Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

Member's Name   SSN   DOB

Address, City, State Zip   Phone

I have received and have had the opportunity to review 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 ask questions to my satisfaction. 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.

- [X] Consent for Evaluation and/or Treatment (SB&H Handbook)
- [X] Informed Consent to Participate in Telehealth Services (SB&H Handbook)
  - [X] I agree [ ] I do not agree to participate in telehealth services
- [X] Consent for Communication [X] Email [X] Voicemail [X] Text Messages
- [X] Attendance Guidelines Agreement (SB&H Handbook)
- [X] Health Plan Member Handbook Acknowledgement (links in SB&H handbook)
- [X] 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 understand that if I have AHCCCS and another insurance plan, AHCCCS requires SBH to bill any/all of my other insurance carriers prior to billing AHCCCS. I authorize my insurance carrier(s), including Medicare, to submit payment directly to SBH.*
- [X] SB&H Member Handbook Acknowledgement *(Program Responsibilities, 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)

[X] AHCCCS for disclosure of my demographics

[X] 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:

[X] 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:* ____________

Advance Directive Durable Mental Health Care Power of Attorney Form

General Instructions: You may use this Advance Directive Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. **The decision about whether you are incapable can only be made by an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent.** Be sure you understand the importance of this document. Talk to your family members, friends, program staff members and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form.

If you decide this is the form you want to use to develop an Advance Directive Durable Mental Health Care Power of Attorney, complete the form. Do not sign the form until your witness or notary and a program staff member are present. You will be asked to place a copy of the form in your clinical record so that we and other providers will follow your wishes if you become incapacitated. You and your representative should retain a copy of this document for your future reference. **At a minimum, you and an SBH Staff Member must sign #2 or #3 below to confirm that you understand your rights and you have been offered a copy of the form.**

1. Information about me:

Name: ____________________ Age: ________

Address, City, State Zip: ____________________ Date of Birth: ________

Telephone: ____________________

2. I decline to exercise my Advance Directive Durable Mental Health Care Power of Attorney at this time. If I choose to exercise this right, at a later time, I will notify the SBH staff member who is responsible for coordinating my services.

____________________ ________

Signature of Member Date

____________________ ________

SB&H Staff Member Date

3. My Advance Directive Durable Mental Health Care Power of Attorney is made pursuant to Arizona law, and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to Arizona law.

____________________ ________

Signature of Member Date

____________________ ________

SB&H Staff Member Date

4. Notification to Primary Care Physician (SBH personnel only)

☐ Mailed ☐ Faxed ☐ Emailed Date: ________ By whom: ________

Note: Retain copy in person's comprehensive clinical record (Do not purge from record).

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

[X] 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:

[X] Clinical Assessment [X] Psychiatric Evaluation [X] Medications
[X] Clinical Services Notes [X] Treatment/Service Plans [X] Test Results/Labs
[X] Discharge Summary [X] Substance Use Information [X] AIDS/HIV Information
[X] Psychological Assessment [X] Verbal disclosure of treatment information [X] 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 [ ] in 6 Months (Substance Use Services only)

[ ] Other: / / (Enter Date, no greater than 1 year/6 months for substance use services)

______ ______
Signature of Member/Guardian/Authorized representative | Date

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

***Parent/legal guardian signatures are required for substance use information for members 12-17 years of age.**

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. ↓ ☐ No ☐ Yes

Key Contacts:

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	Please Select	
	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

Integrated Health Information (12 and older)

Member Name: First__________________Middle___________Last__________________Date of Birth:_____/____/_____

Preventive Care					
	Date		Date		Date
Annual physical		Prostate screen		Cholesterol test	
Colonoscopy/FIT test		Pap screen		Diabetes screen	
Bone density		Mammogram		Eye exam	
Dental exam					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		COVID	

Allergies or intolerances to medications?	
Name	Reaction

Please circle all current or past medical problems or conditions.		
Heart Failure	High Blood Pressure	ADD/ADHD
Chronic Lung Disease	Hyperthyroidism	Seasonal Allergies
Heart Artery Disease	Hypothyroidism	Anemia
Depression	Kidney Disease	Anxiety
Diabetes Type 1	Migraines	Arthritis
Diabetes Type 2	Heart Attack	Asthma
Emphysema	Stomach/Intestine Ulcers	Bipolar Disorder
Heartburn	Seizures	Blood Clots
Glaucoma	Sexually Transmitted Infection	Blood Transfusion
Heart Murmur	Stroke	Cancer
HIV/AIDS	Substance Abuse	Cataracts
High Cholesterol	Valley Fever	

Member Name: First__________________Middle___________Last__________________Date of Birth:_____/____/_____

Please circle all major operations or surgeries.		
None	Colon	Joint Replacement
Appendectomy	Coronary Artery Stent	Spine
Breast Augmentation	Cosmetic Surgery	Thyroid Surgery
Breast Surgery	Eye	Tonsillectomy
Cesarean Section	Fracture Repair	Tubes Tied
Heart Bypass	Hernia repair	Heart Valve surgery
Gallbladder	Hysterectomy	Ovaries

Hospitalizations		
Reason	Year	Comments

Major Injuries		
Type	Year	Comments

Family Medical History – Please check the appropriate box if a condition is/was present.

	Alcohol Abuse	Anxiety	Asthma	Breast Cancer	Colon Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Heart Attack	High Blood Pressure	High Cholesterol	Kidney Disease	Other Cancer	Prostate Cancer	Stroke	Vision Loss	Alzheimer's	Other
Father																				
Mother																				
Paternal Grandfather																				
Paternal Grandmother																				
Maternal Grandfather																				
Maternal Grandmother																				
Siblings																				
Children																				

Member Name: First______________________Middle___________Last__________________Date of Birth:_____/____/_____

Social History											
Alcohol Use – Please circle your response.											
Glasses of wine per week	0	1	2	3	4	5	6	7	8	9	10+
Cans of beer per week	0	1	2	3	4	5	6	7	8	9	10+
Shots of liquor per week	0	1	2	3	4	5	6	7	8	9	10+
Mixed drinks with 0.5 ounces alcohol per week	0	1	2	3	4	5	6	7	8	9	10+

Sexual Activity – Please check your response.

Sexually active? ☐ Currently ☐ Never ☐ Not Currently

Sexual Partners? ☐ Men ☐ Women ☐ Both

Birth control used? ☐ Pulling out ☐ Condom ☐ Diaphragm ☐ Implant ☐ Inserts ☐ IUD
☐ The Pill ☐ Patch ☐ Rhythm ☐ Spermicide
☐ Sponge ☐ Surgical ☐ Not applicable

Drug Use – Please check your response.

☐ None ☐ Amphetamines ☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Cocaine
☐ Heroin ☐ Marijuana ☐ Methamphetamines ☐ PCP ☐ Huff Gasses

Tobacco Use – Please check your response.

☐ Smoke every day ☐ Smoke some days ☐ Former smoker ☐ Heavy smoker
☐ Light smoker ☐ Never smoked ☐ Second-hand exposure

If ever smoked/vaped, how many cigarettes/day average? ☐ 0 ☐ 1-10 ☐ 11-20 ☐ More than 20
How many years smoked?

You ever chewed? ☐ Yes ☐ No

If you currently use any tobacco product, are you ready to quit? ☐ Yes ☐ No

Physical Activity – Please check your response.

How many minutes per week do you do physical activity of moderate to vigorous intensity?

☐ None ☐ Less than 90 minutes/week ☐ More than 90 minutes/week

GAD-7 Anxiety – Please circle your response

Over the <u>last two weeks</u>, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult

Patient Name: First___________________Middle___________Last__________________Date of Birth:_____/____/_____

Patient Health Questionnaire (PHQ-9) – Please circle your response				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Littlie interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better of dead, or of hurting yourself	0	1	2	3
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 difficult	Somewhat difficult	Very difficult	Extremely difficult