Horizon Medical
1957 Thompson Rd, Suite E
Coos Bay, OR - 97420

(*) Insurance Intake

Horizon Medical
541-236-2778

Patient Information

- Name: *
- Employer: *
- Employer Address: *
- SS#: *

Responsible Party: (This is the person financially responsible for the patient's medical bills. If the patient is financially responsible for themselves, you may write “Self” and skip the rest of this section.)

- Name: *
- Relationship to the patient:
- Address (If different than above):
- Phone:
- Email:
- Employer:
- Work Phone:
- Birthdate:
- SS#:

Primary Insurance Information

Horizon Medical
1957 Thompson Rd, Suite E
Coos Bay, OR - 97420

- Name of insured: *
- Relationship to the patient: *
- Birthdate (MM/DD/YYYY): *
- SS#: *
- Employer: *
- Insurance Name: *
- Effective Date (MM/DD/YYYY): *
- Insurance Address: *
- Policy#: *
- Group#: *

Secondary Insurance (If Applicable)

- Name of Insured:
- Relationship to patient:
- Birthdate (MM/DD/YYYY):
- SS#:
- Employer:
- Insurance Name:
- Effective Date (MM/DD/YYYY):
- Insurance Address:
- Policy#
- Group#

Acknowledgement and Consent

Horizon Medical
1957 Thompson Rd, Suite E
Coos Bay, OR - 97420

I understand that my health information may include information both created and receive by this practice, may be in the form of written or electronic records, spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

■ Make decisions about and plan for my care and treatment

■ Refer to, consult with, coordinate, and manage along with other healthcare providers for my care and treatment

■ Determine my eligibility for my healthcare coverage and submit bills, claims and other related information to your insurance or who may be responsible to pay for some or all my healthcare services

■ Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare.

HIPPA laws are for your protection. I understand that I have the right to receive and review written description of how This Practice will handle information about me. This written description is known as a Notice of Privacy Practice and describes the use and disclosure of health information and the information practices followed by the office personnel of This Practice and my rights regarding my health information.

I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This practice is not required by law to agree to such requests.

I understand that failure to sign this Acknowledgement and Consent that this practice will not bill insurance on your behalf and that I will be responsible for paying for the services in full at the time they are performed.

I authorize Horizon Medical LLC and its associates to bill and collect payment for services and care provided to any provided Medical Insurance provider and understand I am responsible for any and all portions of fees not reimbursed by insurance. I understand that I am responsible for all charges not paid by my insurance plan except those amounts that the Clinic is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible the clinic may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by the Clinic as a legal and lawful debt and agree to pay such fee if charged.

Responsible Party Signature: *

Date: *