870 Seven Hills Dr. Suite 203 Henderson, NV 89052
Phone: (702) 463-4788
Fax: (702) 463-4789
Email: support@horizonbehavioralmedicine.com

Patient Registration Form

Patient Information

Last Name	First Name	M.I.	Phone# 1 (Home/Work/Cell)	Phone # 2 (Home/Work/Cell)
Address			Date of Birth	Marital Status
Email Address			Legal Sex □Male □Female	Social Security #
Employer/School Address			Occupation	Department
Emergency Contact			Relationship to Patient	Phone Number
Preferred Pharmacy			Please list any allergies	
How did you hear about us				

Responsible Party / Guardian Information

Last Name	First Name	M.I.	Phone# (Home/Work/Cell)	Relationship to Patient
Address			Date of Birth	Marital Status
Email Address			Legal Sex □Male □Female	Social Security #
Employer: Employer Address:			Occupation	Department

Insured Party Information - Spouse or Parent if different from Responsible Party

Last Name	First Name	M.I.	Phone# (Home/Work/Cell)	Relationship to Patient
Address			Date of Birth	Marital Status
Email Address			Legal Sex □Male □Female	Social Security #
Employer: Employer Address:			Occupation	Department

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Primary Insurance Information

Insurance Company Name	Claims Mailing Address City State Zip		Phone #
Subscriber ID#	Group Name / Number	Insured Party	Date of Birth

Secondary Insurance Information

Insurance Company Name	Claims Mailing Address City State Zip		Phone #
Subscriber ID#	Group Name / Number	Insured Party	Date of Birth

Tertiary Insurance Information

Insurance Company Name	Claims Mailing Address City State Zip		Phone #
Subscriber ID#	Group Name / Number	Insured Party	Date of Birth

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Client Questionnaire For Medication

1. Do you have a family physician ? □Yes □No
   If yes, please provide name and contact information

2. What was the date of your last checkup by a physician?

3. Do you see any other doctor(s)? □Yes □No
   If yes, please provide name, date of visit, and reason for visit(s):

4. Have you ever been hospitalized for any reason ? □Yes □No
   If yes, please provide the date and reason for hospitalization(s)

5. Do you currently have any physical illness ? □Yes □No
   If yes, please provide the date and reason for hospitalization(s)

6. Do you currently take any medications for any reason ?
   If yes, please provide the following

Name of the Medication	Dosage	Reason Taken	Date Prescribed

7. Are you allergic to any medications ? □Yes □No
   If yes, please provide the name of any such medication and any effect on the client:

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8. Have you ever had a negative reaction to psychiatric medication ? □Yes □No
If yes, please provide the name of any such medication and any effect on the client:

9. If applicable have you gone through menopause? □Yes □No

10. If applicable, are you currently pregnant or attempting to get pregnant ? □Yes □No

11. Please check all health-related issues experienced currently or in the past related to the following:

	NOW	PAST		NOW	PAST
Headaches	____	____	Heart	____	____
Head Injury	____	____	Blood Pressure	____	____
Seizures	____	____	Diabetes	____	____
Loss of Consciousness	____	____	Breathing	____	____
Memory	____	____	Thyroid	____	____
Vision	____	____	Liver	____	____
Rashes	____	____	Stomach	____	____
Infections	____	____	Weight Loss	____	____
Bones & Joints	____	____	Weight Gain	____	____
Anemia	____	____	Constipation	____	____
Urination	____	____	Diarrhea	____	____

12. Please provide any additional information related to your medical history or current medical conditions:

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Provider and Patient Services Agreement

Dear Valued Patient,

Horizon Behavioral Medicine regards the patient-provider relationship with the utmost reverence, and we thank you for entrusting us with your mental health care. Communication is at the center of our care, and this Agreement explains how we will work together. You may revoke this Agreement in writing at any time. Please bring up any questions you have during your appointment.

Office Hours: Horizon Behavioral Medicine's office hours are Monday - Saturday 8:00AM to 5:00PM.

Appointment: Patients are seen on an appointment-only basis during office hours. Horizon Behavioral Medicine does not offer walk-in appointments, however we will try to accommodate your scheduling needs whenever possible. Please call our office during business hours to schedule an appointment or request an appointment via Email or Contact Form available on our website horizonbehavioralmedicine.com.

Cancellation Policy: Please call Horizon Behavioral Medicine promptly if you are unable to attend an appointment, so that we can give another person the ability to have access to timely mental healthcare. Please note that if appointment is cancelled with less than 24 hours notice, you may be subjected to a cancellation fee.

Late Policy: Please arrive on time for your appointment. Patients arriving more than 15 minutes late may be asked to reschedule.

Emergencies: All patients are strongly urged to call 911 or go to the nearest hospital emergency room should they become acutely symptomatic or experience suicidal or homicidal thoughts.

Contacting Our Office: Questions regarding your treatment or medication should be addressed during your visit. If you need to report medication effects or changes in your symptoms prior to your next visit, you must explain in detail your situation when you contact our office and the front office will do their best to assist you.

Phone Calls and Email: If you have questions that were not covered during your visit and cannot wait until your next visit, you may reach out to the clinical director via email or leave a detailed message with the front office staff. If the issue is urgent, you may call our office to schedule an urgent visit in the next available time slot. Please let the front desk staff know what you are experiencing so we can determine if the problem can be addressed over the phone.

Payment and Billing Policy: Horizon Behavioral Medicine accepts payment by cash, ATM or Credit Card. Payment is due at the time of your appointment. If we are an in-network provider for your insurance, we will collect the portion of your fee that insurance does not cover. If your account is not paid in a timely manner, Horizon Behavioral Medicine has the option of using legal means to secure the

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payment. This may involve hiring a collection agency. If there is a change in your insurance coverage, your address, or other important information between appointments, please let us know when you check in.

Medication Policy: Prescription refills require close monitoring by your provider to ensure the safe continuation of the appropriate dose, frequency and term of that medication. For this reason, Horizon Behavioral Medicine requires that you keep scheduled appointments to continue receiving refills for medication. We will not respond to automated refill requests that are faxed from the pharmacy. It is your responsibility to schedule an appointment prior to running out of medication. Our schedule fills up quickly and we strongly recommend booking your follow-up appointment at the conclusion of each visit. If appointments are missed or repeatedly rescheduled, a follow-up appointment is warranted before giving refills. If your medication is lost, misplaced, or stolen, they will not be automatically replaced. They may be replaced only at the discretion of your provider. Failure to comply with any of these conditions listed above could result in a delay or termination of medication services from Horizon Behavioral Medicine. Our providers participate in the Nevada Prescription Monitoring Program.

Prior Authorizations For Medications: Some insurance plans require prior authorization for medications that are prescribed to you. If your insurance plan requires a prior authorization, please request your pharmacy to FAX the required information to our office (702) 463 4789. It is ultimately up to your insurance carrier to determine coverage for medications. The processing time for prior authorizations varies, in some cases it may take up to 1-2 weeks. If you have questions about your pharmacy benefits, please contact your insurance carrier directly.

Adhering to the Treatment Plan: You're expected to follow the treatment plan which is developed collaboratively with you. This includes taking prescriptions as recommended by your provider, not to make dosage/frequency changes without your provider's knowledge and/or consent, not to give your medication to other people, keeping appointments and following through with referrals to therapists and other healthcare providers.

Forms and Letter: Due to clinical responsibilities, our providers and clinical staff are unable to complete disability forms during a patient office visit or while patients wait. For compliance purposes, the patient information portions of the form must be completed and signed prior to acceptance. Once we have reviewed your form(s) and your signed authorization to release your medical information, we will process the request. Completing paperwork for schools, FMLA claims, life insurance, disability claims or other purposes goes beyond routine medical care, and it cannot be billed to your insurance company. For this reason, there is a processing fee to cover administrative expenses and staff time, which must be collected at the time of request. Please be advised that if your short-term disability provider is not responsible for reproducing and delivery of medical records, then payment requests will be directed to the patient. Our staff make every effort to complete forms quickly; however they are completed in the order they are received, and the general turnaround time for completion is 5-14 business days. Horizon Behavioral Medicine will not fill out long term disability forms. A copy of the form will be maintained within your permanent personal record.

Continuation of Services: Grounds for dismissal from Horizon Behavioral Medicine include abuse of medications, failure to follow your treatment plan, missing appointments, repeatedly rescheduling or cancelling appointments and failing to pay your bill in a timely manner or being belligerent to Horizon

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Behavioral Medicine staff.

Online Review Policy: We greatly value patient feedback and appreciate that online reviews are a useful tool that consumers use to educate themselves and select medical services. However, please be aware, unlike other businesses who may respond freely to online reviews, as medical professionals, we must, and do, provide complete confidentiality to our patients. That means we are prohibited from responding in any way that acknowledges whether someone has been in our care. When responding to reviews, a response will be written as general as possible. No treatment, diagnosis or other aspects of your visit should be discussed on a third-party site such as Google and Yelp. Furthermore, Horizon Behavioral Medicine will not privately message you or give medical advice online. Horizon Behavioral Medicine takes your feedback seriously. If you have an issue that needs attention, we would like to hear from you directly. We welcome our patients to contact us at (702) 463 4788 to discuss any questions or concerns. Although HIPAA rules apply to a medical clinic, our patients are not bound by them. If you submit or post a review detailing your medical history, diagnosis, and treatment, Horizon Behavioral Medicine will not be responsible for information you voluntarily disclose.

Minor Patients: A parent or legal guardian must accompany patients who are minors on each patient's visit. This accompanying adult is responsible for payment of the account. Parental consent is required for all minor patients.

Confidentiality: Your privacy is important to us. All information is guarded by strict confidentiality and in accordance with HIPAA regulations. In most cases, Horizon Behavioral Medicine will obtain your consent prior to releasing any PHI; however, records and/or PHI may be released regardless of consent in the following circumstances:

- In cases of past or present suspected child abuse or neglect, a report must be made to Child Protective Services.
- In cases of abuse or neglect of 1) an individual older than age 60; or 2) a disabled individual; or 3) individuals adjudicated legally incompetent, a report must be made to local law enforcement agencies.
- For cases in which you are in imminent risk of harming yourself, or others, or you need hospitalization, confidentiality may be suspended in order to protect you or others, and to treat the mental illness.
- If you appear to have been injured by a knife, firearm, or burn, such information must be reported to the applicable local law enforcement or local fire department agencies.
- Confidential information may also be disclosed when required by a valid court order or subpoena signed by a judge or magistrate, including but not limited to, cases in which a court orders a psychological evaluation.
- Horizon Behavioral Medicine may share confidential information about a deceased individual to the executor of the deceased's estate, or if your mental health information is necessary to determine the validity of a will.
- For cases in which your confidential information is part of a government investigation or hearing, including but not limited to, investigation conducted by the Nevada Board of Medical Examiners.

Professional Records: The laws and standards of our profession require that we keep protected health information (PHI) about you in medical records. Except in unusual circumstances that involve danger to

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yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Horizon Behavioral Medicine requires your written consent in order to release/obtain information. Information release forms are available on our website horizonbehavioralmedicine.com. Insurance companies can request and receive a copy of your clinical record.

Patient Rights:
As recipients of Horizon Behavioral Medicine, you are entitled to the following rights:

- To receive services without regard to your race, color, religion, sex, age, material status, natioal origin, veterans status, or disability.
- To be treated with respect, consideration, and dignity.
- To receive prompt, appropriate treatment and services, in accordance with the laws and standards governing the healthcare industry.
- To inquire and learn about the professional skills and qualifications of your clinician.
- To participate in the planning and periodic review of your individual treatment plan.
- To be informed of all of your rights as a patient.
- To refuse any form of treatment.
- To be informed about available treatment options and the effectiveness of any such options.
- To have your conversations and communications with your provider remain confidential, to the extent permitted by laws and professional standards.
- To receive a copy of your medical record, in accordance with our policies and procedures.
- To receive information about the methods available to file a complaint or grievance regarding our provision of services to you, and know that you will not be retaliated against for filing any such grievance.
- To receive a copy of this Patient Rights at any time.

Authorization For Treatment

I hereby authorize Horizon Behavioral Medicine to perform any and all forms of treatment, medication, and therapy that are indicated and in accordance with the Standards of Psychiatric Care. I hereby authorize Horizon Behavioral Medicine to furnish information to the insurance carriers concerning my illness and /or treatment and hereby assign to the providers all payment for medical services rendered to myself, the patient. I understand that I am responsible for any amount not covered by insurance and agree to the above office policies and financial agreement.

_____

Patient/Guardian Name(Print)

_____ _____

Patient/Guardian Signature Date

Debit/Credit Card Payment Authorization Form

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We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. Please sign and complete this form to authorize Horizon Behavioral Medicine to make one time/multiple debit(s) to your credit card listed below. By signing this form, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from Horizon Behavioral Medicine including those covered by my insurance. As a convenience, Horizon Behavioral Medicine will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if Horizon Behavioral Medicine determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. Horizon Behavioral Medicine may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service
4. It is my responsibility to provider my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide Horizon Behavioral Medicine and its designated payment agent with my debit/credit card information.
6. I understand that my signature and payment information will be maintained on file for future use by Horizon Behavioral Medicine.
7. I authorize Horizon Behavioral Medicine and its designated payment agent to apply charges to my payment card for all amounts owed to the practice for medical visits including (i) amounts agreed as part of a payment plan (ii) co-payments (iii) coinsurance (iv) amounts not covered by insurance and (v) fees if applicable charged by the practice for failure to keep a scheduled appointment.
8. I will not be provided with advance notice of payments authorized hereunder for transitions up to an amount specified by me. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
9. I authorize Horizon Behavioral Medicine and its designated payment agent to send electronic invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice.
I agree to notify the practice in writing of any changes in my payment or other information.

Card Holder's Name (as it appeas on card)	**Card Holder's Email Address**		
Card Holder's Billing Address	**City**	**State**	**Zipcode**

Cardholder's Signature

Date