmental Delays	Y N	_____	Stroke	Y N	_____
Diabetes	Y N	_____	Seizure Disorder	Y N	_____
Fractures	Y N	_____	Thyroid Disorder	Y N	_____
Gynecological Disease	Y N	_____	Sexually Transmitted Disease	Y N	_____
High Blood Pressure	Y N	_____			
High Cholesterol	Y N	_____	Other: _____	Y N	_____

Is mother still living? Y N Current Age (or age at death): _____

Is father still living? Y N Current Age (or age at death): _____

SOCIAL HISTORY

Who does child live with? _____

Is child exposed to cigarette smoke? Y N

Are pets present in the home? Y N

Has child been to dentist in the last year? Y N If yes, month/year: _____

Has child been to the eye doctor in the last year? Y N If yes, month/year: _____

Care Settings:

Does child attend daycare? Y N Setting: In-home Daycare Center Family

Does child attend school? Y N Current Grade: _____

Does child participate in activities? Y N List Activities: _____

Other:

Do you have concerns about the safety of the child? Y N