



Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

<input type="text"/>	<input type="text"/>	<input type="text"/>
Member's Name	SSN	DOB
<input type="text"/>	<input type="text"/>	
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)
- 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 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.*
- 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:

Return to Intake Checklist



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

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, clergy person 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

SB&H Staff Member

Date

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

SB&H Staff Member

Date

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: _____ Return to Intake Checklist

STOP: Only complete following sections if the member has an Advance Directive!

5. Selection of my mental health care representative and alternate:

I choose the following person to act as my representative to make mental health care decisions for me when I am incapable of making them for myself.

Name: [redacted] Telephone: [redacted]
Address, City, State Zip: [redacted] Work Phone [redacted]
Cell Phone [redacted]

I choose the following person to act as my alternate representative to make mental health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me.

Name: [redacted] Telephone: [redacted]
Address, City, State Zip: [redacted] Work Phone [redacted]
Cell Phone [redacted]

6. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decision due to mental or physical illness, injury, disability or incapacity. If my wishes are not clear from this Advance Directive Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This person will represent me until it is revoked by me or by an order of a court. My representative is authorized to do the following, which **I have initialed or marked:**

- About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review and consent to disclosure of any of my medical records related to that treatment.
- About medications:** To consent to the administration of any medications recommended by my treating physician.
- About a structured treatment setting:** To admit me to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called a "level one" behavioral health facility.

Additional Directives regarding my mental health treatment are: (See also www.mentalhealthrecovery.com/crisis.html for assistance)

- My Wellness Recovery Action Plan
- Contact Person(s)
- Possible causes of my crisis
- Ways to help avoid hospitalization

Member Name: [redacted]

Member's Name: [redacted] DOB: [redacted]

Note: One adult must witness or notarize the signing of this document and then sign it. The witness cannot be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed (SBH employees are not permitted to witness document signing but may notarize the document).

Witness: I affirm that I personally know the person signing this Advance Directive Durable Mental Health Care Power of Attorney and that I witnessed the person sign or acknowledge the person's signature on this document in my presence. I further affirm that he/she is to be of sound mind and not under duress, fraud, or undue influence. He/she is not related to me by blood, marriage or adoption and is not a person for whom I directly provide care in a professional capacity. I have not been appointed as the representative to make mental health treatment decisions on his/her behalf.

Witness Name (Printed): _____
Witness Address: _____

Witness Signature

Date & Time

OR

On this _____ day of _____, _____ (Year) before me,
_____, the undersigned Notary Public, personally
appeared _____.

Notary Signature

Date

My commission expires: _____

SB&H Staff Name (Printed): _____

SB&H Staff Signature

Date & Time

Member's Name: _____ DOB: _____

Representatives Acceptance of Appointment

I accept this appointment and agree to serve as representative to make mental health treatment decisions for . I understand that I must act consistently with the wishes of the person I represent as expressed in this Advance Directive Durable Mental Health Care Power of Attorney or, if not expressed, as otherwise known by me. If I do not know the Individual’s wishes, I have a duty to act in what I, in good faith, believe to be that person’s best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while (insert individual’s name) has been determined to be incapacitated which means under Arizona law that a licensed psychiatrist or psychologist has the opinion that the individual is unable to give informed consent.

Representative Name (Printed): [Redacted]

[Redacted Signature Line] [Redacted Date & Time Line]

Representative Signature

Date & Time

Alternate Representative Name (Printed): [Redacted]

[Redacted Signature Line] [Redacted Date & Time Line]

Alternate Representative Signature

Date & Time

Note: Retain a copy in the member's comprehensive clinical record.

Member's Name: [Redacted]

DOB: [Redacted]



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):

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
Name of Healthcare Organization with Treatment Relationship
3450 N. 3rd Street, Phoenix, AZ 85012
Address, City, State, Zip
602-265-8338
Phone Number
602-323-2351
Fax Number

AND

Name of Person and Agency (Recipient)
Address, City, State, Zip
Phone Number
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
Clinical Services Notes
Discharge Summary
Psychological Assessment
Other (Please specify i.e. billing records, treatment summary, etc):
Psychiatric Evaluation
Treatment/Service Plans
Substance Use Information
Verbal disclosure of treatment information
Medications
Test Results/Labs
AIDS/HIV Information
School Records

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: <input type="checkbox"/> Gender Variant <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Questioning <input type="checkbox"/> Transgender <input type="checkbox"/> Decline to answer		
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Caucasian		
<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Decline to answer		
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Decline to answer		
Primary Language	Preferred Language	
Insurance Coverage: <i>Attach a copy of medicaid, medicare, commercial and other insurance cards</i>		
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private (Self-pay) <input type="checkbox"/> TriCare <input type="checkbox"/> Blue Cross <input type="checkbox"/> HMO <input type="checkbox"/> Other		
Insurance Co.	Insurance ID#	Policy#
Special Needs:		
Interpreter (spoken)	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify language _____	
Translator (written)	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify language _____	
Mobility Assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes, identify assistance needed _____	
Visual Impairment Assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes, identify assistance needed _____	
Hearing Impairment Assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes, identify assistance needed _____	
Need Childcare Arrangements	<input type="checkbox"/> No <input type="checkbox"/> Yes, identify need _____	
Are there known impairment(s) that require special assistance to participate in the assessment/service planning process. ↓		
Key Contacts:	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If applicable, select custody arrangement <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Ward of Court (DCS) or Legal Guardian		
Parent/Legal Guardian(s):		Phone
<i>Must provide current legal document</i>		Phone
		Phone
		Phone
Emergency Contact:		Phone
<i>Complete ROI</i>	Address	
PCP/Physician:	Phone	Fax
<i>Complete PCP ROI</i>	Address	
Dentist:	Phone	Fax
Other Healthcare Specialist(s):	Phone	Fax
<i>(e.g. Mental health, substance use, OBGYN, neuro, pain, naturopath, etc)</i>	Address	
	Phone	Fax
	Address	
Pharmacy:	Address	
Other Key Contacts: <i>(e.g. school, probation/parole officer, other involved agencies [DDD/DCS], significant other, neighbors, family)</i>		
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.	
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____

Previous Medication(s)	Reason for Medication	Was Medication effective? If no, please explain.	
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
_____	_____	<input type="checkbox"/> No	<input type="checkbox"/> 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 Adult Health Risk Assessment

<input type="text"/>	<input type="text"/>	<input type="text"/>
Member's Name	Member SS#	DOB
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address, City, State Zip	Phone	Email

Substance Related Disorders Screening Adult (18+) Youth (0-17)

During the past year, have you ever drank or used drugs more than you meant to? No Yes

Have you ever neglected some of your usual responsibilities because of alcohol or drugs? No Yes

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? No Yes

Has family, friends, or anyone else ever told you they objected to or were concerned about your alcohol or drug use? No Yes

Have you ever found yourself thinking a lot about wanting to use alcohol or drugs? No Yes

Have you ever used alcohol or drugs to relieve emotional discomfort such as sadness, anger or boredom? No Yes

Who in your family uses alcohol or other substances?

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

Adult Health Risk Screening Questionnaire

Have you been diagnosed with diabetes, asthma, or high blood pressure? No Yes

If yes, what medications are you taking for this?

Have you had a blood pressure reading of 140/90 or higher in the last year? No Yes

Check the symptoms you experience regularly:

High Cholesterol Chest Pain Nausea/Vomiting Headaches Dizziness

Extreme Fatigue Blurry Vision Over/Under Weight Other:

Do you eat a poor diet? No Yes

Are you sedentary or minimally active? No Yes

Do you use tobacco? If so, what and how often? No Yes

None Vape Cigarettes Chew

Daily Weekly Occasionally Never

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

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