Grande Integrated Wellness Services
Suite 3 & 4, 201 E Cottonwood Lane
Casa Grande AZ 85122

Patient Forms

Basic Information

Full Name
First Middle Last Suffix

Sex ○ Male ○ Female ○ Unknown

Date of Birth

Primary Phone ○ Home ○ Mobile ○ Work

Phone Number

Email

Social Security Number

Address Line 1

Address Line 2

City

State Zip

Marital Status

Maiden Last

Driver's License State

Driver's License #

Demographics

Sexual Orientation

Gender Identity

Hispanic or Latino? ○ Yes ○ No ○ Decline to Specify

Ethnicity

Race

Language

Emergency Contact

Relationship to Contact

Full Name
First Middle Last

Primary Phone ○ Home ○ Mobile ○ Work

Phone Number

Email

Address Line 1

Address Line 2

City

State Zip

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company

Policy Number

Insurance Plan

Insurance Phone Number

Group Number

Insurance Company Address

Address Line 2

City

State

Zip

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name

First

Middle

Last

Sex ○ Male ○ Female ○ Unknown

Date of Birth

Insurance ID Number

Social Security Number

Policy Holder Address

Address Line 2

City

State

Zip

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name

Pharmacy Address

How did you hear about us?

INFORMED CONSENT FOR TREATMENT

Grande Integrated Wellness Services (GIWS) LLC cannot give you legal advice on informed consent. The following is a sample for illustration purposes. Please consult your lawyer for advice on appropriate informed consent form for your practice.

I hereby request that ______________________________ DOB ______________________ and
Participant Name   Date of birth

Residing at: ____
Street Address   City   State   Zip code

Be accepted for Psychiatric, mental health, or alcohol and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from GIWS.
2. I have been given information regarding my rights and responsibility as a participant.
3. I have been given information regarding the limits of confidentiality of my records.
4. I understand that I may address any concerns or grievances with my therapist or any other representative of GIWS at any time. I understand that I may also contact the licensing board, which regulates my therapist professional practice.
5. I am freely choosing to enter treatment, and I understand that I may discontinue treatment any time.
6. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternative.

Signature of participant or Legal Consenter __________________________ Date ___________

Witness ____ Date ____________

PARENT OR GUARDIAN: I ____ do hereby state that I am the parent or Legal Guardian natural parent or legal guardian of the participant; therefore, I am authorized to make this request for and given my consent to the treatment and services mentioned in this form.

Signature of Participant ______________________________________ Date ____________

Module 1- Orientation and Introduction.

Limits of Confidentiality and Group Confidentiality.

I understand information that I disclose to Grande Integrated Wellness Services (GIWS) LLC (GIWS) is considered confidential.

However, information may be shared without my consent in event of the following:

1. The GIWS considers you to be a danger to yourself.
2. THE GIWS considers you to be a risk to safe and secure operations of the facility.
3. THE GIWS suspects abuse, neglect or exploitation of a child, if that child is still under the age of 18 years.
   The GIWS suspects abuse and/or neglect of an elder, or other vulnerable person, and reporting is required.
4. The GIWS has a court order that requires disclosure of protected health information.
5. Per state code regarding the exchange of medical and mental health information records (when applicable)

I also understand that information I acquire through group participation at .... will be held in confidence.

I agree to respect the privacy of other group members by not sharing information I acquire in groups.

Acknowledgement		
My signature below indicates that I have been advised of, and understand, the limits of confidentiality as well as the importance of respecting the privacy of others.		
....	....	....
Patient Signature	Patient Number	Date/Time
☐ Patient refuse to sign (will result in exclusion from program).		

Your Right As a Patient

Grande Integrated Wellness as an organization shall ensure that:

1. As a patient, you are treated with dignity, respect, and consideration;

2. As a patient, you are not subjected to:
a. Abuse;
b. Neglect;
c. Exploitation;
d. Coercion;
e. Manipulation;
f. Sexual abuse;
g. Sexual assault;
h. Except as allowed in R9-10-1012(B), restraint or seclusion;
i. Retaliation for submitting a complaint to the Department or another entity; or
j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and

3. A patient or the patient's representative:
a. Except in an emergency, either consents to or refuses treatment;
b. May refuse or withdraw consent for treatment before treatment is initiated;
c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
d. Is informed of the following:
i. The outpatient treatment center's policy on health care directives, and
ii. The patient complaint process;
e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
i. Medical record, or
ii. Financial records.

C. A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;

GRANDE INTEGRATED WELLNESS SERVICES

PATIENT RULES

- NO DRUGS/ALCOHOL OR WEAPONS ARE PERMITTED IN THE CLINIC. Anyone caught with these items in their possession must dispose of them or else they will be escorted off the premises.
- Anyone caught using and exchanging drugs/drug paraphernalia outside will not only be kicked off campus, but also puts themselves at risk of law enforcement involvement.
- Staff has the authority to conduct random bag and pocket searches daily.

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Client Signature

FOR MGT: Grande Integrated Wellness Services

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Winston Onyeani - Manager