

Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

Member's Name	SSN	DOB
Address, City, State Zip	Phone	e

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 X X X X	Consent for Evaluation and/or Treatment (SB&H Handbook) Informed Consent to Participate in Telehealth Services (SB&H Handbook) X I agree I do not agree to participate in telehealth services Consent for Communication X Email X Voicemail X Tex Attendance Guidelines Agreement (SB&H Handbook) Health Plan Member Handbook Acknowledgement (links in SB&H handboo Payment Agreement: <i>I give my consent for SBH to bill my insurance carried</i> <i>the Notice of Privacy Practices referenced below. I understand that if I hav</i> <i>insurance plan, AHCCCS requires SBH to bill any/all of my other insurance of</i> <i>AHCCCS. I authorize my insurance carrier(s), including Medicare, to submitt</i> SB&H Member Handbook Acknowledgement (Program Responsibilities, Se <i>Transition/Discharge Planning, Fees, Safety, SB&H Code of Ethics, SB&H Ne</i> <i>AHCCCS Notice of Privacy Practices, Confidentiality of Substance Abuse Referenced</i> , Additional Rights for Inpatient or Residential Treatment Facilities, with Serious Mental Illness, Notice to Persons with Serious Mental Illness, Notice to Persons with Serious Mental Illness, For Medical Facilities Licensing: 602-364-3030; Bureau of Residential Facilities Licens	for services provided per e AHCCCS and another carriers prior to billing payment directly to SBH. ervice Planning, otice of Privacy Practices, cords, Rights of Persons Legal Rights for Persons Notice to Individuals cy and Procedure). Bureau
	Signature of Member	Date
Signat	ture of Parent, Guardian, or authorized representative (when required)	Date

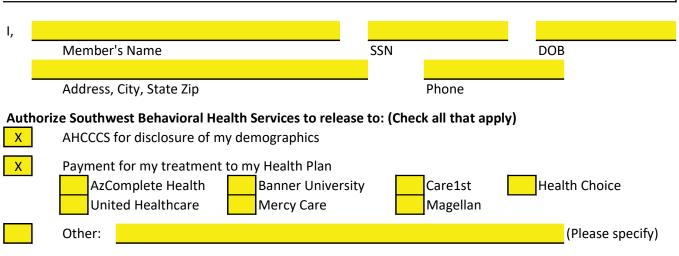
Witness (Staff) Signature

Member's Name:

Date



Authorization to Release Substance Abuse Disorder Records for Payment/Operations

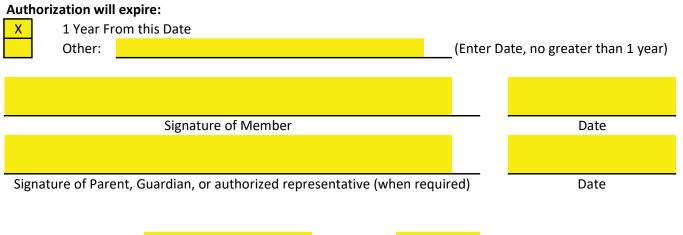


The purpose of this release is to provide only the necessary information for payment of services to your health plan and/or to provide demographics to Arizona Health Care Cost Containment System (AHCCCS).

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).



DOB:

Advance Directive Durable Mental Health Care Power of Attorney Form

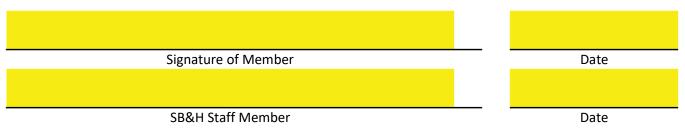
General Instructions: You may use this Advance Directive Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. **The decision about whether you are incapable 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:



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.



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 Mer	nber			Date
	SB&H Staff Men	nber			Date
4. Notification to Primary	Care Physician (S	SBH pers	sonnel only)		
Mailed Faxed	Emailed	Date:		By whom:	
Note: Retain copy in pers	on's comprehens	ive clini	al record (Do not ر	purge from re	cord).
Member's Name:			DOB:		

	^			
	HWEST Relea	Southwest Behavioral se of Information and		orm
	Plea	ase check only ONE of	the following option	<u>s:</u>
	Check here if you would like to	Release/Send your recor	ds Check here if y	ou would like to Request your record:
	· ·	, k here if you would like to b		
	ould you like to ur records? Please Mail select:	Digital format via Mail (50 page minimum requir	ed) Email:	
		past 60 days	past 90 days past	year
Dates of S	Service (for records to be sent):	Other (list date range):		to / /
l, <mark> </mark>				
, <u> </u>	Member's Name		SSN	DOB
	Address, City, Sta	ite, Zip	Phone Nu	Imber
Aut	thorize releases, and/or re	cord requests as select	ed herein between	:
	Southwest Behavioral & Hea	alth Services		602-265-8338
	Name of Healthcare Organizati	on with Treatment Relation	ship	Phone Number
	3450 N. 3rd Street, Phoenix, AZ	85012		602-323-2351
	Address, City, State, Zip			Fax Number
ANI				
	Name of Person and Agency (R	ecipient)		Phone Number
	Address, City, State, Zip			Fax Number
regulations pertains, or understand may be rele Note: Fede	(42 CFR Part 2) prohibit you from makir as otherwise permitted by such regulati that if this information is released to the eased by the third party. Treatment, pay	In g further disclosure of Substance ons. A general authorization for the indicated third party, the third part ment, and/or enrollment is not of separate authorization be comple	Abuse information without spe e release of medical or other i ty may not follow the Federal p conditioned upon whether th	cords are not subject to redisclosure. Federal ecific written consent of the person to whom it information is not sufficient for this purpose. I privacy laws and my personal health information ne member signs this consent. ategories: Information on HIV/AIDS and other
What k	tind information would yo Clinical Assessment Clinical Services Notes Discharge Summary Psychological Assessment Other (Please specify i.e. billing	X Psychiatric Evaluation X Treatment/Service Pla X Substance Use Inform X Verbal disclosure of tr	ns ation eatment information	ed herein? Check all that apply: X Medications X Test Results/Labs X AIDS/HIV Information X School Records
Purpos	e for Release/Request:			
being reque anytime, I r action base	ested and/or what the records will be use nay revoke this authorization by writing t	ed for. The purpose is not required o SBH in keeping with SBH Policie	when members are requestin es and Procedures. The revoc	orized party and signer why the records are g their own records. <u>I understand</u> that at ation will be effective except to the extent that for further information regarding your rights
Author	ization will expire:			
	1 Year From this Date		in 6 Months (Substan	ce Use Services only)
	Other: /	/ (Enter Date, no gre	eater than 1 year/6 months	for substance use services)
	Signature of Member/Guardi	an/Authorized representative		Date
	Other Required Sign	ature (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 S	S# DO	В	
Address, City, State Zip		Phone	Em	ail	
Gender: Gender Variant Male	Female	Intersex Qu	estioning Transg	ender Decline to answe	er
Race: American Indian/Alaskan	Native	Asian or Pacific	Islander Black	Caucasion	
Native Hawaiian	Decline to	answer			
Ethnicity: Hispanic/Latino	Non-Hispa	anic/Latino	Decline to answ	er	
Primary Language			ed Language		
Insurance Coverage: Attach a c	opy of medica	uid, medicare, com	nercial and other insi	rance cards	
Medicaid Medicare	Private	e (Self-pay) Tri	Care Blue Cross	HMO Other	
Insurance Co.		Insurance ID#		Policy#	
Special Needs:					
Interpreter (spoken)	No	Yes, specify lang	guage		
Translator (written)	No	Yes, specify lang	guage		
Mobility Assistance	No	Yes, identify ass	istance needed		
Visual Impairment Assistance	No	Yes, identify ass	istance needed		
Hearing Impairment Assistance	e No	Yes, identify ass	istance needed		
Need Childcare Arrangements	No	Yes, identify nee	ed		
Are there known impairment(s) that require special assistance to participate in the assessment/service planning process. \downarrow					
Key Contacts:				No	Yes
If applicable, select custody arrange	ment	Sole Joint	Ward of Court (DCS) or Legal Guardian	
Parent/Legal Guardian(s):			Phone		
Must provide current legal			Phone		
document			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,	Address				
OBGYN, neuro, pain, naturopath, etc)			Phone	Fax	
	Address				
Pharmacy:			Address		
Other Key Contacts: (e.g. school, prob	ation/parole office	er, other involved agen		nt other, neighbors, family)	
Name:			Relationship:		
	Phone:		Fax:		
Name:			Relationship:		
	Phone:		Fax:		

Personal Information									
		_							
	Initia	·	ate)	Updat		(Date	,		
		e fill out the follo	wing informa	ation on the	e indiv	vidual requestin	g services	i.	
Current Employr	nent:	Household size:	Mo	onthly Income	:				-
		Select any that	Job search	hing Mi	litary	Volunteer	Ho	omemaker	Student
		apply:							
		Highest Grade or [Degree complet	ted				Please Se	elect
Educational/Voc	ational	Do you need help	reading or writ	ing?				No	Yes
Training:		Have you ever bee		ı or your chil	d has a	a developmental o	delay or	No	Yes
		special education							
		Did you or your ch	ild receive spec	cial educatio	n servi	ces?		No	Yes
	If yes, please identify testing, special evaluation, special								
		classes, IEP/504, a	Iternative scho	ol, change o	fteach	ier,			
	nt and Ci	etc.							
Legal Involveme		-							
Current Legal Sta Issues (e.g. appointed									
state, divorce, DCS inv	-								
pending charges):		5 /1							
Number of arrest	ts in past	30 days:	For what sp	ecific offe	nse(s	.):			
Has child/adult p	orotective	services or poli	ce been invo	olved?				No	Yes
Medications (Ple	ease inclu	de any current	and previou	s medicat	ions)				
Current Medicat	tion (s)	Reason for Me	dication	ls	Med	ication effectiv	/e? If no,	please expla	in.
					No	Yes			
					No	Yes			
					No	Yes			
					No	Yes			
					No	Yes			
					No	Yes			
Previous Medica	ation(s)	Reason for Me	dication	и	′as M	ledication effe	ctive? If r	no, please ex	plain.
					No	Yes			
					No	Yes			
					No	Yes			
					No	Yes			
					No	Yes			
Please list all over-	the-count	er medications ar	d/or						
herbal supplement	ts 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:	1 1
		_Lasi		<u> </u>

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		
Туре	Year	Comments

Family Medical History – Please check the appropriate box if a condition is/was present.																				
	Alcohol Abuse	Anxiety	Asthma	Breast Cancer	Colon Cancer	СОРD	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

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?	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 □ F □ Light smoker □ Never smoked □	iorme Seco						moke	ər				
If ever smoked/vaped, how many cigarettes/day How many years smoked?	avera	ige?			1-10		11-20		Mor	e tha	n 20	
You ever chewed? Yes No												
If you currently use any tobacco product, are you	u reac	ly to	quit	? 🗆	Yes	C] No	1				

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

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 <i>any problems</i> , how <i>difficult</i> 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