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)

I hereby attest and acknowledge that I have read this entire consent for evaluation and/or treatment agreement and expressly declare, confirm and certify that I have the authority to execute this agreement on behalf of myself or applicable minor pursuant to any and all of the terms and conditions identified as expressed within this Agreement. I have had ample opportunity to review the contents of this Agreement and hereby authorize SBH to proceed based upon my authority to grant SBH the ability to evaluate and/or treat myself or applicable minor. I unequivocally expressed and represented my ability and authority to grant SBH the right to so proceed.

☐ Informed Consent to Participate in Telepractice Services (SB&H Handbook)

☐ I agree ☐ I do not agree to participate in telepractice 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 elect to receive services with the understanding that I may be personally responsible to pay for the service being rendered to me.* (SB&H Handbook)

☐ SB&H Member Handbook Acknowledgement *(Program Responsibilities, List of Available Services at SB&H, 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 Behavioral Health Facilities Licensing**: 602-542-3422.

Signature of Member Date

Signature of Parent, Guardian, or authorized representative (when required) Date

Witness (Staff) Signature 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:

Member's Name: *DOB:*

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.

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 ________

Name of Healthcare Organization with Treatment Relationship Phone Number

________ ________

Address, City, State, Zip Fax Number

AND

________ ________

Name of Person and Agency (Recipient) Phone Number

________ ________

Address, City, State, Zip Fax Number

Notice to Recipient: On February 16, 2024, the U.S. Department of Health & Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2. The modification allows a single consent for all future uses and disclosures for treatment, payment, and health care operations. It also allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations. However, a separate consent will be required for the use and disclosure of SUD Counseling notes.

What kind information would you like released and/or requested as selected herein? Check all that apply:

☐ Clinical Assessment ☐ Psychiatric Evaluation ☐ Test Results/Labs
☐ Clinical Services Notes ☐ Treatment/Service Plans ☐ AIDS/HIV Information
☐ Discharge Summary ☐ Verbal disclosure of treatment information ☐ School Records
☐ Psychological Assessment ☐ Medications ☐
☐ 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

☐ Other: ________ (Enter Date, no greater than 1 year)

________ ________

Signature of Member/Guardian/Authorized representative Date

________ ________

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

***If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required.**

Southwest Behavioral & Health Services

Release of Information and Records Request Form

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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 ______

Name of Healthcare Organization with Treatment Relationship Phone Number

______ ______

Address, City, State, Zip Fax Number

AND

______ ______

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☐ Clinical Services Notes	☐ Treatment/Service Plans	☐ AIDS/HIV Information
☐ Discharge Summary	☐ Verbal disclosure of treatment information	☐ School Records
☐ Psychological Assessment	☐ Medications	☐

☐ Other (Please specify i.e. billing records, treatment summary, etc): ______

Purpose for Release/Request: ______

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Authorization will expire:

☐ 1 Year From this Date

☐ Other: ______ (Enter Date, no greater than 1 year)

______ ______

Signature of Member/Guardian/Authorized representative Date

______ ______

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

***If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required.**

Dual Enrollment Prevention by Fax (ARIZONA)

Instructions: Member to complete form as part of SB&H intake process. SB&H team to fax completed authorization to all applicable OTPs within a 200-mile radius SAMHSA OTP Directory; then scan document with the fax confirmation into the member's chart as "Faxed Dual Enrollment Prevention".

In compliance with all state and federal regulations (including CFR Part 2) this consent authorizes Southwest Behavioral & Health Services (SBH) to use and disclose Protected Health Information (PHI) with all applicable Opioid Treatment Programs (OTPs) within the designated radius of the clinic listed below.

Member Name ____________________ AHCCCS ID ____________________

DOB ____________________ SSN ____________________

Address, City, State Zip ____________________ Phone ____________________

SBH Site	
Bullhead City ORS	
Flagstaff ORS	
Prescott Valley ORS	
7th AVE ORS	

Member Notification

The above-mentioned clinic is required to notify each member prior to admission that it cannot provide treatment or medication to a member who is simultaneously receiving these same services from another treatment program, unless the medication is being provided in response to an emergency or disaster that forced the closure of the member's regular home clinic.

Purpose of Disclosure

The purpose of this disclosure Is to prevent a member from dual enrollment inn other Opioid Treatment Programs (OTPs)/Medication Assisted Treatment (MAT) programs. This is completed by notifying local OTPs within a 200-mile radius of the above-mentioned clinic, via secure facsimile transmission, that the identified member is enrolled in SBH's Medications for Opioid Use Disorder (MOUD) program.

Information to be Disclosed

Information related to disclosure to prevent multiple enrollments is permitted by 42 CFR Part 2. If it is confirmed that member is receiving duplicative services the information to be disclosed may include the member's demographic Information (e.g., full legal name, alias, last four numbers of social security number, date of birth, admission date, medication type/form/dose, discharge date and reason, and last dose of medication) and may include records related to substance use, communicable diseases, mental health, medical history, and physical treatment.

Storage of Information and Confidentiality

Member records/information is protected under federal regulations governing Confidentiality of Alcohol and DrugAbuse Patient Records, including 42 CFRPart 2, the Health Insurance Portabilityand Accountability Act of 1996 ("HIPAA"), and 45 CFR Parts 160-164. The recipientof the Information may re-disclose the information, and it may no longer be protected by the HIPAA privacy law. However, 42 CFR Part 2 will continue to protect the confidentiality of information that identifies the member as a patient in an alcohol or other drug program from any re-disclosure.

Programs To Receive Disclosed Information and Means of Disclosure

The information is disclosed to all OTPs/MATs programs within a 200-mile radius of the above-mentioned clinic via secure facsimile transmission.

Terms of This Consent

☐ **The above-mentioned member's records are protected under the Federal Confidentiality Regulations and may not be disclosed without the member's express written consent, unless otherwise provided for in the regulations; and the client may revoke this consent at any time except to the extent that action has been taken in accordance with it, and in any event, this consent expires automaticallyas set forth below.**

☐ **This is a limited disclosure for the purposes described above, and so indicated by the person whose records this information has been extracted from.**

The member may view and request a copy of the information described above and/or in this form.

This consent will expire 90 days from discharge of the program unless otherwise indicated below.

☐ By selecting this option, this consent will expire on: ____________ (specify date)

Member Acknowledgement:

By signing below,
I confirm that I have thoroughly read and understand the Information outlined in this document and attest to the following statements:

- I am not receiving medication and/or treatment from another Opioid Treatment Program/Medication Assisted Treatment facility, its satellite, or an Office Based Opioid Treatment provider.
- I release the above-mentioned clinic from liability which may arise as a result of information disclosed under this authorization if such information disclosed is later used to my detriment.
- I understand if I do not sign this statement, I will not be admitted for treatment or provided emergency medication services.
- I understand that I have the right to revoke this consent, in writing. at any time by sending such written notification to Southwest Behavioral & Health Services (SBH).
- **I permit all opioid treatment programs within a 200-mile radius of the above-mentioned clinic to disclose information Indicated on this form.**

Member Signature ____________ Date ____________

Parent, Guardian Signature ____________ Date ____________

Staff/Witness Signature ____________ Date ____________

Receiving OTP

A response is requested only if the receiving OTP has Information that the above-named member may also be enrolled in the receiving clinic's OTP services. If the above-named member Is currently enrolled with your clinic, please contact the Southwest Behavioral & Health Services (SBH) clinic listed below via fax or phone to provide information regarding the member's enrollment with your organization.

SBH Site	Address

Bullhead City ORS	809 Hancock Road #1, Bullhead, AZ 86442 P:928-763-7111 F: 928-542-4031
Flagstaff ORS	1515 E. Cedar Avenue #E-2, Flagstaff, AZ 86004 P:928-714-0010 F: 928-714-0024
Prescott Valley ORS	7600 E. Florentine Road Ste. 101 Prescott Valley, AZ 86314 P:928-775-7088 F:928-775-7099
7th AVE ORS	1424 S. 7th Ave, Bldg. C. Phoenix, AZ 85007 P: 602-258-3600 F: 602-256-0514

Notice to recipient:

Any substance use disorder treatment information disclosed under this authorization has been disclosed from records that may be protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit the recipient from making any further disclosureof this information unless further disclosure is exclusively permitted by the written consent of the person to whom it pertains or otherwise permitted 42 CFR Part2. A general authorization for the release of medical or other Information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any substance use disorder patient

Communicable disease-related information, pursuant to this release, cannot be re-disclosed without specific written authorization. (A.R.S. 36-664.H.)

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: ______

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)

Question		
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

Southwest Behavioral Health Services, INC. SELF PAY FEE AGREEMENT

Member Name:____________________________

I understand that my full fee payment is due and payable at the time of service, even if I have insurance, and acknowledge that I am responsible for any and all charges for services received. I understand that I am responsible for any cost incurred from services not provided by Southwest Behavioral & Health Services. I understand that by choosing to self-pay for services, I have waived my right to have the services billed to my insurance company and Southwest Behavioral & Health Services will not provide me with a superbill of self-pay services rendered. **I further agree to pay a $25 fee FOR APPOINTMENTS MISSED OR CANCELLED WITHOUT A 24-HOUR NOTICE.** I understand that payments are **due at time of service** with cash, credit/debit card, cashier's check or money order (NO personal checks will be accepted). I also understand that any medications that may be prescribed are my full financial responsibility.

Behavioral Health Services- Self-Pay Rates

***To include Medical visits provided in-office, by phone or via telepractice**

Description	Billing Frequency	Private Pay Rate
Initial Intake/Assessment	Per visit	$220.00
Individual Counseling	Per hour	$110.00
Family Counseling/Family Coaching	Per hour	$110.00
Group Counseling	Per hour	$28.00
Skills Training	Per 15 min	$28.00
Psychological Testing/Evaluation: Face-to-Face Evaluation	Per hour	$165.00
Psychologist Testing/Evaluation: Non-Face-to-Face post-evaluation Test Administration & Scoring.	Per 30 minutes	$66.00

Description	Billing Frequency	Private Pay Rate
Psychiatric Evaluation	Per visit (1 hours)	$275.00
Medication Monitoring	Per visit (20 to 30 min)	$110.00
Case Management	Per 30 min	$28.00
Health Promotion	Per 30 min	$28.00
Peer Support	Per 15 min	$22.00
Vocational Services (on site)	Per hour	$28.00

Physical Health Services - Self-Pay Rates

***To include Medical visits provided in-office, by phone or via telepractice**

Description	Billing Frequency	Private Pay Rate
Initial Visit	Per visit	$83.00
Established Member Visit	Per visit	$83.00
Preventive Care Visit	Per visit	$83.00

Description	Billing Frequency	Private Pay Rate

Medication Assisted Treatment Services - Self-Pay Rates

***To include Medical visits provided in-office, by phone or via telemed.**

Description	Billing Frequency	Private Pay Rate
1st Appointment includes: Intake/Annual Assessment/History & Physical	Per visit	$165.00
Methadone includes one (1) group per week and one (1) monthly clinician visit	Weekly	$77.00
Medication Monitoring	Per visit	$110.00

Description	Billing Frequency	Private Pay Rate
Courtesy Dosing	Per day	$22.00
Suboxone includes one (1) monthly clinician visit, one (1) Medication Monitoring and two (2) Group sessions	Monthly	$220.00
Psychological Testing (requires 6-98 hours)	Per hour	$110.00

Sliding Fee Schedule

Poverty Level*	0 - 100 %		101 - 125 %		126 - 150 %		151 - 175 %		176 - 200 %	
Percent Discount	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
Family Size	Minimum Fee		20% Pay		40% Pay		60% Pay		80% Pay	
1	$0	$15,960	$15,961	$19,790	$19,791	$24,540	$24,541	$30,430	$30,431	$37,730
2	$0	$21,640	$21,641	$26,840	$26,841	$33,280	$33,281	$41,270	$41,271	$51,180
3	$0	$27,320	$27,321	$33,880	$33,881	$42,010	$42,011	$52,090	$52,091	$64,590
4	$0	$33,000	$33,001	$40,920	$40,921	$50,740	$50,741	$62,920	$62,921	$78,020
5	$0	$38,680	$38,681	$47,960	$47,961	$59,470	$59,471	$73,740	$73,741	$91,440
6	$0	$44,360	$44,361	$55,010	$55,011	$68,210	$68,211	$84,580	$84,581	$104,880
7	$0	$50,040	$50,041	$62,050	$62,051	$76,940	$76,941	$95,410	$95,411	$118,310
8	$0	$55,720	$55,721	$69,090	$69,091	$85,670	$85,671	$106,230	$106,231	$131,730
For Each Additional person, add	$5,680									

Based on 2026 HHS Poverty Levels: Federal Register- HHS 2026 poverty guidelines

Qualifying Discount (check one): ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐ None

Member or Parent/Guardian Name (print):

Signature:

Witness: (Staff Name/Signature) ____ Date: ______________