

Date:		
PATIENT INFORMATION:		
Name:		
(Last Name)	(First Name)	(Middle Name)
Date of Birth:	Gender: ☐ Male ☐ ☐ Prefer not to answ	Female $\square$ Transgender $\square$ Other ver
Marital Status: $\square$ Single $\square$ Married $\square$ Divor	ced $\square$ Separated $\square$	Widowed ☐ Domestic Partner
Social Security Number:	Preferred Language:	
Street Address:		
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Preferred Phone:   Landline:	🗆 Cell Ph	none:
Email Address:		
Custody (if applicable): $\square$ Sole $\square$ Joint $\square$ W	ard of the Court (DCS/I	DDD) 🗆 Permanent Guardianship
$\Box$ Temporary Guardian	ship 🗆 Power of Atto	orney
FOR MINORS (Check all that apply):		
☐ Parent ☐ Step-Parent:		Phone:
☐ Parent ☐ Step-Parent:		Phone:
☐ Foster Parent(s):		_ Phone:
☐ Legal Guardian(s):		_ Phone:
Legal Guardian Relationship:	Preferred La	anguage:
☐ Group Home Manager:		Phone:
School Name:	Grade:	Phone:
FOR ALL CLIENTS:		
Emergency Contact Name:		Phone:
Address:	Relat	tionship:



#### **OTHER KEY CONTACTS:**

Probation Officer (if applicable):	Phone:		
DDD Worker (if applicable):	Phone:		
Primary Care Physician/Doctor:	Phone:		
Address:	Fax Number:		
Pharmacy Name:	Phone:		
Address or Cross Streets:	Fax Number:		
SPECIAL NEEDS:			
☐ Mobility Assistance ☐ Visual Impairment Ass	sistance   Hearing Impairment Assistance		
☐ Cognitive Impairment Assistance ☐ Interpret	er – Language:		
INSURANCE INFORMATION: (Please present your	insurance card(s) to the front office staff)		
Name of Responsible Person:	DOB:		
(Only if Patient is a Minor and NOT the Subscriber	) SSN (Required):		
Primary Insurance Company:	Subscriber: 🗆 Yes 🗀 No		
Policy ID:	Group Number:		
Policy Holder's Name:	Subscriber DOB:		
Relationship to Patient:	Subscriber SSN:		
Secondary Insurance Company:	Subscriber: 🗆 Yes 🗀 No		
Policy ID:	Group Number:		
Policy Holder's Name:	Subscriber DOB:		
Relationship to Patient:	Subscriber SSN:		
HOUSEHOLD INCOME:			
Number of people in patient's household:			
Monthly Household Income: \$(	or) Annual Household Income: \$		
Employer:	_ Occupation:		
Address:	City:		
State: Zip Code:	Work Phone:		
Employment Status:			



## **PREFERRED METHOD OF COMMUNICATION:**

I prefer to be contacted by:   Mail   Phone   Patient Porta	al (PCP only – Email Address Required)
PCP PATIENTS ONLY -  Do you want access to your medical information online thro	ough our patient portal?   Yes   No
ADDITIONAL PATIENT INFORMATION:	
Race: $\square$ American Indian or Alaska Native $\square$ Asian $\square$ Other F	Pacific Islander 🔲 Native Hawaiian
$\square$ White $\square$ Black or African American $\square$ More than on	e race
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Are you a Veteran? ☐ Yes ☐ No Do you	live in Public Housing? $\square$ Yes $\square$ No
Are you Homeless? $\ \square$ Yes $\ \square$ No If "Yes": $\ \square$ Doubling Up $\ \square$	Shelter $\square$ Street $\square$ Traditional $\square$ Other
Sexual Orientation: $\square$ Straight (not lesbian or gay) $\square$ Lesbian or	or Gay   Bisexual   Something Else
☐ Prefer not to answer ☐ Does not app	oly (Patient under 18 year of age)
Religious or Spiritual preferences? ☐ Yes ☐ No Type:	
Cultural considerations to know:	
How did you hear about us (Radio, Newspaper, Friend, Agency R	Referral, etc.)?
CONSENT AND ACKNOWLEDGEMENT:	
The above information is true to the best of my knowledge. I he treatment and care by Horizon Health and Wellness (HHW). I un clinic and that my treatment and care may include routine care, other services considered medically necessary.	derstand that HHW is an integrated care
I understand that I must provide 24-hour advance notice of call HHW reserves the right to terminate, discharge, dis-enroll, translack of contact/participation and/or failure to respond to effort would not occur without advanced written notice and an opport	nsfer, and/or reduce services if there is a s of engagement. I understand that such
I understand that HHW will serve patients in the home, communappropriate in assessing issues, needs, and development of a set the aim of resolving problems which I define. I agree to coopprogram(s) as necessary. I have been fully informed about servi involved in setting and modifying service goals and making decisions.	ervices plan with goals and objectives, in perate with HHW and participate in the ice options and understand that I will be
Patient's Printed Name	_
Patient's Signature	 Date

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## **AUTHORIZATION TO TREAT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION**

Name of Patient: \_\_\_\_\_\_ DOB: \_\_\_\_\_ MR#: \_\_\_\_\_

(Print)	(mm/dd/yyyy)
	<ul> <li>to provide routine evaluation and services as may be deemed medically stand that this consent shall remain valid for one year or until I withdraw my</li> </ul>
treatment. If I refuse any treatment, HHW will work with me to eith be provided with appropriate referrals for treatment that I need. I	of my ability and understand that I have the right to refuse any recommended ner develop acceptable recommendations, including a second opinion, or I will understand that HHW operates as a treatment team and that this means that nderstand that HHW utilizes supervision/consultation regarding clinical issues that within the laws governing behavioral health professionals.
HHW staff. If this should occur, I will be provided notice of this action that the treatment services offered will prove beneficial to me. F administered, that such medications may or may not be effective a	lict of interest, it may become necessary to terminate the relationships with an and I will be referred to another staff. I understand that there is no guarantee furthermore, I have been advised that should medications be prescribed ound, in a small number of situations, they may even have serious side effects. onsibility to keep those individuals involved in my treatment informed of any
	ent at HHW is confidential. However, information may be released without my spected abuse or neglect of a minor or vulnerable adult, court order, insurance are otherwise legally required.
to whom the parent or legal guardian has delegated his/her power legal documentation) can provide consent for services, and	HW. I understand that only the patient, parent, or legal guardian (or someone rs regarding the care or custody of the minor(s) as evidenced through officia I have provided documentation as such if applicable. If any proposed hose risks will be discussed verbally with me and outlined on a separate form
I understand that consent is voluntary and may be withheld or with By initialing EACH LINE below and signing this form I consent to provided and explained to me.	ndrawn at any time. treatment and/or services and agree that the below documents have been
HHW Notice of Privacy Practices (effective 4/11/20	003; revised 2/11/2021)
HHW Patient Rights (effective 4/12/2000; revised	7/11/2018)
Notice of Health Information Practices regarding H	HW's participation in the Health Information Exchange
Website for the applicable AHCCCS Complete Care	Health Plans' Member Handbook:
☐ Arizona Complete Health ☐ Banner Univer	sity Family Care    Care 1 <sup>st</sup> Magellan Complete Care
☐ Mercy Care ☐ Health Choice Arizona	☐ United Healthcare Community Plan
Release of Information	
Patient Name (Printed)	Patient's Signature and Date
Patient's Parent/Legal Guardian Name (if applicable)	Patient's Parent/Legal Guardian's Signature and Date
Staff Member's Name (Witness)	Staff Member's Signature and Date



# **INFORMED CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES**

I,, understand that Horizon H	ealth and Wellness (HHW) utilizes
telehealth services. HHW has explained to me that telehealth services invo	
that services provided over telehealth will not be the same as direct patien	-
will not be in the same room as my provider. I understand that HHW can ut	tilize telehealth services for case
management, therapy, psychiatric, medical, and other services.	
I understand there are potential risks to this technology, including interrup technical difficulties. I understand that HHW or I can discontinue the telene videoconferencing connections are not adequate to the situation. I also un information may be shared with other individuals for scheduling and billing coordination. Others may also be present during the telehealth appointme equipment. The above mentioned people will all maintain confidentiality or understand that I will be informed of their presence in the appointment an the following: omit specific details that are personally sensitive to me; asks telehealth appointment; and terminate the appointment at any time.	ealth appointment if it is felt that the derstand that my healthcare purposes as well as treatment in order to operate the video f the information obtained. I further d thus I will have the right to request
I have had the alternatives to telehealth appointments explained to me and whether I engage in telehealth appointments. I understand that engaging is exclude me from having to physically attend in person appointments when tests, etc. If I have questions regarding telehealth services, I understand that for additional clarification.	n telehealth appointments does not needed, such as for vitals, laboratory
I understand that my sessions will not be recorded without my expressed v	vritten consent on an additional form.
I have read this document and I hereby consent to participate in receiving s described above. I understand this document will become part of my medic	
Please check the appropriate box below:	
$\ \square$ I agree to participate in and receive services via telehealt	h.
$\hfill \square$ I have chosen not to participate in telehealth sessions.	
Patient Signature	Date
Witness Signature	Date
If the patient is a minor or has been determined to be incompetent to give	consent:
Parent, Legal Guardian, or Government Agency Authorized by the Court	Date
Relationship to Patient:	

Telehealth Consent Page 1 of 1 Revised 4/14/2021



### FINANCIAL INFORMATION FORM

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable care. We ask all Horizon Health and Wellness patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

- Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a place we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. If you refuse to participate in any aspect of the AHCCCS (Title XIX/XXI) health Insurance screening and referral process established by AHDS, including refusal to enroll in Medicare, Part D or Medicaid, that you are eligible for, AHCCCS will, therefore, deny or revoke payment and you will be personally and fully responsible for payment for all services.
- 2. Patient Payment: All copayments and deductibles are to be paid at the time of services unless other arrangements are made during your visit.
- 3. Registration: All new patients must complete our patient Registration Form, which will be entered into our computer to maintain accurate information for proper billing. Established patients will be asked to verify a printout of the current information in our computer system and make any changes necessary. A copy of your driver's license (or other photo identification) and current valid insurance card will need to be provided for proof of insurance at every visit. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify use in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of services, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
- 4. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. You insurance benefit is a contract between you and the insurance company, we are not party to that contract.
- 5. Credit and Collection: If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at that time be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our staff will be able to treat you only on an emergency basis.
- 6. Sliding Fee Scale: We strive to help patients regardless of insurance status. If you do not have insurance or have an out of network insurance provider, we offer a sliding fee scale for services based upon income. I understand that I will be provided with a Fee Agreement regarding the amount I will be responsible for paying prior to the start of services.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.




l,	, DOB	, hereby agree to be involved
in the program(s) at Horizon Health and	Wellness (HHW).	
	ces be offered on a slidi payers. Any services pa	Care Cost Containment System (AHCCCS) ng fee scale based upon my ability to pay id on a fee-for-service basis are exempt
	e that I will be required Information related to	
	ost even though insura ce may result in change derstand that HHW wil mount indicated here v	Il not raise their fees or our adjusted fee will be honored for six (6) months, after
If payment of a fee is required, I agree to time service is provided.	o pay the agreed-upon	fee to the HHW representative at the
Please refer to the second page of this d	locument for the Servic	e Fee Schedule and Discount Thresholds.
Patient's/Legal Guardian's Printed Name	2	
Patient's/Legal Guardian's Signature		Date
Approved on:b	oy:	
Date	HHW Staff Signature	9
HHW Employee (Printed Name and Title	):	

Fee Agreement Page 1 of 1 Revised 4/14/2021



# **COMMUNICATION CONSENT**

Patient Name:	DOB:
VOICEMAIL	
$\hfill\Box$ I give Horizon Health and Wellness permission to leave voicem understanding that voicemail may not be a secure form of commu	
Approved Voicemail Phone Number:	
$\square$ I do not authorize leaving a voicemail.	
TEXT MESSAGES	
$\hfill \square$ I give Horizon Health and Wellness permission to text informat appointment reminders with the understanding that text may not communication.	
Approved Text Message Number:	
$\square$ I do not authorize text messages.	
EMAIL MESSAGES	
$\hfill\Box$ I give Horizon Health and Wellness permission to email information with the understanding that email may not be a secure form of course	
Approved Email Address:	
$\square$ I do not authorize email messages.	
Voicemail, email, and text messaging may not be an encrypted and some structure of the second	
$\hfill\Box$ By agreeing to any of the communication methods approved a my Protected Health Information might be captured by persons n information.	
$\hfill\square$ I am aware that I may revoke these permissions at any time.	
$\square$ I am aware these permissions are good for 1 year from the dat	e on this form.
Patient's Signature	Date
Legally Responsible Party/Guardian Signature (if applicable)	Date
Witness Signature	



### LANGUAGE ASSISTANCE SERVICES

All patients have the right to receive language assistance services in their preferred language. Language assistance services are provided at no charge to the patient and are provided in a timely manner during all hours of operation and at all points of contact. Language assistance services are available through oral interpretation and written translation. Patients can have written materials identified as informational and vital translated to the patient's primary language. Patients can also have the translated materials fully explained to them and receive assistance in the use of these materials when requested.

Horizon Health and Wellness provides the following language assistance services upon request to our patients and their families:

- Bilingual staff;
- Certified interpreters;
- American Sign Language (ASL) interpreters;
- Telephonic interpreters when bilingual staff or other in-person interpreters are not available.

I understand that I have a right to oral interpretation services. I currently: ☐ Request oral interpretation services ☐ Decline oral interpretation services By signing below, I acknowledge that I have been fully informed through this notice and review with Horizon Health and Wellness staff that oral and written language assistance services are available at Horizon Health and Wellness. I understand that should I require language assistance at any time during services I can outreach to Horizon Health and Wellness staff regarding my request in order to obtain interpretation and translation services. Patient Printed Name **Patient Signature** Date Legal Guardian Signature (if applicable) Date Staff Member's Printed Name (Witness) Staff Member's Signature Date



Horizon Health and Wellness Attn. Medical Records | 210 E. Cottonwood Lane | Casa Grande, Arizona 85122 Office: (520) 836-1688 ext. 15024 | Fax: 520-876-1796 | Medical.records@hhwaz.org

#### **AUTHORIZATION FOR DISCLOSURE AND RELEASE OF PROTECTED HEALTH INFORMATION**

I hereby authorize use and disclosure of my Protected Health I	Information (PHI) as follows:		
Patient's full name:		Date of Birth:	
Name of Authorized Individual and relationship (if applicable):_			
I authorize Horizon Health and Wellness to disclose written or v	verbal information to:		
Name/Organization:	Address:		
Phone:Fax:	Email:		
IF THIS RELEASE AUTHORIZES A TWO-WAY EXCHANGE OF INFO			
INDIVIDUAL TO INITIAL HERE			
Purpose of use or disclosure: ☐ Personal Use ☐ Legal ☐ Co	oordination of Care $\ \square$ Othe	er:	
Information to be disclosed (check all that apply):  ☐ Behavioral Health Record ☐ Assessments/Evaluations ☐ Medical Health Record ☐ Treatment/Service Plans ☐ HIV/Aids Information ☐ Medication Lists ☐ Drug/Alcohol Information ☐ Lab/Pathology Reports  Method of delivery: ☐ Fax ☐ Mail ☐ Email (Encrypted/Se  EXPIRATION: If not previously revoked, this consent will terminate RESTRICTIONS: Protected health information that is disclosed prinformation may not re-disclose this information without the wromaker, unless otherwise provided by law, ARS §12-2294 (F). Fedisclosure of substance abuse and/or HIV health reports. This few with other types of health information (42 CFR 164.508(b)(ii)).	☐ History and Physica ☐ Consultation Repo ☐ Other:  ecure) ☐ Office Pick-Up (Picate one year from the signate oursuant to this Authorization ritten authorization of the parederal (42CFR Part 2) and statorm may not be used to rele	al rt(s)  ture ID Required)  ure date. <b>Date of Expira</b> remains privileged. The tient or the patient's hea te law (ARS 36-664) pro ase psychotherapy note	tion:e recipient of this alth care decision ohibit any furthe es in combination
YOUR RIGHTS: I understand that I may refuse to sign this Authoris or payment or my eligibility for benefits. I may inspect or copy a information is contraindicated as determined by my psychiatris the information disclosed by this authorization may be subject Health Insurance Portability and Accountability Act of 1996. He any legal responsibility or liability for disclosure of the above information and the accountability and revoke this Authorization. I may revoke this Authorization may be subject that the Requesting Party or to others have acted in reliance up By signing below, I hereby authorize Horizon Health and Welln	ization. My refusal to sign will any information used or disclest. I have a right to receive at to re-disclosure by the recipely, its employees, officers, aformation.  Suthorization at any time. My on will be effective upon receiped this Authorization and already and support the support of	I not affect my ability to osed under this Authorization of this Authorization of the and no longer be and physicians are here revocation must be in vipt, but will not be effect eady made disclosures.	zation, unless the ion. I understand protected by the by released from writing, signed by tive to the exten
and financial record of the patient identified above, which include	· · · · · · · · · · · · · · · · · · ·		
Signature of Patient:		Date:	
Signature of Authorized Individual, if applicable:		Date:	
OFFICE USE ONLY: Identity of Requestor Verified by: □ Photo ID □ Matching Signatur	re $\square$ Other:		<del></del>
Verified by (staff printed name):	Date:	Time:	AM/PM