

# Basic Information

First name

Middle name

Last name

Suffix

Sex

Date of birth

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

- Traveled domestically or internationally within the past 6 months.

Any other comments

## 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

# Surgical History

Please check all that apply:

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

# Healthy Wings Family & Psychiatric Healthcare

## General Consent – Page 2 of 2

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:**

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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

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

## 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*

**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 its 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): 

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Full Billing Address: \_\_\_\_\_

Billing City, State, Zip Code: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

# 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 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LAST & FIRST Name:

Date of Birth:

Today's Date:

