



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: _____



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
Address, City, State, Zip
Phone Number
Fax Number

AND

Name of Person and Agency (Recipient)
Address, City, State, Zip
Phone Number
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.

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
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.

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

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 record:
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
Address, City, State, Zip
Phone Number
Fax Number

AND

Name of Person and Agency (Recipient)
Phone 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
Clinical Services Notes
Discharge Summary
Psychological Assessment
Other (Please specify i.e. billing records, treatment summary, etc):
Psychiatric Evaluation
Treatment/Service Plans
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
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 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 _____			Phone _____		
<i>Must provide current legal document</i>			Phone _____			Phone _____		
Emergency Contact:			Phone _____			Address _____		
<i>Complete ROI</i>			Phone _____			Fax _____		
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: _____					



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*

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 alcohol 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: _____

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](#)



Katie Hobbs, Governor
Carmen Heredia, Cabinet Executive Officer
and Executive Deputy Director

Transportation Authorization and Release of Liability

I, _____ (name of parent or legal guardian). Herein referred to as Legal Guardian, residing
at _____ (address) hereby affirm that I am the parent or legal guardian
of _____ (full name of minor), whose AHCCCS ID is _____
and date of birth is _____, herein referred to as Minor.

Minor is _____ (age) years old. Upon completion and signing of this form, I hereby provide my limited consent for Minor to be
transported for the purpose of _____ (include purpose of transportation),
herein referred to as Purpose. The Minor may be transported for this Purpose from _____ (start date of authorization)
to _____ (end date of authorization; cannot be more than 3 months after the start date of the authorization).

Minor will be transported without the presence of their Legal Guardian.

By providing this authorization and release of liability, I represent that Minor is capable of being transported without the presence of their
Legal Guardian and will comply with all safety rules and regulations communicated by the driver. I understand if Minor does not follow the rules, the
Minor may no longer be transported without a Legal Guardian. I agree to ensure that Minor will be ready for their pickup for their trip and will be able to
get themselves to the specific pickup location at the scheduled time.

**I agree to inform the AHCCCS enrolled provider within 48 hours if for any reason I cease being the Legal Guardian of Minor and agree to provide the
name and contact information for the newly designated Legal Guardian. I agree to inform the AHCCCS enrolled provider immediately in the event
that I no longer consent to Minor receiving non-emergency transportation for medical necessary services. I agree to provide an updated signed
Transportation Authorization and Release of Liability form 3 months after the date of signature below to continue the authorization for the Purpose
outlined above. I may ask at any time, in writing, that this authorization be canceled.**

Upon execution of this authorization and release for transportation of a Minor, I hereby release AHCCCS and the AHCCCS contracted health plan, its
employees, officers, agents, and subcontractors from any and all liability, causes of action, or claims in connection with the transportation.

If any of the above information should change, the Legal Guardian is responsible for providing an updated
Authorization and Release of Liability Form.

Signature of Legal Guardian

Date

Printed Name of Legal Guardian

Date

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	Description	Billing Frequency	Private Pay Rate
Initial Intake/Assessment	Per visit	\$220.00	Psychiatric Evaluation	Per visit (1 hours)	\$275.00
Individual Counseling	Per hour	\$110.00	Medication Monitoring	Per visit (20 to 30 min)	\$110.00
Family Counseling/Family Coaching	Per hour	\$110.00	Case Management	Per 30 min	\$28.00
Group Counseling	Per hour	\$28.00	Health Promotion	Per 30 min	\$28.00
Skills Training	Per 15 min	\$28.00	Peer Support	Per 15 min	\$22.00
Psychological Testing/Evaluation: Face-to-Face Evaluation	Per hour	\$165.00	Vocational Services (on site)	Per hour	\$28.00
Psychologist Testing/Evaluation: Non-Face-to-Face post-evaluation Test Administration & Scoring.	Per 30 minutes	\$66.00			

Physical Health Services - Self-Pay Rates

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

Description	Billing Frequency	Private Pay Rate	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			

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	Description	Billing Frequency	Private Pay Rate
1 st Appointment includes: Intake/Annual Assessment/History & Physical	Per visit	\$165.00	Courtesy Dosing	Per day	\$22.00
Methadone includes one (1) group per week and one (1) monthly clinician visit	Weekly	\$77.00	Suboxone includes one (1) monthly clinician visit, one (1) Medication Monitoring and two (2) Group sessions	Monthly	\$220.00
Medication Monitoring	Per visit	\$110.00	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: _____