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.

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: 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)

[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:* ______________ Return to Intake Checklist

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:

- X Clinical Assessment
- X Clinical Services Notes
- X Discharge Summary
- X Psychological Assessment
- X Psychiatric Evaluation
- X Treatment/Service Plans
- X Substance Use Information
- X Verbal disclosure of treatment information
- X Medications
- X Test Results/Labs
- X AIDS/HIV 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. ↓

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:		Please Select
	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

Question	No	Yes
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:

Question	No	Yes
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