Southwest Behavioral & Health Services

Intake/Annual Consent Packet Acknowledgement

Member's Name	SSN	DOB

Address, City, State Zip	Phone

I have received and have had the opportunity to review 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 ask questions to my satisfaction. 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:

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:* _____

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

[X] 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] Psychiatric Evaluation	[X] Medications
[X] Clinical Services Notes	[X] Treatment/Service Plans	[X] Test Results/Labs
[X] Discharge Summary	[X] Substance Use Information	[X] AIDS/HIV Information
[X] Psychological Assessment	[X] Verbal disclosure of treatment 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:	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.*
		☐ 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

Integrated Health Information (Birth to 11)

Member Name: First_____Middle_____Last_____Date of Birth:_____/____/_____

Preventive Care – Please provide the Month/Year of your last:					
Annual Wellness Visit	___/____	Dental exam	___/____	Vision/Hearing exam	___/____
Flu Vaccine	___/____	COVID Vaccine	___/____	Labs/Blood test	___/____
Immunizations are up to date?			☐ Yes ☐ No ☐ Not Sure		

Immunizations					

Allergies or intolerances to medications?	
Name	Reaction

Birth History	
Preterm or full term?	
Vaginal or C-Section Delivery?	
Birth Weight:	
Birth Length:	
Complications during pregnancy or delivery? If yes, please explain.	

Please circle all current or past medical problems or conditions.		
ADHD	Ears (multiple infections)/Hearing	Seizures/Headaches
Asthma/RAD	Eyes/Vision	Skin (eczema)
Anemia/Blood Disorders	Gastrointestinal (GE Reflux/ Constipation/diarrhea)	Urine/Kidneys
Bones/Joints	Heart	Other
Diabetes	Repeated Infections	

Member Name: First_____Middle_____Last_____Date of Birth:____/____/____

Hospitalizations, major operations, surgeries, or injuries		
Type/Reason	Year	Comments

Family Medical History – Please check the appropriate box if a condition is/was present.

	Alcohol Abuse	Anxiety	Allergies/Asthma	Cancer	Depression	Diabetes	Drug Abuse	Early Death	Endocrine Disorders	Gastrointestinal Disorders	Heart Attack/Disease	High Blood Pressure	High Cholesterol	Immunologic Disorder	Kidney Disease	Mental Illness (Other)	Rheumatologic or Autoimmune disorder	Vision Loss	Seizures	Other
Father																				
Mother																				
Paternal Grandfather																				
Paternal Grandmother																				
Maternal Grandfather																				
Maternal Grandmother																				
Siblings																				
Children																				

Physical Activity – Please check your response.

How many minutes per week does the child do physical activity of moderate to vigorous intensity?

☐ None ☐ Less than 90 minutes/week ☐ More than 90 minutes/week

Social Activity – Please check your response.

Do you have any concerns regarding the child's:

☐ Alcohol/Drug Use ☐ Developmental Growth ☐ Eating/Nutrition ☐ Emotional Health

☐ Social Activity ☐ School/Academics ☐ Sexual Activity ☐ Other: