PATIENT REGISTRATION

HORIZON Health Care

PATIENT'S PERSONAL INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: __________

Mailing Address: ____________________________ Physical Address: ____________________________

City: ______________________ State: __________ Zip: ________ Marital Status: S M D W

SSN: ______________________ Date of Birth: ________________ Previous Name(s): __________________

Home Phone: _______________ Cell Phone: __________________ Work Phone: ____________________

Email: _____________________________ Do you require interpretive services? ☐ Yes________________

Would you like to sign up for My Horizon Chart? ☐ Yes ☐ No

RESPONSIBLE PARTY (Who is responsible for payment for services?) ☐ Same as above

Name: __________________________ Relationship to Patient: ___________________________________

Mailing Address: ______________________ City: __________________ State: __________ Zip: ________

Phone: __________________________ Date of Birth: _______________

MEDICAL INSURANCE and PHARMACY INFORMATION

Name of Insurance Carrier: ____________________________________ ☐ No Insurance

Policy Holder Name: ______________ Policy Holder DOB: ____________ Relationship to Patient: _________

Pharmacy: _______________________ City of Pharmacy: _____________________

HOUSEHOLD INFORMATION (Used for governmental reporting and to determine eligibility for billing discounts.)

What is your household gross income? _______________ How many people live in your household? _______

ALLOWED COMMUNICATION

☐ Home ☐ Cell ☐ Work

Do you have a preference on how you receive healthcare communications from Horizon? (Circle One)

Text Message or Voicemail

In order to disclose or discuss any personal health information to your family or designee, we must have a signed consent on file allowing Horizon Health Care to share information about your care at our office. Please list the names of those you would like to be involved in your health care. This information can be changed or revoked at any time with your permission.

Name: _____________________ Relationship: _____________________ Phone #: ____________________

Name: _____________________ Relationship: _____________________ Phone #: ____________________

Name: _____________________ Relationship: _____________________ Phone #: ____________________

☐ I authorize Horizon Health Care to share information related to my health to the individual(s) listed.

☐ I decline to have my medical information shared with family or designee.

Signature: _____________________________ Date: _____________________

EMERGENCY CONTACT INFORMATION (Please indicate parent, guardian, spouse, friend, etc.)

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

Name: _____________________ Relationship: _____________________ Phone #: ____________________

Name: _____________________ Relationship: _____________________ Phone #: ____________________

HORIZON Health Care

The following information is requested by the Federal Government to monitor compliance with Federal Laws prohibiting discrimination. You are not required to furnish this information but are encouraged to do so.

Race (Select all that apply)

☐ White ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Asian Indian
☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian or Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Choose not to disclose

Ethnicity (Select one)

☐ Hispanic/Latino or Spanish Origin ☐ Non-Hispanic/Latino or Spanish Origin ☐ Mexican
☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Choose not to disclose

Are you a: Migrant Worker? ☐ Yes ☐ No **Seasonal Worker?** ☐ Yes ☐ No **Veteran?** ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No **If yes, please describe your housing status:** ☐ Shelter ☐ Street
☐ Doubling Up ☐ Permanent Supportive Housing ☐ Transitional ☐ Other ☐ Unknown

Horizon realizes that every patient has a unique set of health needs. We feel that it is important to respect an individual's choice about how to identify. The following questions are voluntary to complete.

Sex at Birth: ☐ Male ☐ Female

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Other
☐ Transgender Female/Male-to-Female ☐ Unknown ☐ Choose not to disclose

Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian or Gay ☐ Other ☐ Don't Know
☐ Unknown ☐ Choose not to disclose

Financial Responsibility and Assignment of Payer Benefits

I agree that I am financially responsible for all charges related to services provided by Horizon Health Care (HHC). I agree HHC will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan, or insurance policy that I have or another third party that will pay the charges I have incurred. I give my authorization for HHC to file a claim and request for direct payment of benefits to HHC.

Consent to Treatment

I consent to exams, treatments, diagnostic tests, and medications that any provider at HHC feels is necessary for the health of me or my child. I acknowledge that no guarantees have been made to me and I am aware that I have the right to ask my provider or nurse questions regarding my treatment or exam. I authorize HHC to disclose my confidential information only for treatment, payments, or health care operations. I give consent to health supervision and assessments, immunizations, and release of information as indicated to the school district.

Notice of Privacy Practices & No Show/Late Policy

I have been offered a copy of this office's Notice of Privacy Practices and No Show/Late Policy.

Authorization

______________________________ ________________________ __________________
Signature of Patient or Authorized Person | Print Name | Date

____
Relationship to Patient (if Patient not signing)