Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

Member's Name	SSN	DOB

Address, City, State Zip	Phone

I have received a copy of the Southwest Behavioral and Health Services Consent Packet, summarized below. I understand each form as they have been presented to me and agree to expectations and guidelines. I have been offered the opportunity to review the below consent forms and understand that I have the ability to ask questions to my satisfaction as part of the SB&H intake process. I understand that a copy of this page will be placed in my clinical record to show that I received the contents of this document.

☐ Consent for Evaluation and/or Treatment (SB&H Handbook)

I hereby attest and acknowledge that I have read this entire consent for evaluation and/or treatment agreement and expressly declare, confirm and certify that I have the authority to execute this agreement on behalf of myself or applicable minor pursuant to any and all of the terms and conditions identified as expressed within this Agreement. I have had ample opportunity to review the contents of this Agreement and hereby authorize SBH to proceed based upon my authority to grant SBH the ability to evaluate and/or treat myself or applicable minor. I unequivocally expressed and represented my ability and authority to grant SBH the right to so proceed.

☐ Informed Consent to Participate in Telehealth Services (SB&H Handbook)
☐ I agree ☐ I do not agree to participate in telehealth services

☐ Consent for Communication ☐ Email ☐ Voicemail ☐ Text Messages

☐ Attendance Guidelines Agreement (SB&H Handbook)

☐ Health Plan Member Handbook Acknowledgement (links in SB&H handbook)

☐ Payment Agreement: *I give my consent for SBH to bill my insurance carrier for services provided per the Notice of Privacy Practices referenced below. I elect to receive services with the understanding that I <u>may</u> be personally responsible to pay for the service being rendered to me.* (SB&H Handbook)

☐ SB&H Member Handbook Acknowledgement *(Program Responsibilities, List of Available Services at SB&H, Service Planning, Transition/Discharge Planning, Fees, Safety, SB&H Code of Ethics, SB&H Notice of Privacy Practices, AHCCCS Notice of Privacy Practices, Confidentiality of Substance Abuse Records, Rights of Persons Served, Additional Rights for Inpatient or Residential Treatment Facilities, Legal Rights for Persons with Serious Mental Illness, Notice to Persons with Serious Mental Illness, Notice to Individuals Receiving Substance Abuse Services, Grievance, Appeal and Complaint Policy and Procedure*). **Bureau of Medical Facilities Licensing**: 602-364-3030; **Bureau of Residential Facilities Licensing**: 602-364- 2639

Signature of Member	Date

Signature of Parent, Guardian, or authorized representative (when required)	Date
Witness (Staff) Signature	Date

Member's Name: DOB:

Authorization to Release Substance Abuse Disorder Records for Payment/Operations

I, _____ _____ _____
Member's Name SSN DOB

_____ _____
Address, City, State Zip Phone

Authorize Southwest Behavioral Health Services to release to: (Check all that apply)

☐ AHCCCS for disclosure of my demographics

☐ Payment for my treatment to my Health Plan

☐ AzComplete Health ☐ Banner University ☐ Care1st ☐ Health Choice
☐ United Healthcare ☐ Mercy Care ☐ Magellan

☐ Other: _____ (Please specify)

The purpose of this release is to provide only the necessary information for payment of services to your health plan and/or to provide demographics to Arizona Health Care Cost Containment System (AHCCCS).

Notice to Recipient

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a Member as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any Member with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

I understand that at any time, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the SBH Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164).

Authorization will expire:

☐ 1 Year From this Date

☐ Other: _____ (Enter Date, no greater than 1 year)

_____ _____
Signature of Member Date

_____ _____
Signature of Parent, Guardian, or authorized representative (when required) Date

Member's Name: _____ *DOB:* _____

Southwest Behavioral & Health Services

Release of Information and Records Request Form

Please check only **ONE** of the following options:

☐ Check here if you would like to **Release/Send** your records ☐ Check here if you would like to **Request** your records

☐ Check here if you would like to **both Release AND Request** your records

How would you like to receive your records? Please select: ☐ Mail ☐ Digital format via Mail (50 page minimum required) ☐ Email: _____

Dates of Service (for records to be sent): ☐ past 60 days ☐ past 90 days ☐ past year

☐ Other (list date range): _____ to _____

I, _____ _____ _____

Member's Name SSN DOB

_____ _____

Address, City, State, Zip Phone Number

Authorize releases, and/or record requests as selected herein between:

Southwest Behavioral & Health Services — 602-265-8338

Name of Healthcare Organization with Treatment Relationship — Phone Number

3450 N. 3rd Street, Phoenix, AZ 85012 — 602-323-2351

Address, City, State, Zip — Fax Number

AND

_____ _____

Name of Person and Agency (Recipient) Phone Number

_____ _____

Address, City, State, Zip Fax Number

Notice to Recipient: This information has been disclosed to you from records that Federal law protects. These records are not subject to redisclosure. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of Substance Abuse information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. I understand that if this information is released to the indicated third party, the third party may not follow the Federal privacy laws and my personal health information may be released by the third party. **Treatment, payment, and/or enrollment is not conditioned upon whether the member signs this consent.**

Note: Federal and state government rules require a separate authorization be completed for each of the following categories: Information on HIV/AIDS and other communicable diseases, and Alcohol/Substance Abuse Records.

What kind information would you like released and/or requested as selected herein? Check all that apply:

☐ Clinical Assessment	☐ Psychiatric Evaluation	☐ Medications
☐ Clinical Services Notes	☐ Treatment/Service Plans	☐ Test Results/Labs
☐ Discharge Summary	☐ Substance Use Information	☐ AIDS/HIV Information
☐ Psychological Assessment	☐ Verbal disclosure of treatment information	☐ School Records

☐ Other (Please specify i.e. billing records, treatment summary, etc): _____

Purpose for Release/Request: _____

A purpose for the request/disclosure is required for all 3rd party releases only. This section identifies to the authorized party and signer why the records are being requested and/or what the records will be used for. The purpose is not required when members are requesting their own records. **I understand** that at anytime, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the SBH Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164).

Authorization will expire:

☐ 1 Year From this Date

☐ Other: _____ (Enter Date, no greater than 1 year)

_____ _____

Signature of Member/Guardian/Authorized representative Date

_____ _____

Other Required Signature (If Applicable) Witness (if Member is unable to sign)

***If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required.**

Southwest Behavioral & Health Services Cover Sheet

Member's Name | Member SS# | DOB

Address, City, State Zip | Phone | Email

Gender: ☐ Gender Variant ☐ Male ☐ Female ☐ Intersex ☐ Questioning ☐ Transgender ☐ Decline to answer

Race: ☐ American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ Caucasion ☐ Native Hawaiian ☐ Decline to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to answer

Primary Language | Preferred Language

Insurance Coverage: *Attach a copy of medicaid, medicare, commercial and other insurance cards*

☐ Medicaid ☐ Medicare ☐ Private (Self-pay) ☐ TriCare ☐ Blue Cross ☐ HMO ☐ Other

Insurance Co. | Insurance ID# | Policy#

Special Needs:

Interpreter (spoken)	☐ No	☐ Yes, specify language	
Translator (written)	☐ No	☐ Yes, specify language	
Mobility Assistance	☐ No	☐ Yes, identify assistance needed	
Visual Impairment Assistance	☐ No	☐ Yes, identify assistance needed	
Hearing Impairment Assistance	☐ No	☐ Yes, identify assistance needed	
Need Childcare Arrangements	☐ No	☐ Yes, identify need	

Are there known impairment(s) that require special assistance to participate in the assessment/service planning process. ↓

Key Contacts: ☐ No ☐ Yes

If applicable, select custody arrangement ☐ Sole ☐ Joint ☐ Ward of Court (DCS) or Legal Guardian

Parent/Legal Guardian(s): Phone

Must provide current legal document Phone

Phone

Phone

Emergency Contact: Phone

Complete ROI Address

PCP/Physician: Phone Fax

Complete PCP ROI Address

Dentist: Phone Fax

Other Healthcare Specialist(s): Phone Fax

(e.g. Mental health, substance use, OBGYN, neuro, pain, naturopath, etc) Address

Phone Fax

Address

Pharmacy: Address

Other Key Contacts: *(e.g. school, probation/parole officer, other involved agencies [DDD/DCS], significant other, neighbors, family)*

Name: Relationship:

Phone: Fax:

Name: Relationship:

Phone: Fax:

Personal Information

☐ Initial _____ *(Date)* ☐ Update _____ *(Date)*

Please fill out the following information on the individual requesting services.

Current Employment:	Household size: ☐ Monthly Income: _____ Select any that apply: ☐ Job searching ☐ Military ☐ Volunteer ☐ Homemaker ☐ Student
Educational/Vocational Training:	Highest Grade or Degree completed _____ Do you need help reading or writing? ☐ No ☐ Yes Have you ever been told that you or your child has a developmental delay or special education needs? ☐ No ☐ Yes Did you or your child receive special education services? ☐ No ☐ Yes If yes, please identify testing, special evaluation, special classes, IEP/504, alternative school, change of teacher, etc.

Legal Involvement and Significant Events

Current Legal Status/ Other pending Legal or Civil Issues (e.g. appointed guardian, court ordered treatment, ward of the state, divorce, DCS involvement custody issues, probation, parole, pending charges):

Number of arrests in past 30 days: _____ For what specific offense(s):

Has child/adult protective services or police been involved? ☐ No ☐ Yes

Medications (Please include any current and previous medications)

Current *Medication* (s)	*Reason for Medication*	*Is Medication effective? If no, please explain.*
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
Previous *Medication(s)*	*Reason for Medication*	*Was Medication effective? If no, please explain.*
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

Please list all over-the-counter medications and/or herbal supplements that you take:

Member's Name: _____ *DOB:* _____ Return to Intake Checklist

Southwest Behavioral & Health Services Youth Health Risk Assessment

Member's Name | Member SS# | DOB

Address, City, State Zip | Phone | Email

Substance Related Disorders Screening ☐ Adult (18+) ☐ Youth (0-17) As appropriate, ask the youth these questions

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	☐ No	☐ Yes
Do you ever use alcohol or drugs while you are by yourself alone?	☐ No	☐ Yes
Do you ever forget things you did while using alcohol or drugs?	☐ No	☐ Yes
Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	☐ No	☐ Yes
Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐ No	☐ Yes
Have you ever gotten into trouble while you were using alcohol or drugs?	☐ No	☐ Yes

Who in your family uses alchohol or other substances?

Please list any history and treatment of behavioral health or substance use issues that your family members have had:

Youth Health Risk Screening Questionnaire

Have you been diagnosed with diabetes or asthma? ☐ No ☐ Yes

If yes, what medications are you taking for this?

Check the symptoms the youth experiences regularly:

☐ Headaches ☐ Dizziness ☐ Nausea/Vomiting ☐ Persistent cough or wheezing

☐ Extreme Fatigue ☐ Blurry Vision ☐ Over/Under Weight ☐ Other:

Does the youth eat a poor diet?	☐ No	☐ Yes
Is the youth sedentary or minimally active?	☐ No	☐ Yes
Is the youth up to date on immunizations?	☐ No	☐ Yes
Does the youth use tobacco or are they exposed to second hand smoke?	☐ No	☐ Yes

If yes, what and how often?

☐ Vape ☐ Cigarettes ☐ Chew ☐ Other:

☐ Daily ☐ Weekly ☐ Occasionally ☐ Other:

Health History (Please include all medical, dental, and behavioral health history)

☐ PCP on file Date of last Physical Visit Current health issues

Any Allergies? ☐ No ☐ Yes Please Specify

☐ Dentist on file Date of last Dental Visit Current oral issues

☐ Other: Date of last Visit Other health issues

☐ Other: Date of last Visit Other health issues

Untreated physical and/or behavioral needs can impact overall health and negatively impact progress toward Goals.

A PCP appointment is recommended for further evaluation.

Would you like help with the above or other physical health needs? ☐ No ☐ Yes

Return to Intake Checklist