HORIZON SURGICAL

Patient's Full Name _____ Birthdate _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

E-mail Address _____

Have you ever been seen by any of our physicians? ❑ **Yes** ❑ **No**

Emergency Phone # _____ ❑ Relative ❑ Friend ❑ Other

Patient's Social security # _____ ❑ Retired ❑ Disabled

Patient's Employer _____ Work Phone _____

Employer Address _____ Phone Extension _____

Sex _____ Age _____ ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed

Responsible Party's Name _____

(Responsible Party Signature Required at Bottom of Form)

Address (if different) _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

S.S. # of Spouse of Patient or Spouse of Responsible Party _____

Primary Insurance Company _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ **Insured's Employer** _____ **Insured's Birthday** _____

Contract # _____ Group # _____ Effective Date _____

*****How Much Is Your Co-Payment $** _____

Secondary Insurance Company _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ **Insured's Employer** _____ **Insured's Birthday** _____

Contract # _____ Group # _____ Effective Date _____

*****How Much Is Your Co-Payment $** _____

*****DrugAllergies***** _____

Who Referred You to Horizon Surgical? _____

Who is Your Primary Care Physician? _____

Your Pharmacy Name and Phone Number: _____

PAYMENT - IN FULL - DUE 90 DAYS REGARDLESS OF INSURANCE STATUS

In the event this account is not paid in full within 90 days, the undersigned agrees to pay all costs of collection including reasonable attorney fees/court costs. I understand that any "hold harmless" clause included in my insurance contract does not apply unless Horizon Surgical is a member of the insurance plan. I also authorize release of medical records to patient's physicians and insurance carriers.

Date _____ Responsible Party's Signature _____

(Required)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Horizon Surgical, P.C. is dedicated to protecting the privacy of each and every patient. It is your right to receive quality care without concern that your personal health information will be shared or disclosed with others. Your medical information is protected by law and will only be used in treatment, payment and healthcare operation scenarios. Employees of Horizon Surgical, P.C. and affiliated business associates have signed confidentiality statements and contractual agreements agreeing to follow the policies and procedures often necessary for treatment, your medical information will not be sold to any outside agency or pharmaceutical company nor will it be released for any reason other than treatment, payment, healthcare operations or when required by state and federal laws without your written authorization. You have the right to access and request changes to your medical record, find out what disclosures have been made, and request restrictions on users and disclosures of your health information. If at any time you have any questions or concerns, you may contact our Compliance Officer at *(256)736-2263*. This privacy notice is subject to change.

List names and relationships of anyone (i.e. spouse, child) that may contact us about your appointments, tests, or treatment: *Please list phone numbers.*

1)_____

2)_____

3)_____

4)_____

Initial Here _____

HORIZON
SURGICAL

AUTHORIZATION FOR DIAGNOSTIC SERVICES AND/OR MEDICAL TREATMENT

I, the undersigned, a patient of HORIZON SURGICAL, P.C., hereby authorize this clinic to administer such diagnostic/medical services considered necessary based on findings of the attending physician. I understand that no guarantee has been (or will be) made to me as a result of diagnostic findings and/or medical treatment. I hereby certify that I have read and fully understand this Authorization for Diagnostic Services and/or Medical Treatment.

AUTHORIZATION MUST BE SIGNED PRIOR TO DIAGNOSTIC/MEDICAL SERVICES.

PATIENT'S SIGNATURE (or Mark) _____

SIGNATURE OF PARENT/GUARDIAN/RELATIVE _____
(REQUIRED if patient is a minor or physically/mentally unable to sign Authorization)

RELATIONSHIP TO PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____

CONCERNING INSURANCE

All professional services are charged to the patient. Necessary forms will be submitted to your insurance carrier(s) based on the information you have furnished. We are **REQUIRED** to submit claims to **ALL** insurance carriers with which you are enrolled for MEDICAL benefits. If you are covered by more than one policy, we **MUST** file with your PRIMARY carrier first, SECONDARY next, etc. Should payment be made directly to patient, you must send us a copy of the EXPLANATION OF BENEFITS before we will be able to file with any other insurance company. As a service, at no charge to you, we file claims with all carriers you list on our information sheet. If you have not given us all information at the time of service, there will be a charge for other claims filed - due to additional time involved in reprocessing notifying first carrier of other coverage, possible refilings/refunds to companies with which we originally filed, etc.).

The patient (parent/guardian) is responsible for all fees–regardless of insurance coverage. Should benefits be paid directly to policy holder by insurance company, you should forward payment to Horizon Surgical, P.C., (along with a copy of the EXPLANATION OF BENEFITS) to be applied to any unpaid balance on your account. ****WE CANNOT FILE WITH YOUR SECONDARY CARRIER WITHOUT A COPY OF THE EXPLANATION OF BENEFITS.** **Please **READ** and **SIGN** the following authorization and assignment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize HORIZON SURGICAL, P.C., to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to HORIZON SURGICAL, P.C., all payments for medical services rendered to myself or my dependent. I understand that any **"Hold Harmless"** provision written into the contract does not apply unless HORIZON SURGICAL, P.C., is a member of the carrier's plan. I understand that I am responsible for any amount not covered by insurance. I agree to pay the difference or the entire balance, if necessary.

PATIENT'S SIGNATURE _____

INSURED'S SIGNATURE _____
Insured or Responsible Party

INSURANCE AUTHORIZATION **MUST BE SIGNED** PRIOR TO SERVICES BEING RENDERED.

HORIZON SURGICAL

1890 AL Hwy. 157
POB II, Suite 420-B
Cullman, AL 35058

K. McCLAIN COTTINGHAM, M.D., F.A.C.S.
General Surgery & Bariatric Surgery

Phone (256) 736-2263
Fax (256) 736-2265

NON-COVERED BARIATRIC SERVICES POLICY

As our patient, we want to provide you with the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good health that are not covered by your Blue Cross, Blue Cross Preferred Care, Medicare and all other health insurance contracts. You will be expected to pay for these services in full. For example, we may order lab tests, x-rays, CAT scans, MRI scans, bone scans, or other tests deemed medically necessary that may not be covered by your contract. We may also need to perform an in-office procedure that may not be covered by your contract. Lastly, the initial consult visit with Dr. Cottingham is a non-refundable fee of $150.00. Let us reassure you that we will only order tests or perform a procedure that we feel is necessary for your treatment and care. Thank you very much for your understanding.

I have read and understand the above paragraph and will be responsible for paying the extra charges for services not covered by my insurance.

_____

Patient Signature

_____

Date of Service

HORIZON
SURGICAL

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
PLEASE PRINT ALL INFORMATION

Release from: _____
_____
_____
_____

Release to: Horizon Surgical, P.C.
1890 Alabama Hwy, 157
POB II, Suite 420-B
Cullman, AL 35058
(256)763-BAND phone
(256)736-2265 fax

Patient's Full Name : _____
Patient's Birth date: _____

_____ This authorization is limited to the following treatment: Obesity related medical records only, never entire chart.

_____ This authorization is limited to the following time period: _____

_____ This authorization is limited to a worker's compensation claim for injuries of _____ date.

This authorization may be revoked at any time. The only exception is when action has been taken in the reliance on this authorization. Unless revoked earlier, this consent will expire 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. "I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatments. I give MY specific authorization for these records to be released. "I understand that Horizon Surgical, P.C. cannot limit to or control the subsequent use or dissemination of medical information by the party to whom I request the information to be furnished. I hearby release Horizon Surgical, P.C. and its staff from all legal responsibility that may arise from the release of the medical information herby authorized.

_____	_____	_____	_____
Date	Signature of Patient	Date	Signature of Authorized Person

Please return completed forms and insurance information to: **Horizon Surgical, P.C.**
1890 Alabama Hwy. 157
POB II, Suite 420-B
Cullman, AL 35058
(256)736-BAND phone
(256)736-2265 fax