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)

☐ 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:

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:* _____

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:* _____

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:		Telephone:	
Address, City, State Zip:		Work Phone	
		Cell Phone	

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:		Telephone:	
Address, City, State Zip:		Work Phone	
		Cell Phone	

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.mentalhealtrecovery.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:

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 0. 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): _____

_____ _____

Representative Signature | Date & Time

Alernate Representative Name (Printed): _____

_____ _____

Alternate Representative Signature | Date & Time

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

☐ 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 ☐ 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. ↓

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 Adult Health Risk Assessment

Member's Name | Member SS# | DOB

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 alchohol 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

Return to Intake Checklist