Healthy Horizons Clinic

Patient Demographics

Patient Name: _____ **Date**: ____/____/____

Preferred Language: English____ Spanish____ Other: _____

Marital Status: Married __ Single__ Divorced__ Widowed__ **Gender**: Female__ Male__

DOB: ____/____/____ **Race**: _____ **Ethnicity**: _____ **Religion**: _____

Street address: _____

City: _____ **State**: _____ **Zip code**: _____

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

SSN _____-_____-_____ **Email Address**: _____

Emergency Contact

Emergency Contact Name: _____ **Relationship**: _____

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

Street Address: _____

City: _____ **State**: _____ **Zip code**: _____

Responsible Party

Name: _____ **Relationship to patient**: _____

Street address the same: __ Yes __ No **Street address**: _____

City: _____ **State**: _____ **Zip code**: _____

Healthy Horizons Clinic

Insurance Information

Primary Insurance: _____ **Policy#** _____

Group# _____

Secondary Insurance: _____ **Policy#** _____

Group# _____

Tertiary Insurance: _____ **Policy#** _____

Group# _____

If insurance is under someone OTHER than the patient, please provide the following information below

Policy holder's name: _____ **Relation to patient**: _____

SSN: ____-____-____ **DOB**: ____/____/____ **Home Phone**: _____

Cell Phone: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSUARNCE CARRIER PAYMENTS; HOWEVER, THE PATIENT IS RESPONSIABLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEM RENDERED UNLESS OTHER ARRANGMENTS HAVE BEEN MADE IN ADVANCE WITH HEALTHY HORIZONS CLINIC.

Healthy Horizons Clinic

Insurance Authorization and Assignment

Name of Policy Holder: _____

I request that the payment of authorized Medicare/Other Insurance Company benefits be made either to me, or on my behalf, to Moazam P.A. DBA Healthy Horizons Clinic for any services furnished to me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section1129B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____ Date: _____

Healthy Horizons Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*** PLEASE REVIEW IT CAREFULLY ***

Healthy Horizons Clinic ("Practice") may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Probability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care, and conducting health care operations. The Practice has established policies to guard against unnecessary disclosure of your health information.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you with a description of our practices. We will abide by terms of this notice and notify you if we cannot agree to a requested restriction. We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Uses and Disclosures

How we may use and disclose Medical Information about you.

The following categories describe examples of the way we use and disclose medical information.

For Treatment: We may use medical information about you to provide you with treatment services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Practice personnel who are involved in taking care of you at our office. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healthy process. Different departments of the Practice may also share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, and x-rays. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

Healthy Horizons Clinic

I, _____, have reviewed and verified that the information regarding my demographics and my insurance that I provided is accurate and valid for billing. Any delays, incurred charges, or balances that occur due to missing and/or incorrect insurance and/or demographic information will result in patient responsibility.

Patient Name (Print): _____

Signature: _____

Date: _____

Healthy Horizons Clinic

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Healthy Horizons Clinic to release my medical and/or billing information to the information to the following individual(s): following individual(s):

1._____ Relation to Patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____Date:_____

Healthy Horizons Clinic

Notice of policy practice

This is to inform all our patients that our providers in the office use a video conference application that allows our medical scribes to make their notes/dictate for our providers to ensure better care during your visit. Zoom in encrypted and HIPPA complaint. You may opt out of this option.

☐ Yes, I will allow Zoom to be used during my visit.

☐ No, I do not want Zoom to be used during my visit.

☒ _____ ☒ _____

Patient or Legal Guardian Date

Healthy Horizons Clinic

Current Medications:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Preferred Pharmacy: _____

Allergies to food or medications: _____

_____

Please wait 24 - 48 hours for medication refills, no controlled substances will be prescribed after business hours

Healthy Horizons Clinic

Current Medications:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Preferred Pharmacy: _____

Allergies to food or medications: _____

_____

Please wait 24 - 48 hours for medication refills, no controlled substances will be prescribed after business hours

Healthy Horizons Clinic

CONSENT FOR RELEASE OF THE MEDICAL INFORMATIOM

Paitent: _____ DOB: _____

Address:_____ Phone: _____

Release From: _____ _____ Phone number: _____ Fax: _____ Address: _____ _____ _____	Release To: Dr Mustafa Moazam Phone: 720-388-7071 Fax: 915-209-8289 or 877-761-6002 Address: ☐ El-Paso – Horizon City ☐ El-Paso – Northeast ☐ Houston – Pasadena ☐ Colorado –Thornton ☐ Anthony- Texas

Records Requested: • X-Ray Results • Progress Notes • Laboratory Result • Consultations • Copy of Imaging Study • Diagnostic Studies • All • Other	I hereby authorize "Release From" as stated above,to deliver to "Release To" as stated above the medical records as defined above in the checked "Records Requested"box. I, the patient or patient representative have the legal right to inspecgt,copy and request delivery as specified of the protected Health information within 30days in accordance with Public Law 104-191.U accept responsibility for any fees that may be associated with this request.

Patient Signature : _____ Date: _____

Patient Legal Representative: _____ Date: _____

Printed name of Legal Representative: _____