APPENDIX A

When you register as a new patient, we ask for some information about you. This includes things like your age, race, and where you live. We call this “demographic information”.

We collect this information to help everyone in our community get better healthcare. It helps us see if some groups of people need more help than others.

We keep your information private and safe. Our Notice of Privacy Practices explains how we do this. It also tells you how we use general information (not personal details) to make decisions about our care.

You don't have to give us this information if you don't want to. It's your choice.

If you don't fill out parts of the Registration Form today, we might ask you for it later. This is just to make sure we have complete information.

Do you have any questions?

Horizon Health and Wellness

APPENDIX A

REGISTRATION FORM

Date: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Name)

Gender: ☐ Male ☐ Female ☐Transgender ☐ Other ☐ Chose not to disclose

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex ☐ Chose not to disclose

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

Social Security Number: _____- _____- _____ Preferred Language: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: ☐ Landline: _____ ☐ Cell Phone: _____

Email Address: _____

Custody (if applicable): ☐ Sole ☐ Joint ☐ Ward of the Court (DCS/DDD) ☐ Permanent Guardianship

☐ Temporary Guardianship ☐ Power of Attorney

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 Language: _____

☐ Group Home Manager: _____ Phone: _____

School Name: _____ Grade: _____ Phone: _____

FOR ALL CLIENTS:

Emergency Contact Name: _____ Phone: _____

Address: _____ Relationship: _____

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 ☐ Visual Impairment ☐ Hearing Impairment ☐ Cognitive Impairment

☐ Interpreter – 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 Portal (PCP only – Email Address Required)

PCP PATIENTS ONLY -

Do you want access to your medical information online through our patient portal? ☐ Yes ☐ No

ADDITIONAL PATIENT INFORMATION:

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Other Pacific Islander ☐ Native Hawaiian

☐ White ☐ Black or African American ☐ More than one race ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Chose not to disclose

Are you a Veteran? ☐ Yes ☐ No Do you live in Public Housing? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No If "Yes": ☐ Doubling Up ☐ Shelter ☐ Street ☐ Traditional ☐ Other

Sexual Orientation: ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Something Else

☐ Chose not to disclose ☐ Does not apply (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 Referral, etc.)? _____

CONSENT AND ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I hereby and voluntarily consent to treatment and care by Horizon Health and Wellness (HHW). I understand that HHW is an integrated care clinic and that my treatment and care may include routine care, laboratory testing, and a variety of other services considered medically necessary.

I understand that I must provide 24-hour advance notice of cancelled appointments. I understand that HHW reserves the right to terminate, discharge, dis-enroll, transfer, and/or reduce services if there is a lack of contact/participation and/or failure to respond to efforts of engagement. I understand that such would not occur without advanced written notice and an opportunity to appeal such decision.

I understand that HHW will serve patients in the home, community setting (e.g. schools), and/or office as appropriate in assessing issues, needs, and development of a services plan with goals and objectives, in the aim of resolving problems which I define. I agree to cooperate with HHW and participate in the program(s) as necessary. I have been fully informed about service options and understand that I will be involved in setting and modifying service goals and making decisions about the services I receive.

_____

Patient's Printed Name

_____ _____

Patient's Signature Date

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

INFORMED CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES

I, _____, understand that Horizon Health and Wellness (HHW) utilizes telehealth services. HHW has explained to me that telehealth services involve video conferencing technology and that services provided over telehealth will not be the same as direct patient/provider visits due to the fact that I will not be in the same room as my provider. I understand that HHW can utilize telehealth services for case management, therapy, psychiatric, medical, and other services.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that HHW or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate to the situation. I also understand that my healthcare information may be shared with other individuals for scheduling and billing purposes as well as treatment coordination. Others may also be present during the telehealth appointment in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the appointment and thus I will have the right to request the following: omit specific details that are personally sensitive to me; asks non-clinical personnel to leave the telehealth appointment; and terminate the appointment at any time.

I have had the alternatives to telehealth appointments explained to me and I understand that I have a choice as to whether I engage in telehealth appointments. I understand that engaging in telehealth appointments does not exclude me from having to physically attend in person appointments when needed, such as for vitals, laboratory tests, etc. If I have questions regarding telehealth services, I understand that I am able to outreach to HHW staff for additional clarification.

I understand that my sessions will not be recorded without my expressed written consent on an additional form.

I have read this document and I hereby consent to participate in receiving services via telehealth under the terms described above. I understand this document will become part of my medical record.

Please check the appropriate box below:

☐ I agree to participate in and receive services via telehealth.

☐ 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: _____

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

FEE AGREEMENT

I, _____, DOB _____, hereby agree to be involved in the program(s) at Horizon Health and Wellness (HHW).

I understand that HHW is funded in part by the Arizona Health Care Cost Containment System (AHCCCS) and it is the policy of AHCCCS that services be offered on a sliding fee scale based upon my ability to pay or on contractual basis with third-party payers. Any services paid on a fee-for-service basis are exempt from co-payments for all covered members.

I further understand that my annual gross income and the number of persons residing in my household will determine the percentage of the fee that I will be required to pay. In some cases, third-party payers will be responsible for a contracted fee. Information related to the fee agreement and sliding fee scale are available to me at Horizon Health and Wellness as well as in your patient packet.

I understand that I am eligible for payment of services at _____ (percentage or dollar amount) and that I could be responsible for the cost even though insurance and other third party payers may be involved. Changes in this policy or practice may result in changes to the fee amount that I am responsible for paying in the future. I understand that HHW will not raise their fees or our adjusted fee without a 30-day notice. This payment amount indicated here will be honored for six (6) months, after which time a re-eligibility will need to be completed to determine any adjustment to your payment amount.

If payment of a fee is required, I agree to pay the agreed-upon fee to the HHW representative at the time service is provided.

Please refer to the second page of this document for the Service Fee Schedule and Discount Thresholds.

_____
Patient's/Legal Guardian's Printed Name

_____ _____
Patient's/Legal Guardian's Signature Date

Approved on: _____ by: _____
Date HHW Staff Signature

HHW Employee (Printed Name and Title): _____

COMMUNICATION CONSENT

Patient Name: _____ DOB: _____

VOICEMAIL

☐ I give Horizon Health and Wellness permission to leave voicemails related to services provided, understanding that voicemail may not be a secure form of communication.

Approved Voicemail Phone Number: _____

☐ I do not authorize leaving a voicemail.

TEXT MESSAGES

☐ I give Horizon Health and Wellness permission to text information about my scheduling and appointment reminders with the understanding that text may not be secure form of communication.

Approved Text Message Number: _____

☐ I do not authorize text messages.

EMAIL MESSAGES

☐ I give Horizon Health and Wellness permission to email information related to services provided with the understanding that email may not be a secure form of communication.

Approved Email Address: _____

☐ I do not authorize email messages.

Voicemail, email, and text messaging may not be an encrypted and secure form of communication. There is a risk that your Protected Health Information might be captured by persons not authorized to receive such information.

☐ By agreeing to any of the communication methods approved above, I am accepting the risk that my Protected Health Information might be captured by persons not authorized to receive such information.

☐ I am aware that I may revoke these permissions at any time.

☐ I am aware these permissions are good for 1 year from the date on this form.

_____ _____

Patient's Signature Date

_____ _____

Legally Responsible Party/Guardian Signature (if applicable) Date

_____ _____

Witness Signature Date

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 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