SAHARA BEHAVIORAL HEALTH
Satinder S. Purewal, MD LLC
6677 W. Thunderbird Rd, Suite I-164
Glendale, AZ 85306 Ph: 623-878-2100

Last Name: _____ First Name: _____ MI: ____ Date: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ Gender: M or F Email_____

Occupation: _____ Employer: _____

Work Phone: _____

Preferred Language: _____ Race/Ethnicity: _____

Referred by: _____ Phone Number: _____

Preferred Pharmacy: _____

Pharmacy Address: _____ Phone Number: _____

AUTHORIZED PERSONS TO DISCUSS YOUR ACCOUNT / TREATMENT / MEDICAL RECORDS

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

PRIMARY INSURANCE INFORMATION

Insurance Plan: _____

Address: _____ City: _____ State: _____ Zip: _____

Owner: _____ Relationship: _____

Policy #: _____ Group #: _____ Social Security #: _____

SECONDARY INSURACE INFORMATION

Insurance Plan: _____

Address: _____ City: _____ State: _____ Zip: _____

Owner: _____ Relationship: _____

Policy #: _____ Group #: _____ Social Security #: _____

INSURANCE RELEASE & CONSENT TO DISCUSS WITH AUTHORIZED PERSONS

I authorize and request that payment under my insurance program/s be made directly to Sahara Behavioral Health for any services furnished to me. I also authorize the provider to release any information needed for the payments of claims. I further permit copies of this authorization to be used in place of the original.

Patient or Guardian Signature: _____ Date: _____

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OFFICE POLICIES

1. _____ Initial — All Medications will be refilled by Appointments only. No refill by phone or after office hours, including weekends.

2. _____ Initial — Please give a 24-hour notice if you cannot keep an appointment. Failure to do so will result in a charge of $25.00.

3. _____ Initial — Your insurance company will be notified of 2 or more missed appointments.

4. _____ Initial — All CO-PAYS, DEDUCTIBLES and BALANCES OWED are due at the time of your appointment.

5. _____ Initial — All forms for Attorneys, Disability, etc. will be filled out at your appointment time only. Form fees will vary. Forms will not be completed for New patients until patient has been seen at least 3 times.

6. _____ Initial — Inappropriate language, threats and/or behavior will not be tolerated, and will be grounds for dismissal from practice.

7. _____ Initial — Absolutely no alcohol, hard drugs, or weapons are allowed in the building.

8. _____ Initial — The use of electronics for the purpose of recording or videoing is strictly Prohibited in the building, including the patient lobby.

I have read and understand the policy as stated above.

_____

Signature Date

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Glendale, AZ 85306
Phone 623-878-2100

Client's Informed Consent

I have chosen to receive mental health services through **Sahara Behavioral Health**. My choice has been voluntary and I understand that I may terminate treatment at any time.

I understand that confidentiality of records or information collected about me will be held and released in accordance with state laws regarding confidentiality of such records and information.

I understand state and local law requires all cases in which there exists a danger to self or others be reported by this office.

I have read and understand the above.

_____
Patient's Name

_____ _____
Patient's/Guardian Signature Date

Please Print

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Glendale, AZ 85306
Phone: 623-878-2100 Fax: 623-776-9419

Health Care Coordination Form

Patient Name _____ DOB _____

Member ID Number or Social Security Number _____ - _____ - _____

I hereby authorize, **Sahara Behavioral Health,** the release of all clinical/medical and mental information about me which pertains to my medical history, medications, mental and physical condition, and/or treatment, and my mental health diagnosis and treatment of substance abuse to my Primary Care Physician.

☐ I do not have a Primary Care Physician at this time.

_____
Primary Care Physician Name

_____
Address

_____ _____
Phone Number Fax Number

I understand that the release information is to permit my primary care physician to monitor my health status and to coordinate all the care which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
Signature of Patient or Legal Guardian Date

SAHARA BEHAVIORAL HEALTH 6677 W. Thunderbird Rd., Suite I-164
Glendale, AZ 85306
Satinder S. Purewal, MD LLC.

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you [as a patient of this practice] may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Ace of 1996 {HIPPA}

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Law suits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization about to help prevent the threat.

5. If you are a member of U.S. or foreign military forces [including veterans] and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official

8. For Workers Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INSURANCE

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our

disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree. We are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient, medical, records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Sahara Behavioral Health, Attn.: Medical Records, 6677 W. Thunderbird Rd., Suite I-164, Glendale, *AZ* 85306.**

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Sahara Behavioral Health, Attn: Medical Records. 6677 W. Thunderbird Rd., Suite I-164, Glendale, *AZ* 85306.**

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department-of Health and Human Services. To file a complaint with our practice, contact **Sahara Behavioral Health, 6677 Thunderbird Rd., Suite I-164, Glendale, AZ 85306.** All complaints must be submitted in writing. You will not be penalized for filing a complaint

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact **Sahara Behavioral Health, Attn: Medical Records, 6677 W. Thunderbird Rd., Suite I-164, Glendale, AZ 85306.**

I hereby acknowledge that I have been presented with a **copy of Sahara Behavior Health Notice of Privacy Practices.**

Signature: ----------

Date: ----------

Name of Patient: ----------

Sahara Behavioral Health Controlled Drug Policy

Controlled medications are controlled for medical and legal reasons. If not used properly they can cause medical problems. If sold for street use they contribute to addiction and crime. Our office must manage these medications in ways that are medically appropriate and that meet all Federal and State regulations. Please read the following carefully. By signing it, you are agreeing to follow every one of the agreements it contains. Exceptions cannot – and will not – be made.

1. *Controlled substances are habit forming and can cause physical dependence. Suddenly stopping the medication may cause physical withdrawal symptoms. These symptoms may include flu-like feelings, crawling skin, sleeplessness, irritability, anxiety, and even seizures.* ***I understand that I may develop physical dependence from medication. _____(initial here)***

2. ***I understand that patients with a history of substance abuse, including alcohol abuse, are at high risk of relapse by taking certain medications.*** *Patients with a strong family history of substance abuse are also at high risk for potential addiction. I also understand that in case I do develop psychological dependence or addiction on controlled substance, my provider at his or her discretion will taper me off the addicting prescription or refer me to a detox center. I have notified Sahara Behavioral of any personal or family history of substance abuse, including alcohol abuse****. _____(initial here)***

3. ***I understand that my medication may not be taken more often than prescribed.*** *If your medication is not working, you must contact the office****. You cannot take extra medicine.*** *Controlled medications will never be refilled more than 2 days early. If you run out of medication early, you may suffer withdrawal symptoms.* ***_____(initial here)***

4. *I will* notify *Sahara Behavioral, if I receive pain medication, sleeping pills, tranquilizers, or other controlled medications from any other doctors (including emergency room doctors).* ***I understand that I may be dismissed from the practice if I do not notify Sahara Behavioral that I have received controlled medications from another source.*** *I also understand that obtaining controlled medications from more than one doctor without notifying all providers who prescribe for me is a felony. The only exception is medication taken during an inpatient hospitalization*. **_____(initial here)**

5. *To get medication refills, I must be seen in this office at least every 30 days**; the visit schedule is at the discretion of provider, but never more than 90 days. I understand it is my responsibility to schedule and keep all appointments.** I understand that if I have not been seen in 90 days, no medication can be refilled until I come to the office for an appointment. _____**(initial here)***

6. ***I understand that I am receiving medications that are at high risk of being stolen.** I am responsible for protecting these medications. Sahara Behavioral cannot replace medications or prescriptions that are lost or stolen, including prescriptions lost in the mail. I also understand that if my medications are stolen, I must file a report with local law enforcement agencies**. _____(initial here)***

7. ***I understand that selling, trading, or giving a medication to another person, including a family member, is illegal. _____ (initial here)***

8. ***I understand that controlled medication is refilled only at the time of visit. and only in the amount as discussed above, regardless of insurance coverage. _____ (Initial here)***

9. *It is the policy of Sahara Behavioral to request urine drug tests on those patients taking controlled medications at anytime. There may, or may not be a cost to the patient for these tests, but we will be unable to prescribe medications to any patient who refuses such a test no matter what the reason**. _____(initial here)***

10. *I give my permission for Sahara Behavioral to contact any pharmacy, physician, or hospital to specifically discuss my medications whenever they feel it is necessary. Understand that providers at Sahara Behavioral also check data on state prescription drug monitoring program. _____**(initial here)***

11. *Most patients are medically capable of driving once they have adjusted to taking their medication on a regular basis. However, laws in most states consider anyone driving while taking sedating medication(s) to be driving under the influence (DUI). In such cases, it does not help or matter if your doctor believes it was safe for you to drive**. _____ (initial here)***

Patient Name _____

Signed_____ Date_____
Patient

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Name_____ Date of Birth ___/____/___ Date___/___/___
(This is confidential record of your medical history and will be kept in this office. Please fill out completely.)

Previous Psychiatrist_____ Phone Number_____

Reason for visit_____

Are you here to get any forms filled ___no ___yes (if yes, then please describe)_____

Are you <u>CURRENTLY</u> having any of the following complaints: (Circle "no" or "yes" and describe)

Anxiety or panic attacks	no	yes	Sad or depressed feelings	no	yes
Crying spells	no	yes	Sleep disturbances	no	yes
Social isolation	no	yes	Fatigue or tired feelings	no	yes
Appetite changes	no	yes	Loss of interest	no	yes
Feelings of hopelessness	no	yes	Feelings of helplessness	no	yes
Inability to focus or concentrate	no	yes	Racing mind or thoughts	no	yes
Mood swings	no	yes	Irritability	no	yes
Anger feelings	no	yes	Impulsive behavior	no	yes
Hearing voices	no	yes	Seeing things that are not there	no	yes
Paranoia	no	yes	Excessive guilt	no	yes

<u>PAST</u> MENTAL HEALTH HISTORY:

Have you ever been diagnosed with: (Circle "no" or "yes", leave blank if uncertain)

Anxiety d/o……	no	yes	Major depression……..	no	yes
Bipolar d/o…….....	no	yes	Schizophrenia……...	no	yes
Alcoholism……..	no	yes	Drug addiction……..	no	yes
Auditory hallucinations…	no	yes	Diabetes……	no	yes
Suicidal attempt……	no	yes	Heart disease……	no	yes
Drug Overdose……..	no	yes	Liver disease…….	no	yes
Visual hallucinations…….	no	yes	High Blood Pressure…….	no	yes
Self cutting behavior…….	no	yes	Seizures d/o……..	no	yes
ADD or ADHD ……	no	yes	Kidney Disease…….	no	yes

PAST MEDICAL HISTORY:

_____
_____
_____
_____

PAST SURGICAL HISTORY:

_____
_____
_____
_____

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SUBSTANCE ABUSE HISTORY:

Alcohol	no	yes
Opiates (pain pills or Heroin)	no	yes
Benzodiazepines (Xanax, Valium, Ativan, Klonopin, etc.)	no	yes
Cocaine	no	yes
Amphetamines	no	yes
Any other illicit drugs	no	yes
Vaping	no	yes
Marijuana	no	yes
Tobacco	no	yes

Current Smoker ☐ How Long:_____ How Many:_____
Never Smoked ☐ Quit Smoking: ☐ How Long Ago:_____

PERSONAL AND SOCIAL HISTORY:

Place of birth:_____
Highest level in school:_____
Occupation:_____ Previous occupation:_____
Marital Status:_____
Any children:_____
Who do you live with?_____
Present weight:_____ Usual weight:_____ Height:_____
Have you gained or lost any weight?_____

Do you exercise?	no	yes
Are you on any diet?	no	yes
Any history of trauma or abuse?	no	yes
Any litigation (active or pending)?	no	yes (describe)_____

FAMILY HISTORY:

Mental problem	no	yes
Alcoholism	no	yes
Drug addiction	no	yes
Heart disease	no	yes
Diabetes	no	yes

REVIEW OF SYMPTOMS:

Headaches	no	yes	Dizziness	no	yes
Tremors	no	yes	Falls	no	yes
Visual difficulties	no	yes	Hearing difficulties	no	yes
Chest pains	no	yes	Palpitations	no	yes
Shortness of breath	no	yes	Nausea	no	yes
Vomiting	no	yes	Diarrhea	no	yes
Constipation	no	yes	Urinary Problem	no	yes
Cold chills	no	yes	Sweats	no	yes
Back pain	no	yes	Abdominal pain	no	yes
Weakness	no	yes	Numbness	no	yes
FOR MEN:					
Any sexual difficulties	no	yes			
FOR WOMEN:					
Any sexual difficulties	no	yes	Date of last period…….		
Are you pregnant	no	yes	On birth control	no	yes

Patient's signature…….

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MEDICATION LIST:

Allergies:_____

Current Medications:

Name	Dose	Frequency
Ex. Zoloft	*25mg*	*Once daily*

Previous Psychiatric Medications:

Name	Dose	Last Date Used

Sahara Behavioral Health

CONFIDENTIAL EXCHANGE OF INFORMATION RELEASE FORM

Sahara Behavioral Health is required to coordinate treatment with other behavioral health practitioners and providers, primary care practitioners (PCPs), and other appropriate care provider(s) treating the member.

Fill This Section Only

Treating Behavioral Health Clinician/ Facility Information:

Sahara Behavioral Health 6677 W. Thunderbird Rd. Suite I – 164, Glendale AZ. 85306

Phone: (623) 878 – 2100 Fax: (623) 776 – 9419

Patient Name: _____ DOB_____

PCP, medical Clinician Name: _____ Phone/Fax: _____

PCP, medical Clinician Name: _____ Phone/Fax: _____

I hereby freely, voluntarily and without coercion, authorize the Sahara Behavioral Health to release the information contained on this form to the practitioner/ provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

_____

Patient Signature **Date**

_____

Behavioral Health Clinician/ Facility Representative **Date**

I do not want to have information shared with: ☐ My PCP/ medical practitioner

DATE MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: _____

Fill This Section Only

For Provider use Only, Do not fill Below This

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health problem(s):

☐ ADHD/ Behavior D/O ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar D/O

☐ Depressive D/O ☐ Anxiety D/O ☐ Eating Disorder ☐ Adjustment D/O

☐ Personality D/O ☐ Other_____

2. The patient is taking the following prescribed psychotropic medication(s):

☐ Antidepressant-SSRI/SNRI ☐ Antidepressant- Tricyclic ☐ Antidepressant-MAOI ☐ Antidepressant- Wellbutrin

☐ Lithium ☐ Antipsychotic- Atypical ☐ Antipsychotic- Typical ☐ Clozaril

☐ Stimulant ☐ Anxiolytic ☐ Anticonvulsant/ Mood Stabilizer

☐ Other_____

3. Expected length of treatment: ☐ <3months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. Coordination of care issues/ Other significant information impacting medical or behavioral healthcare:

_____

5. _____

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the 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.

SAHARA BEHAVIORAL HEALTH
SATINDER PUREWAL MD LLC
6677 W. THUNDERBIRD RD. SUITE I – 164 GLENDALE, AZ, 85306
TEL: (623) 878 – 2100 FAX: (623) 776 – 9419

PATIENT HEALTH QUESTIONNAIRE -9 (PHQ – 9)

Patient Name: _____ **Date:** _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

For Office Coding _____ + _____ + _____ + _____

= Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐