Basic Information

First name

Middle name

Last name

Suffix

Sex

Date of birth

MM/DD/YYYY

Primary phone type

Phone number

(___) ___-____

Email

Social security number

___-__-____

Address line 1

Address line 2

City

State

Zipcode

_____

Maiden last name

Marital status

Upload a photo of your driver's license

Drag & drop your files here

(.jpeg, .jpg, .png, .gif, .pdf)

Browse and upload

Driver's license state

Driver's license #

Demographics

Sexual orientation

Gender identity

Hispanic or latino?

Ethnicity

☐ Decline to specify

Race

Specific races

☐ Decline to specify

Languages

Emergency Contact

Relationship to contact

First name

Middle name

Last name

Primary phone type

Phone number

(___) ___-____

Email

Address line 1

Address line 2

City

State

Zipcode

Financial Information

Responsible Party

Who will be financially responsible for you?

- ◯ Myself
- ◯ Same as emergency contact
- ◯ Other

Method of Payment

What will be your method of payment?

- ◯ Selfpay
- ◯ Insurance

Additional Information

Preferred pharmacies

How did you hear about us?

Medication & Allergy

Are you currently taking any medication? (If you're taking herbal supplements, vitamins, or over-the-counter medications, please list them as well.)

e.g. Ibuprofen 200mg - 2x/day

Do you have any allergies? Please list the allergic reaction (e.g. coughing, swelling, etc.)

e.g. Peanuts, shellfish, etc.

Past Medical History

Please check all that apply:

Head

- [ ] Trauma

Eyes

- [ ] Blindness
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Wears glasses/contacts

Ears

- [ ] Hearing aids

Nose/Sinuses

- [ ] Allergic Rhinitis
- [ ] Sinus infections

Mouth/Throat/Teeth

- [ ] Dentures

Cardiovascular

- [ ] Aneurysm
- [ ] Angina
- [ ] DVT
- [ ] Dysrhythmia
- [ ] HTN
- [ ] Murmur
- [ ] Myocardial infarction
- [ ] Other heart disease

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] COPD - Bronchitis/Emphysema
- [ ] Pleuritis
- [ ] Pneumonia

Gastrointestinal

- [ ] Cirrhosis
- [ ] GERD
- [ ] Gallbladder disease
- [ ] Heartburn
- [ ] Hemorrhoids

Endocrine

- [ ] Goiter
- [ ] Hyperlipidemia
- [ ] Hypothyroidism
- [ ] Thyroid disease
- [ ] Thyroiditis
- [ ] Type I DM
- [ ] Type II DM

Heme/Onc

- [ ] Anemia
- [ ] Cancer

Infectious

- [ ] HIV
- [ ] STDs
- [ ] Tuberculosis (dz)
- [ ] Tuberculosis (exposure)

Musculoskeletal

- [ ] Arthritis
- [ ] Gout
- [ ] M/S injury

Skin

- [ ] Dermatitis
- [ ] Mole(s)
- [ ] Other skin condition(s)
- [ ] Psoriasis

Neurological

- [ ] Epilepsy
- [ ] Seizures
- [ ] Severe headaches, migraines
- [ ] Stroke
- [ ] TIA

Psychiatric

- [ ] Bipolar disorder
- [ ] Depression
- [ ] Hallucinations, delusions
- [ ] Suicidal ideation
- [ ] Suicide attempts

Social History

Please check all that apply:

Tobacco

- [ ] Current every day smoker
- [ ] Current some day smoker
- [ ] Former smoker
- [ ] Heavy tobacco smoker
- [ ] Light tobacco smoker
- [ ] Never smoker
- [ ] Smoker, current status unknown
- [ ] Unknown if ever smoked

Alcohol

- [ ] Do not drink
- [ ] Drink daily
- [ ] Frequently drink
- [ ] History of Alcoholism
- [ ] Occasional drink

Drug Abuse

- [ ] IVDU
- [ ] Illicit drug use
- [ ] No illicit drug use

Cardiovascular

- [ ] Eat healthy meals
- [ ] Regular exercise
- [ ] Take daily aspirin

Safety

- [ ] Household Smoke detector
- [ ] Keep Firearms in home
- [ ] Wear seatbelts

Sexual Activity

- [ ] Exposure to STI
- [ ] Not sexually active
- [ ] Safe sex practices
- [ ] Sexually active

Birth Gender

- [ ] Male
- [ ] Female
- [ ] Undifferentiated

- [ ] Traveled domestically or internationally within the past 6 months.

Any other comments

Surgical History

Please check all that apply:

- [ ] Aneurysm repair
- [ ] Appendectomy
- [ ] Back surgery
- [ ] Bariatric surgery/gastric bypass
- [ ] Bilateral tubal ligation
- [ ] Breast resection/mastectomy
- [ ] CABG
- [ ] Carotid endarterectomy/stent
- [ ] Carpal tunnel release surgery
- [ ] Cataract/lens surgery
- [ ] Cesarean section
- [ ] Cholecystectomy/bile duct surgery
- [ ] Dilation and curettage
- [ ] Hemorrhoid surgery
- [ ] Hip arthroplasty
- [ ] Hip replacement
- [ ] Hysterectomy
- [ ] Inguinal hernia repair
- [ ] Knee arthroplasty
- [ ] LASIK
- [ ] Laminectomy
- [ ] Nasal surgery
- [ ] PTCA/PCI
- [ ] Pacemaker/defibrillator
- [ ] Prostate surgery
- [ ] Prostatectomy
- [ ] Rotator cuff surgery
- [ ] Sinus surgery
- [ ] Skin cancer excision
- [ ] Spinal fusion
- [ ] TAH-BSO
- [ ] TURP
- [ ] Tonsillectomy/Adenoidectomy
- [ ] Vasectomy

Any other past surgeries/comments

OB/GYN Screen

Gynecology

Age of onset of menstruation:

Age of menopause:

Do you have a history with any of the following?

History of irregular menstruation:

○ No ○ Yes

Hormone replacement therapy:

○ No ○ Yes

History of fertility drugs:

○ No ○ Yes

Abnormal PAP smear:

○ No ○ Yes

Cervical biopsy:

○ No ○ Yes

Pregnancy

How many pregnancies have you experienced? Include if you are currently pregnant.

Total pregnancies:

Of your total pregnancies, how many were the following:

Full term:

Pregnancies passing 37 weeks

Pre term:

Pregnancies between 20-36 weeks

Lost pregnancies:

Miscarriages, abortions before 20 weeks

How many living children were born from your pregnancies?

Living children:

Healthy Wings
Family & Psychiatric Healthcare

GENERAL CONSENT

I hereby authorize nursing and medical evaluation, diagnosis, physical examination, laboratory testing, psychiatric or mental health therapy, and/or treatment or procedures at Healthy Wings LLC, d/b/a Healthy Wings Family & Psychiatric Healthcare, by its healthcare providers, clinicians, contractors, employees, and/or assigns (collectively referred to as "HWLLC"). HWLLC's scope of services includes some of the following:

- Diagnosis and treatment (including prescribing medications when appropriate) for common illnesses including psychiatric/mental health disorders;
- Labs and tests; treatment of minor abrasions, skin conditions, and/or injuries; common vaccinations;
- Department of Transportation's Commercial Motor Vehicle Drivers' exams, Medical Marijuana Certification exams, camp, sports, school, and/or college physicals;
- Wellness services designed to help patients identify lifestyle changes needed to improve their current and future health, including screenings and monitoring for thyroid disorders, diabetes, high blood pressure, and/or high cholesterol, etc., and/or programs and counseling for weight loss and smoking cessation.

You have the right to discuss with your healthcare provider any cultural, religious, spiritual, and/or other preferences that impact your visit or treatment plan. If you have any language or communication challenges, please notify the healthcare provider.

Email/Text Consent

I consent to receive text messages or emails from HWLLC on my cell phone or other devices. I understand that text messages and emails sent by HWLLC may include appointment reminders or changes in previously scheduled appointments or may provide advice or education. HWLLC does not charge for this service, but I understand that standard text messaging rates may apply as provided in my wireless plan. I have been advised that I may contact my carrier for pricing plans and details. I understand that I may revoke my request for further communications via text or email at any time by notifying HWLLC in writing. However, if I continue to communicate with HWLLC via text or email, HWLLC can assume that my consent remains valid.

Because e-mails sent over the Internet or texts sent over the control channel without encryption are not secure, I understand the risks associated with e-mail and text messaging, including, without limitation, that e-mails and text messages could be intercepted by unknown third parties; e-mail content can be changed without the knowledge of the sender or receiver; backup copies of my e-mail(s) may still exist even after the sender and receiver have deleted the messages; and e-mail can contain harmful viruses and other programs. HWLLC has recommended that I delete all text messages or emails as soon as possible after reviewing them to limit any unauthorized exposure.

Vaccination Services

HWLLC does not provide vaccination services. I understand the benefits and risks of the vaccine(s). I understand and consent to HWLLC sharing information related to vaccine(s) that I may have received and/or have previously been administered by others with the AZ State Immunization Information System for the sole purpose of archiving and/or retrieving such information.

Use or Disclosure of Health Information

HWLLC may use or release your health information to other healthcare provider(s) and/or their staff for treatment purposes, to third party payors and other third parties as necessary for HWLLC to obtain payment for services that you may receive. I understand and consent to HWLLC retrieving a historical record of my current and/or prior prescribed medications to assist in providing quality healthcare services to me or the minor child listed below. Please see the **HWLLC Notice of Privacy Practices & Patient-Provider Policies** for full details which you acknowledge will be a part of your Electronic Medical Record.

Patient Financial Responsibility

You are responsible for paying for services at the time they are provided, unless HWLLC has an agreement with your health plan or

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

insurer and the services are covered under the health plan or insurer. If HWLLC has an agreement with your health plan or insurer, you are responsible for paying a co-payment and/or deductible amounts at the time of service. It is understood, however, that **THE PATIENT AND/OR THE UNDERSIGNED ARE RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS ACCOUNT; especially, if any policy that ensures the patient fails to make payment or timely payment (within 45 days of bill submission) to Healthy Wings Family & Psychiatric Healthcare and/or the Healthcare Provider. In addition, instead of sending you a bill, you hereby authorize HWLLC to automatically charge your balance to the credit card provided at the time of service.**

Notice of Self-Payment for Health Screenings and Administrative Services

Health screenings for Sports, Camp, School/College, Department of Transportation, Medical Marijuana Certifications or for work and/or Administrative Services may be limited services at HWLLC. **Your health plan or insurer or Medicaid WILL NOT pay for these services**. These services cannot be billed to your health plan, insurer, or Medicaid plan whether HWLLC accepts the plan or not.

You will be advised of the limited service requested and the related costs prior to the service being rendered by HWLLC.

Authorization to Obtain Needed Information:

I grant Healthy Wings LLC permission to obtain all medical information regarding me (which may contain confidential HIV/AIDS related information, communicable disease related information, information relating to mental health, medications prescribed, immunizations, and/or alcohol/drug use) that any health care provider may have on record for the purpose of further medical care.

Information to be requested: History & Physical; Discharge Summary; Pathology Reports; Physician's Progress Notes; Radiology Reports; Operative Reports; and/or Laboratory Reports

MEDICAL RECORDS REQUESTED FOR THE FOLLOWING:

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Revocation must be in writing. **This authorization will automatically expire 12 months from the date on which it is signed below.**

Waiver of Liability:

By signing this Consent, I agree to waive, release, and discharge HWLLC from any and all liability, including, without limitation, any injuries that may occur during the provision of services under this Consent.

By signing below, I am confirming that I understand the above disclosures, consent to the authorization to obtain needed information, and consent to treatment(s) (including vaccination(s), if applicable) that I will receive and/or that will be received by the minor named below for whom I attest that I am the parent, legal guardian, or authorized representative of and that I may provide effective consent for services at HWLLC.

In addition, I acknowledge that I have received the HWLLC Notice of Privacy Practices & Patient-Provider Policies.

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

Patient's/Representative's Signature: _____ Today's Date: _____

Print Representative's Name: _____

Print Mailing Address: _____

If signed by anyone other than the patient, indicate the relationship to the patient: ____ Parent ____ Guardian ____ Agent

CONSENT FOR TELEHEALTH VIDEO VISITS

What is Telehealth?

Telehealth is healthcare provided by any means other than a face-to-face visit. In Telehealth services, nursing, medical, and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and/or remote patient monitoring are all considered Telehealth services.

I hereby consent to participate in Telehealth with, Dr. Jennifer Muhammad, DNP, NP-BC a Family & Psychiatric Nurse Practitioner, Healthy Wings LLC, Healthy Wings Family & Psychiatric Healthcare, its employees, contractors and/or assigns, as part of my care.

I understand that Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two separate locations.

I understand the following with respect to psychiatric and/or mental Telehealth:

- I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- There are risks, benefits, and consequences associated with Telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to psychiatric and/or mental Telehealth unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; or I raise mental/emotional health as an issue in a legal proceeding).
- If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telehealth services are not appropriate, and a higher level of care is required.
- Electronic communication may be used to communicate extremely sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- During a Telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, please immediately end the session, and restart the session. If we are unable to reconnect within five (5) minutes, please telephone me at (520) 477-1815 to discuss since we may have to re-schedule.
- I understand my provider(s) and/or their staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
- **Electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made DIRECTLY to the provider's office at (520) 477-1815, or to the existing emergency 911 services in my community especially if after regularly scheduled office hours.**

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a Telehealth visit.

I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical and/or psychiatric mental health care is provided.

To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution, practice, and/or assigns from any claims I may have about the Telehealth visit.

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

Patient's/Representative's Signature: _____ Today's Date: _____

Print Representative's Name: _____

Print Mailing Address: _____

If signed by anyone other than the patient, indicate the relationship to the patient: ____ Parent ____ Guardian ____ Agent

Healthy Wings Family & Psychiatric Healthcare 2055 E. Southern Ave., Suite B., Tempe, AZ 85282-7507; Tel: (520) 477-1815; Fax: (949) 543-2787

Healthy Wings, LLC
2055 East Southern Ave., Ste B, Tempe, AZ 85282-7507

CREDIT CARD ON FILE AUTHORIZATION

Information to be completed by Cardholder:

The undersigned agrees and authorizes Healthy Wings, LLC, d/b/a Healthy Wings Family & Psychiatric Healthcare, and/or it's third-party billing company (i.e., Headway, Alma, Square, Stripe) (herein referred to as "HWLLC"), to save the credit/debit card on file as entered into this document and/or into my electronic health record.

I authorize HWLLC to process the credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit/debit card account, at which point, it will be updated with a valid credit/debit card. Patients may also revoke this form by submitting a written request to HWLLC at the address above. If a charge is processed to the card on file and is declined, the Patient will be billed for any fee(s) associated with the decline of the card.

I understand that if the invoice sent to me prior to my appointment is not paid at least 24-hours prior to the appointment, HWLLC will charge the amount due to my card on file.

If applicable, I further understand that if there is a balance due after my insurance benefits has paid for my visit, my card on file will be charged for the balance without prior notification. This is not "balance billing," as the balance due would be considered the patient's responsibility as noted in your Explanation of Benefits (EOB) provided by your insurance company.

I acknowledge that I am an authorized user of the card being used, or I have been given permission to utilize such card. If a fraudulent accusation results from the use of this card, HWLLC will cooperate with the authorities to prosecute any illegal activity. Please make sure you have the permission of the cardholder to use the credit/debit card on file.

Patient's Printed Name: _____

Patient's Legal Representative's Name: _____ Birth Date: _____

Name as it Appears on the Credit/Debit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Card #:

Expiration Date:

Security Code (CVV):

Full Billing Address: _____

Billing City, State, Zip Code: _____

Patient's Signature: _____

OFFICE USE: Recorded By: _____ Date Recorded: _____ Rev: 03/2023

ADDENDUM TO NOTICE OF PRIVACY PRACTICES & PATIENT-PROVIDER POLICIES

PAYMENT POLICY

Thank you for choosing Healthy Wings Family & Psychiatric Healthcare (HWLLC) as your Healthcare Provider. We are committed to providing you with personal, quality, and affordable health care. This document spells out the important elements of our Payment Policies that may be found in our ***Notice of Privacy Practices & Patient-Provider Policies***. Please read it, ask any questions that you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured with a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full is required for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please be advised, that according to the Patient Privacy and Affordable Care Act and most insurance contracts, the **Annual Physical Exam** that is typically provided ***FREE, once every 12 months***, by your insurance company is reserved for patients that are **WELL** and are not experiencing any sickness and/or acute concerns.
2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and/or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment or deductible at every visit.
3. **Non-Covered Services and/or Outstanding Balances.** Please be aware that some – and perhaps all – of the services you receive may require you to pay a portion of the services, may not be covered, and/or may not be considered reasonable or necessary by Medicare or your Insurance company. You must pay for these services in full at the time of the visit or immediately after Medicare or your insurance company advises us of your cost sharing amounts; (note, your insurance company automatically mails this information to you, as well). In addition, instead of sending you a bill, you hereby authorize HWLLC to automatically charge your balance to the credit card provided at the time of service.
4. **Proof of Insurance.** All patients must complete our Patient Registration forms before seeing the healthcare provider(s). We must obtain a copy of your valid driver's license or state photo ID and the current, valid insurance information to obtain proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the full balance of the claim.
5. **Claim Submission.** We will submit your claims and assist you in any way we can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request within five (5) days of the request. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays your claim or not. Your insurance benefits are a contract between you and your insurance company.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is 60 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 with our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period, our healthcare provider(s) may be able to treat you on what we consider an emergency basis only.
8. **Missed appointments.** Our policy is to charge for missed appointments not rescheduled or canceled within 24 hours of the scheduled appointment. These charges will be your responsibility and billed directly to you and are payable at the time of cancellation, rescheduling, or no show. Please help us to serve you better by keeping your regularly scheduled appointment or by telephoning our office directly if you need to cancel a scheduled appointment.
9. **It is important to clarify that the fee(s) charged is for the time, expertise, and professional services provided, not for a guaranteed prescription(s) and/or specific outcome(s). Controlled substances and other medications are prescribed only when clinically appropriate and safe, based on professional medical judgment. Thus, all fees paid or to be billed on your behalf to your insurance(s) are non-refundable once services have commenced and/or have been provided by our professional staff members.**

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges of the area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or the Responsible Party **Date**

_____ _____

Print Name of Patient **Date of Birth**

PATIENT-PROVIDER CONSENT FOR CONTROLLED SUBSTANCE MEDICATIONS

Patient Name: _____

Date of Birth: _____

Healthcare Provider: **Healthy Wings, LLC, its affiliates, assigns, and/or licensed healthcare providers.**

1. **Required Healthcare Provider Team Members:** I agree to maintain a primary care provider while I am receiving controlled substances.
2. **Addiction Potential:** I understand that addiction is real risk associated with controlled substances and I am accepting of this risk. I will not hold the Healthcare Provider, Healthy Wings Family & Psychiatric Healthcare, Healthy Wings LLC, their officers, assigns, and/or employees or contractors, responsible for the addiction.
3. **Substance Abuse Prohibited:** I understand that I am absolutely prohibited from abusing alcohol, marijuana, other recreational drugs, or other prescription drugs while under the treatment of the Healthcare Provider named above. Random monitoring may be necessary at the Healthcare Provider's discretion, please see Section 7 below.
4. **Getting Controlled Substances elsewhere is prohibited except for special circumstances:** I will not get controlled substance from other healthcare providers except in the case of another medical specialty (i.e., primary care, psychiatry, pain management, an emergency or surgery). If an emergency occurs, I will contact my healthcare provider immediately following the emergency. I agree to discuss all prescribed controlled substance with my Healthcare Provider. I agree not to "shop" for controlled substances or other non-controlled muscle relaxants, neuropathic or joint pain relievers, from other healthcare providers and for continuity of care. I give the Healthcare Provider named above permission to speak with any and all other healthcare provider regarding my controlled substance and/or other prescriptions.
5. **I will not take more medication/increase my dose without permission:** I agree not to take more than the dose prescribed until my next visit with the Healthcare Provider listed above. For safety purposes, no significant medication changes will be made over the telephone. I will not be given more medication if I run out early or suffer a loss or theft of the controlled substances.
6. **Allergy or significant side effects to mediations:** I understand that controlled substances may cause nausea, vomiting, constipation, tolerance, dependence, addiction, respiratory depression, drowsiness, mood changes, anxiety, mental clouding, and problems with urination, jerkiness, and even death. I agree to contact the Healthcare Provider listed above if I experience any these symptoms.
7. **Monitoring of Medications Use:** I understand that controlled substances will be strictly monitored including via the Arizona Prescription Monitoring Program, random drug testing, and pill counts. I agree to present to the clinic within 24 hours of a request for random drug testing or pill counts. I agree to use only ONE pharmacy for controlled substances, and I will contact the Healthcare Provider listed above if there are any changes.
8. **Medication Theft or Loss:** I understand that the Healthcare Provider listed above will not replace lost, stolen, or spilled medications or prescriptions.

9. **Forgery, Altered Prescriptions, Giving Away, or Selling Medication is Forbidden:** I understand that this is a federal crime that is subject to prosecution.
10. **Failed Compliance:** I agree to follow the treatment plan as determined by my Healthcare Provider, including the required work-up, trying alternative treatments to controlled substances, and keeping my scheduled appointments. I will miss no more than three (3) appointments during the course of my patient-provider relationship, and refills, if required, will not be fulfilled without an appointment for medication evaluation as stipulated by the Healthcare Provider listed above.
11. **Pregnancy:** I agree to inform the Healthcare Provider listed above if I become or plan to become pregnant as controlled substances may affect the fetal health and result in dependency at birth.
12. **Safety Issues:** The Healthcare Provider listed above reserves the right to reduce or stop the controlled substances if there is a concern for the patient or involved party's safety. This includes felony charges, convictions, and/or imprisonment. I understand that the Healthcare Provider will not tolerate lies, misrepresentations, or deception as well as rude, obnoxious, threatening, or belligerent behavior to ensure the safety of the patient, clinic staff, and/or other patients.
13. **Patient Responsibility:** I have discussed the side effects and risks of the medications with Healthcare Provider listed above. I understand that taking controlled substances with sedatives (i.e., Alcohol, Valium, Ativan, narcotics, etc.) presents a significant health risk including death. I understand that abrupt discontinuation of controlled substances after 24-48 hours may result in withdrawal symptoms.
14. **Trial Period:** I agree that if a trail of controlled substances does not result in improvement and functional benefit I will taper off as directed by the Healthcare Provider listed above.

I agree and consent to the terms documented above, and I understand that violation will result in termination of the professional medical relationship between myself, the patient, and the Healthcare Provider listed above for the prescribing of controlled substances.

Print Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

Healthcare Provider's Name: _____ MRN: _____

Healthcare Provider's Signature: _____ Date: _____

Witness: _____ Date: _____

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT FOR BEHAVIORAL HEALTH SERVICES

I understand that I am eligible to receive a range of services from my Provider, Healthy Wings LLC, d/b/a Healthy Wings Family & Psychiatric Healthcare, its clinician, Dr. Jennifer Muhammad, DNP, NP-BC, a Family & Psychiatric Nurse Practitioner, its contractors, employees and/or staff (collectively referred to as my "Provider"). The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my Provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my Provider.

I am aware that I must authorize my Provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my Provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my Provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my Provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my Provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your Provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my Provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

In addition, I acknowledge that I have received the HWLLC Notice of Privacy Practices & Patient-Provider Policies.

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

Patient's/

Representative's Signature: _____ Today's Date: ____/ _____ / _____

Print Representative's

Name: _____

Print Full

Mailing Address: _____

If signed by anyone other than the patient, indicate the relationship to the patient: ____ Parent ____ Guardian ____ Agent

Healthy Wings Family & Psychiatric Healthcare 2055 E. Southern Ave., Suite B., Tempe, AZ 85282-7507; Tel: (520) 477-1815; Fax: (949) 543-2787

ASPA | Connected Community

Independent physicians working together for a healthier community

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Last & First Name: **Date of Birth:** **Today's Date:**

NAME: _____ DOB: _____ DATE: _____

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ☐ = **Add Columns** _____+_____+_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**
_____	_____	_____	_____

BEHAVIORAL/MENTAL HEALTH ASSESSMENT

NAME: _____ BIRTH DATE: _____ DATE: _____

I am here today because: _____

_____

The concerns I mentioned above are causing problems with the following (circle any that apply):

WORK:	Tardiness	Leaves early	Misses days	Takes days off
	Work performance hindered (quality, speed, and/or thoroughness)	Emotions interrupt work (crying, snapping, and/or intrusive thoughts)	Co-Workers/Supervisor noticed behavior changes	Job is in jeopardy Co-Worker Issues
SCHOOL:	Affecting attendance	Performance	Quality of Coursework	Discipline/Suspensions
	Classmates/Instructors have noticed behavior	Inappropriate behavior/emotions at school	Grades	Unable to start/finish assignments
ABILITY TO SELF-CARE:	Skipping meals	Binge eating	Eating unhealthily	Weight changes
	Not bathing, grooming, and/or dressing	Unable to maintain home/room (cleaning, shopping, or cooking)	Hoarding/cluttering	Not managing mail, phone calls, emails, and/or bills
	Not taking medications	Not following medical advice/misses appointments	Increased physical symptoms (body aches, headaches, menstrual issues, pain, stomach issues, and/or tension)	
MY RELATIONSHIPS:	Dynamics with Spouse/Partner, Children, and/or Parents	Irritated/Impatient with others	Escaping behaviors (not participating in family, social, and/or religious activities)	Withdrawn or Overly dependent on others No friends
MY SLEEP:	Unable to get to sleep	Unable to stay asleep	Sleeping too much	Waking tired
	Daytime drowsiness/fatigue	Falls asleep at work/school	Nightmares	Sleepwalking
FINANCIAL CONCERNS:	Self-destructive financial behaviors (compulsive buying, overspending, and/or gambling)	Helping others and cannot afford to help	Unemployed/Disabled	Underemployed
	Unable to afford healthcare (no insurance or high deductible)			
SUBSTANCE USE:	Increased use or abuse of: Alcohol, Cigarettes, Marijuana, and/or Drugs	Negative consequences from substance use/abuse	Others concerned about my substance use/abuse	
MY JUDGMENT:	Demonstrating poor judgment	Makes impulsive decisions	Takes self-defeating actions	Negative self-talk