SAHARA BEHAVIORAL HEALTH

SAHARA BEHAVIORAL HEALTH

Reset Form

Last Name: First Name: MI: Date:

Date of Birth: Social Security Number:

Address: City: State: Zip:

Home Phone: Cell Phone:

Marital Status: Gender: Male Female Transgender Other

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 #: Ins. Phone Number

SECONDARY INSURACE INFORMATION

Insurance Plan:

Address: City: State: Zip:

Owner: Relationship:

Policy #: Group #: Sec. Ins. Phone Num.

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:**

SAHARA BEHAVIORAL HEALTH

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OFFICE POLICIES

1. _____ Initial — All Medications will be refilled by Appointments only. Refills are not provided by phone, email, or outside of office hours.

2. _____ Initial — Please give a 24-hour notice if you cannot keep an appointment. Failure to do so will result in a charge of $50.00.

3. _____ Initial — The insurance company will be notified of 2 or more "no show" appointments and the practice may not continue to provide services.

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

5. _____ Initial — All forms (Attorneys, Disability, etc.) will be filled out at your forms appointment time. Form fees will vary and are collected prior to completion. Forms may not be completed until a patient has been sufficiently established with a provider.

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, illegal 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

SAHARA BEHAVIORAL HEALTH

SAHARA BEHAVIORAL HEALTH

Phone 623-878-2100
Fax 623-776-9419

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

SAHARA BEHAVIORAL HEALTH

Please Print

SAHARA BEHAVIORAL HEALTH

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. 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

SAHARA BEHAVIORAL HEALTH

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.

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 at any location.

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

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.

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 am seen for an appointment. _____ **(initial here)**

SAHARA BEHAVIORAL HEALTH

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: _____

Patient Signature: _____ Date: _____

SAHARA BEHAVIORAL HEALTH

SAHARA BEHAVIORAL HEALTH
www.saharabehavioralhealth.com
(623) 878-2100

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 Pick one (if yes, then please describe) _____

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

Anxiety or panic attacks	Pick One	Sad or depressed feelings	Pick One
Crying spells	Pick One	Sleep disturbances	Pick One
Social isolation	Pick One	Fatigue or tired feelings	Pick One
Appetite changes	Pick One	Loss of interest	Pick One
Feelings of hopelessness	Pick One	Feelings of helplessness	Pick One
Inability to focus or concentrate	Pick One	Racing mind or thoughts	Pick One
Mood swings	Pick One	Irritability	Pick One
Anger feelings	Pick One	Impulsive behavior	Pick One
Hearing voices	Pick One	Seeing things that are not there	Pick One
Paranoia	Pick One	Excessive guilt	Pick One

PAST MENTAL HEALTH HISTORY:

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

Anxiety d/o	Pick One	Major depression	Pick One
Bipolar d/o	Pick One	Schizophrenia	Pick One
Alcoholism	Pick One	Drug addiction	Pick One
Auditory hallucinations	Pick One	Diabetes	Pick One
Suicidal attempt	Pick One	Heart disease	Pick One
Drug Overdose	Pick One	Liver disease	Pick One
Visual hallucinations	Pick One	High Blood Pressure	Pick One
Self cutting behavior	Pick One	Seizures d/o	Pick One
ADD or ADHD	Pick One	Kidney Disease	Pick One

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

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SUBSTANCE ABUSE HISTORY:

Alcohol	Pick One
Opiates (pain pills or Heroin)	Pick One
Benzodiazepines (Xanax, Valium, Ativan, Klonopin, etc.)	Pick One
Cocaine	Pick One
Amphetamines	Pick One
Any other illicit drugs	Pick One
Vaping	Pick One
Marijuana	Pick One
Tobacco	Pick One

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?
Are you on any diet?
Any history of trauma or abuse? Pick One
Any litigation (active or pending)? Pick One (describe)

FAMILY HISTORY:

Mental health problem	Pick One
Alcoholism	Pick One
Drug addiction	Pick One
Heart disease	Pick One
Diabetes	Pick One

REVIEW OF SYMPTOMS:

Headaches	Pick One	Dizziness	Pick One
Tremors	Pick One	Falls	Pick One
Visual difficulties	Pick One	Hearing difficulties	Pick One
Chest pains	Pick One	Palpitations	Pick One
Shortness of breath	Pick One	Nausea	Pick One
Vomiting	Pick One	Diarrhea	Pick One
Constipation	Pick One	Urinary Problem	Pick One
Cold chills	Pick One	Sweats	Pick One
Back pain	Pick One	Abdominal pain	Pick One
Weakness	Pick One	Date of last period	Pick One
Any sexual difficulties	Pick One	On birth control	Pick One
Are you pregnant	Pick One		

Patient's signature

SAHARA BEHAVIORAL HEALTH

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www.saharabehavioralhealth.com
(623) 878-2100

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

info@sbharizona.com

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 Sahara Behavioral Health to release the information contained on this form to the practitioner/ provider listed in the section 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

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:

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

SAHARA BEHAVIORAL HEALTH

TEL: (623) 878 – 2100 FAX: (623) 776 – 9419

PATIENT HEALTH QUESTIONNAIRE (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**
○	○	○	○

SAHARA BEHAVIORAL HEALTH

SAHARA BEHAVIORAL HEALTH
Therapy Consent Form

Counseling and Therapy Services

1. Purpose of Treatment
   Sahara Behavioral Health offers individual and family counseling, psychotherapy, and consulting services to adults, adolescents, and children addressing mental health and addiction needs. Services are provided by Licensed Clinical Social Workers and Licensed Professional Counselors. Therapists may refer the patient to a more appropriate clinician if they feel they are not a good match for the patients individualized needs.

2. Treatment Process
   Your treatment will begin with an initial assessment to determine your background, history, and the issues or problems you are seeking counseling for. Once the initial assessment is complete, the therapsit and patient will identify specific goals that will focus on the problems and issues identified in the assessment. The goals will be incorporated in a treatment plan that patients will participate and collaborate with throughout the course of treatment. Patients will participate in the development, review, and revisions of the plan and may refuse any recommendation by the team or therapist. Patients have the right to end therapy at any time for any reason without any moral, legal, or financial obligations other than for services that have already occurred.

3. Risk and Benefits of Treatment
   Counseling is intended to improve coping skills, reframe perspective, and reduce stress that patients may be experiencing. Counseling is not an exact science and individuals report varying benefits. Counseling is a process that requires a time investment in order to best work through issues that can cause distress like sadness, anger, and feelings of lonlieness. Some issues can be worked through quickly with positive outcomes but other issues or conflicts may take more time. Sometimes positive change in the patient may be viewed negatively by family and loved ones who are also adjusting to the changes the patient is experiencing. Benefits of therapy include healing, healthier choices, improved communication skills, stronger relationships, positive self image, and healthy boundaries.

4. Telehealth
   Telehealth involves the use of electronic communication to enable access to providers without requiring travel to a location outside of the home. In very rare cases, information transmitted may have poor quality or imaging and may not be sufficient for providers to review. Delays in treatment could occur due to equipment or program failure. In very rare cases, security protocols could fail resulting in a breach of security. Confidentiality applies for telehealth services and neither the therapist or patient may record in audio, visual, or any other format.

   *If video technology fails at the time of a scheduled session, patient will provide a telephone number the therapist can call to continue the session or reschedule.

   *Patients should be in a quiet private area using a secure connection through a webcam or phone. Patients will need to provide their location during a session in case of an emergency or safety concern. Patients may call the crisis line at 602-222-9444 or 911 or go to the nearest emergency room in case of a crisis situation.

SAHARA BEHAVIORAL HEALTH

5. Attendance
   Attendance is part of each patient's commitment to treatment. Appointments must be cancelled prior to 24 hours from the appointment time. If a patient does not cancel within appropriate time or attend the appointment, it will result in a $50.00 "No Show" fee. If a patient has 2 or more incidents of "No Show" they will no longer be eligible to receive therapy services with SBH.

6. After Hours Procedures
   Sahara Behavioral Health is open M-Th 8:30-4:30 and F 8:30-12:00 and can be reached at 623-878-2100. After hours leave a message with our answering service. For emergencies please call 911 or go to the nearest emergency room.

7. Confidentiality
   All information shared in counseling is strictly confidential according to HIPAA laws and regulations. However there are some exceptions that require confidentiality be broken. These include:
   - Information released with your consent and release of information
   - Disclosure of intent to harm self or others
   - Disclosure of child, elder, or vulnerable adult abuse
   - Court ordered release of records

   Sahara Behavioral Health is an integrated practice meaning patients may receive medical and therapeutic services from multiple providers within our practice. All providers within the practice have access to patient medical records for the purpose of providing care. It is our policy that records are not accessed for purposes other than providing care, billing, and maintaining medical records.

8. Therapist/Patient Relationship
   The relationship between the therapist and patient is meant to be therapeutic. This means the therapist will not attend personal events with patients or participate in social media communication. The purpose of these boundaries is to ensure confidentiality is maintained and the therapeutic relationship is honored. If there is ever an occasion that a patient feels they have been treated unfairly, please speak to your therapist directly first to discuss the concerns so that the issue does not impact the therapsit/patient relationship.

I have read and understand the policies as stated above.

Signature	Date
Parent/Guardian Signature	Date
Therapist Signature	Date