Horizon Health and Wellness

PEDIATRIC PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Sex: ☐ Female ☐ Male Preferred Pronouns: _____

As applicable: Gender Identity: _____ Sexual Orientation: _____

Home Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Patient Resides with: _____ Preferred Phone Number: _____

Email Address: _____ Preferred Language: _____

Custody: ☐ Sole ☐ Joint ☐ DCS Ward of the State ☐ Guardianship

PARENT INFORMATION

Mother's Name: _____ Date of Birth: _____

Address (if different from patient's): _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Relationship: ☐ Natural ☐ Step ☐ Adoptive

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Employer: _____

Employer Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Father's Name: _____ Date of Birth: _____

Address (if different from patient's): _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Relationship: ☐ Natural ☐ Step ☐ Adoptive

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Employer: _____

Employer Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy ID Number: _____ Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number: _____

Employer: _____

Secondary Insurance: _____

Policy ID Number: _____ Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Nearest Friend/Relative in Phoenix: _____

ADDITIONAL INFORMATION

Patient's Former Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Address: _____ Fax Number: _____

City: _____ State: _____ Zip Code: _____

Who referred you to us? _____

I acknowledge the above is true to the best of my knowledge and hereby authorize Horizon Health and Wellness to examine and treat my child when necessary. I understand that my treatment and care may include routine care, laboratory testing, and a variety of other medical services considered medically necessary. By signing below I am giving consent for any medical treatment of procedure deemed necessary by the professional Staff of Horizon Health and Wellness.

_____ _____ _____

Printed Name Signature Date

PEDIATRIC PATIENT MEDICAL HISTORY

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

BIRTH HISTORY:

Place of Birth: _____ Type of Birth: ☐ Vaginal ☐ Cesarean Section

Birth Weight: _____ Length: _____ Apgar Score: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

How long was the baby in the hospital after birth? _____ Hospital Discharge Weight: _____

Newborn Problems (i.e. Jaundice, Infection, etc.): _____

Did Mother Smoke During Pregnancy? ☐ Yes ☐ No If yes, number of cigarettes per day: _____

Did Mother Drink Alcohol During Pregnancy? ☐ Yes ☐ No If yes, amount per day: _____

Did Mother use any Prescription or Nonprescription Drugs During Pregnancy? ☐ Yes ☐ No

Prenatal/Neonatal Number of Pregnancies: _____ Number of Living Children: _____

Number of Miscarriages: _____

DEVELOPMENTAL HISTORY:

At what age did the child complete the following:

Sit Alone: _____ Crawl: _____ Walk Alone: _____ Say First Word: _____

Say First Sentence: _____ Achieve Daytime Bladder Control: _____

Achieve Nighttime Bladder Control: _____ Achieve Bowel Control: _____

Get Their First Tooth: _____

How many teeth did the child have at 1 (one) year of age? _____

How do you think the child's development compares with that of his/her siblings or peers?

☐ About the same

☐ More advanced than others – Explain: _____

_____

☐ Slower than others – Explain: _____

_____

Has the child ever experienced a period in which he/she did not grow? ☐ Yes ☐ No

If yes, please explain: _____

SCHOOL PERFORMANCE:

Is the child enrolled in school? ☐ Yes ☐ No If yes, what grade? _____

How does the child do in school? ☐ Good ☐ Fair ☐ Poor

What grades does the child usually earn? ☐ As ☐ Bs ☐ Cs ☐ Ds ☐ Fs

Has the child ever been held back in school? ☐ Yes ☐ No

Has the child ever skipped a grade? ☐ Yes ☐ No

Has the child ever been in Special Education: ☐ Yes ☐ No

What is the child's attitude about school? _____

How do you feel about the child's school performance? _____

FAMILY HISTORY:

Name	Gender	Date of Birth
Patient's Father:	☐ F ☐ M	
Patient's Mother:	☐ F ☐ M	
Patient's Sibling:	☐ F ☐ M	
Patient's Sibling:	☐ F ☐ M	
Patient's Sibling:	☐ F ☐ M	
Patient's Sibling	☐ F ☐ M	
Patient's Sibling:	☐ F ☐ M	
Patient's Sibling:	☐ F ☐ M	

Have any of the child's brothers or sisters died? ☐ Yes ☐ No

If yes, list age and cause of death: _____

Mother: Age: _____ Education Level: _____ Deceased: ☐ Yes ☐ No

History of: ☐ Asthma ☐ Allergies ☐ Epilepsy ☐ Convulsions ☐ Seizures
☐ Cancer ☐ Diabetes ☐ Sickle Cell ☐ Kidney Disease ☐ TB
☐ Mental Retardation ☐ High Blood Pressure
☐ High Cholesterol ☐ Other: _____

Maternal Grandmother: Age: _____ Education Level: _____ Deceased: ☐ Yes ☐ No

History of: ☐ Asthma ☐ Allergies ☐ Epilepsy ☐ Convulsions ☐ Seizures
☐ Cancer ☐ Diabetes ☐ Sickle Cell ☐ Kidney Disease ☐ TB
☐ Mental Retardation ☐ High Blood Pressure
☐ High Cholesterol ☐ Other: _____

Maternal Grandfather: Age: _____ Education Level: _____ Deceased: ☐ Yes ☐ No

History of: ☐ Asthma ☐ Allergies ☐ Epilepsy ☐ Convulsions ☐ Seizures
☐ Cancer ☐ Diabetes ☐ Sickle Cell ☐ Kidney Disease ☐ TB
☐ Mental Retardation ☐ High Blood Pressure
☐ High Cholesterol ☐ Other: _____

Father: Age: _____ Education Level: _____ Deceased: ☐ Yes ☐ No

History of: ☐ Asthma ☐ Allergies ☐ Epilepsy ☐ Convulsions ☐ Seizures
☐ Cancer ☐ Diabetes ☐ Sickle Cell ☐ Kidney Disease ☐ TB
☐ Mental Retardation ☐ High Blood Pressure
☐ High Cholesterol ☐ Other: _____

Paternal Grandmother: Age: _____ Education Level: _____ Deceased: ☐ Yes ☐ No

History of: ☐ Asthma ☐ Allergies ☐ Epilepsy ☐ Convulsions ☐ Seizures
☐ Cancer ☐ Diabetes ☐ Sickle Cell ☐ Kidney Disease ☐ TB
☐ Mental Retardation ☐ High Blood Pressure
☐ High Cholesterol ☐ Other: _____

Paternal Grandfather: Age: _____ Education Level: _____ Deceased: ☐ Yes ☐ No

History of: ☐ Asthma ☐ Allergies ☐ Epilepsy ☐ Convulsions ☐ Seizures
☐ Cancer ☐ Diabetes ☐ Sickle Cell ☐ Kidney Disease ☐ TB
☐ Mental Retardation ☐ High Blood Pressure
☐ High Cholesterol ☐ Other: _____

Is there a history of the above conditions with any of the child's other blood relatives? ☐ Yes ☐ No

If yes, please state relationship and condition: _____

REVIEW OF SYSTEMS:

How is the child's general health? ☐ Good ☐ Fair ☐ Poor

Does the child have any allergies to foods, medications, or pollens? ☐ Yes ☐ No

If yes, please list: _____

Please indicate if the child has had any problems in the following areas:

☐ Asthma ☐ Behavioral/Discipline Problems ☐ Bones/Joints ☐ Cough
☐ Nutrition ☐ Digestion ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Toileting
☐ Ears ☐ Hearing ☐ Epilepsy ☐ Seizures ☐ Convulsions
☐ Eyes ☐ Vision ☐ Feet ☐ Heart ☐ Blood Pressure

☐ Bluish Skin Color ☐ Infections ☐ Lungs ☐ Breathing ☐ Skin

☐ Eczema ☐ Acne ☐ Contact Dermatitis ☐ Teeth ☐ Urine

☐ Kidney ☐ UTIs ☐ Bedwetting/soiling ☐ Reproductive

☐ Menstrual Cramps ☐ Testes ☐ Sexually Transmitted Diseases/Infections

☐ Other: _____

PREVIOUS ILLNESS AND/OR HOSPITALIZATIONS:

Have you provided us with a copy of the child's immunization record? ☐ Yes ☐ No

If no, please provide us with a copy of the child's immunization record.*

Has the child ever had the following? ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox

☐ Covid-19 ☐ Other: _____

Has the child ever been hospitalized? ☐ Yes ☐ No

If yes, why? _____

MEDICATION:

Please indicate any currently prescribed medications for the child:

Medication:	Dose and Frequency:	Prescribed by:

Does the child take any over the counter medications? ☐ Yes ☐ No

If yes, please list: _____

SOCIAL:

Are natural parents: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

☐ Living Together ☐ Other: _____

If applicable, Visitation/Involvement with non-custodial parent: _____

Does the child have a Step-Parent(s)? ☐ Yes ☐ No Step-Brother(s)/Step-Sister(s)? ☐ Yes ☐ No

Does the child go to a babysitter, preschool, or daycare regularly? ☐ Yes ☐ No

Who lives in the home with the child? (List name, age, relationship, and any health problems)

_____

_____

_____

Have there been any recent major changes or stresses in the child's life? ☐ Yes ☐ No

If yes, please explain: _____

AUTHORIZATION TO TREAT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Name of Patient: _____ **DOB:** _____ **MR#:** _____
(Print) (mm/dd/yyyy)

I hereby grant permission to Horizon Health and Wellness (HHW) to provide routine evaluation and services as may be deemed medically necessary or advised for diagnosis and/or treatment/care. I understand that this consent shall remain valid for one year or until I withdraw my consent.

I agree to participate in my treatment planning process to the best of my ability and understand that I have the right to refuse any recommended treatment. If I refuse any treatment, HHW will work with me to either develop acceptable recommendations, including a second opinion, or I will be provided with appropriate referrals for treatment that I need. I understand that HHW operates as a treatment team and that this means that my care will be coordinated among HHW staff as indicated. I also understand that HHW utilizes supervision/consultation regarding clinical issues to the extent necessary to ensure clinically appropriate care to operate within the laws governing behavioral health professionals.

I understand that in rare instances, such as the potential for a conflict of interest, it may become necessary to terminate the relationships with a HHW staff. If this should occur, I will be provided notice of this action and I will be referred to another staff. I understand that there is no guarantee that the treatment services offered will prove beneficial to me. Furthermore, I have been advised that should medications be prescribed or administered, that such medications may or may not be effective and, in a small number of situations, they may even have serious side effects. I may have an adverse reaction to such medication and it is my responsibility to keep those individuals involved in my treatment informed of any medication effects.

I understand that all information gathered in the course of treatment at HHW is confidential. However, information may be released without my consent in cases of medical emergency, danger to self or others, suspected abuse or neglect of a minor or vulnerable adult, court order, insurance billing claim requirements, audit and program evaluation, and where otherwise legally required.

I understand that in signing below, I am consenting to services by HHW. I understand that only the patient, parent, or legal guardian (or someone to whom the parent or legal guardian has delegated his/her powers regarding the care or custody of the minor(s) as evidenced through official legal documentation) can provide consent for services, and I have provided documentation as such if applicable. If any proposed treatment/service is of a specialized nature with associated risks, those risks will be discussed verbally with me and outlined on a separate form requiring my signature.

I understand that consent is voluntary and may be withheld or withdrawn at any time.
By initialing EACH LINE below and signing this form I consent to treatment and/or services and agree that the below documents have been provided and explained to me.

_____ HHW Notice of Privacy Practices (effective 4/11/2003; revised 2/11/2021)

_____ HHW Patient Rights (effective 4/12/2000; revised 7/11/2018)

_____ Notice of Health Information Practices regarding HHW's participation in the Health Information Exchange

_____ Website for the applicable AHCCCS Complete Care Health Plans' Member Handbook:

☐ Arizona Complete Health ☐ Banner University Family Care ☐ Care 1st ☐ 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

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.

1. 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.

_____

Patient's Printed Name (or legal guardian)

_____ _____

Patient's Signature (or legal guardian) Date

PRIMARY CARE MEDICAL RECORDS REQUEST FORM
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information:

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone Number: _____

Information to be Released from:

Name of Organization: _____

Organization Address: _____

Organization Phone Number: _____

Organization Fax Number:_____

Information to be Released to:

Name of Organization: _____

Organization Address: _____

Organization Phone Number: _____

Organization Fax Number: _____

Purpose of this Request:

Coordination and Continued Care – Patient is now being seen at Horizon Health and Wellness for primary care services.

Type of Information to be Released:

☐ General Medical Records – Excluding Protected Records

☐ All Records – Including information protected by State/Federal law (AIDS/HIV and other Communicable Disease Information, Behavioral Health/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

☐ Other Records – Specify: _____

Expiration:

This authorization will expire upon its completion, unless revoked by the patient or guardian.

Signature of Patient or Guardian:

I understand authorizing the disclosure of the information above is voluntary. I do not need to sign this form to ensure healthcare treatment.

_____ _____ _____

Signature of Patient or Guardian | Date | Printed Name of Signing Party

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 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 verbal information to:

Name/Organization:_____ Address: _____

Phone:_____ Fax:_____ Email: _____

IF THIS RELEASE AUTHORIZES A TWO-WAY EXCHANGE OF INFORMATION BY THE ABOVE NAMED PARTIES, PATIENT/AUTHORIZED INDIVIDUAL TO INITIAL HERE_____.

Purpose of use or disclosure: ☐ Personal Use ☐ Legal ☐ Coordination of Care ☐ Other: _____

Information to be disclosed (check all that apply):

☐ Behavioral Health Record	☐ Assessments/Evaluations	☐ PCP Progress Notes
☐ Medical Health Record	☐ Treatment/Service Plans	☐ History and Physical
☐ HIV/Aids Information	☐ Medication Lists	☐ Consultation Report(s)
☐ Drug/Alcohol Information	☐ Lab/Pathology Reports	☐ Other: _____

Method of delivery: ☐ Fax ☐ Mail ☐ Email (Encrypted/Secure) ☐ Office Pick-Up (Picture ID Required)

EXPIRATION: If not previously revoked, this consent will terminate one year from the signature date. **Date of Expiration**:_____

RESTRICTIONS: Protected health information that is disclosed pursuant to this Authorization remains privileged. The recipient of this information may not re-disclose this information without the written authorization of the patient or the patient's health care decision maker, unless otherwise provided by law, ARS §12-2294 (F). Federal (42CFR Part 2) and state law (ARS 36-664) prohibit any further disclosure of substance abuse and/or HIV health reports. This form may not be used to release psychotherapy notes in combination with other types of health information (42 CFR 164.508(b)(ii)). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other protected health information.

YOUR RIGHTS: I understand that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this Authorization, unless the information is contraindicated as determined by my psychiatrist. I have a right to receive a copy of this Authorization. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. HHW, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.

ABOUT REVOKING THIS AUTHORIZATION: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or my legally responsible party, on my behalf. My revocation will be effective upon receipt, but will not be effective to the extent that the Requesting Party or to others have acted in reliance upon this Authorization and already made disclosures.

By signing below, I hereby authorize Horizon Health and Wellness (HHW) or agent to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in paper and/or electronic format.

Signature of Patient:_____ **Date**: _____

Signature of Authorized Individual, if applicable:_____ **Date**: _____

OFFICE USE ONLY:
Identity of Requestor Verified by: ☐ Photo ID ☐ Matching Signature ☐ Other: _____

Verified by (staff printed name): _____ Date:_____ Time:_____ AM/PM