Desert Sage Behavioral Health

Daniel Chafetz, FNP, PMHNP

3395 N Campbell Ave
Tucson,AZ 85719
Phone (520) 771-6782
Fax (520) 230-8126

GENERAL INFORMATION

Welcome to Desert Sage Behavioral Health (DSBH). Dealing with a mental health disorder can be challenging, but you don't have to go through it alone. We're excited for the opportunity to help you reach your goals through effective quality care. We are a small privately owned company of psychiatric mental health practitioners that aim to help people of all backgrounds with any mental health disorders. We provide office and telehealth visits through doxy. We are also open until 8pm and we're available on the weekends. We have partnered with Genoa to provide in-office pharmacy services. We are here to help you and your loved ones take back your lives.

OFFICE HOURS

Monday: 8:00am-8:00pm
Tuesday: 8:00am-8:00pm
Wednesday: Special arrangement - Mainly doxy visits
Thursday: Special arrangement - Mainly doxy visits
Friday: 8:00am-8:00pm
Saturday: 8:00am-8:00pm
Sunday: 8:00am-8:00pm

EMERGENCIES AND URGENT CALLS

If you have a life-threatening medical emergency such as chest pain or difficulty breathing, please call 911 or go to the nearest Emergency Room.

For any mental health crisis, you can call the Pima County crisis line at 520-622-6000 or the National Suicide & Crisis Lifeline by calling "988" or texting the word "HOME" to 741741.

During business hours, urgent messages can be left with the receptionist who will relay the message to the provider. You may also ask the receptionist to attempt to book an appointment for you within the week.

For general messages, urgent needs after hours, on weekends, or holidays you will have the option of following the voice prompts on the voicemail and leave a verbal message with your phone number. This voicemail is checked daily each morning during business days. Please allow 48 business hours for return call. Please be patient as occasional delays are inevitable. If you suspect your message was not received, please try contacting us again.

Please use our fax or email, which has HIPAA compliant encryption, to send documents.

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PATIENT REGISTRATION FORM

Date: _____

Name: _____ Preferred Name:_____ Pronoun: _____

Date of Birth: _____ Age: _____ SSN: _____

Address: _____ City:_____ State: _____
(Number, Street, Box, Apt, Space)

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____

Emergency contact: _____ Phone: _____ Relationship:_____

Employer: _____ Title: _____ Address: _____

Referred by: _____ Family Physician: _____

RESPONSIBLE PARTY / CARD HOLDER

Name: _____ Relation to patient: _____ Phone: _____

Date of Birth: _____ Age: _____ SSN: _____

Address: _____ City:_____ State: _____
(Number, Street, Box, Apt, Space)

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Behavioral Insurance _____ Self-Pay: Yes [ ] No [ ]

Identification No: _____ Group No: _____ Phone: _____

Authorization No: _____

I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefits to the physician or supplier for services rendered. **I fully understand that if my insurance denies payment for any services defined as a non-covered service, or if my account becomes delinquent due to missed appointments, late cancellations, or returned check fees then I will be responsible for any amount due.** I further understand if my account gets referred to or placed with a collection agency that I will be fully responsible for all fees assessed with collections.

Patient, or authorized Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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FEE SCHEDULE

The following fees apply to patients paying out of pocket and insurance plans not contracted with our office. These treatment fees are kept within the standard of the Tucson community.

Service		**Charge**	**No Show/Cancelation**
Initial Diagnostic Evaluation (60 mins)		$300	$100
Medication Management (30 mins)		$150	$75
Phone sessions:	10-15 mins	$40	
	16-25 mins	$75	
	26-30 mins	$90	
Other charges:			
Returned check fee		$35	
Late co-payment fee		$5	
Overdue balance per month (30 days past due)		$5 (balance under $100)	
Overdue balance per month (30 days past due)		$10 (balance over $100)	
Early refills (see prescription policies)		$30	

FINANCIAL POLICIES

•**Payment is due and expected at the time of service**. Personal checks, cash, and Visa/MasterCard/AmEx are accepted. There is a $35 charge for returned checks.

• Missed appointments, late cancellations, or changing appointments with less than **24 business hours'** notice will result in the patient being responsible for a full fee of the scheduled service (please refer to the fee schedule above for further details about fees). $75 for follow up, $100 for longer appointments. Please give more than 24 business hours' notice in order to avoid having to pay out of pocket for missed, late canceled or changed appointments. (Example: if your appointment is Monday at 3:15pm, you must cancel before Sunday at 3:15pm). If you call and there is no answer, leave a message. The voicemail will timestamp your message.

• All accounts must be paid off to keep any scheduled appointments, including, but not limited to No Show fees, Late Cancelation Fees, Deductible Balances, Co-Pays and Past Due Balances. If you have a balance and payment is not received before your next scheduled appointment it will be canceled. Special arrangements can be made for Life-threatening Emergencies.

• Delinquent accounts (balances in excess of 30 days) will be subject to a $5 (for balances less than $100) or a $10 (for balances above $100) service charge per month. You further agree that should your account be turned over to a collection agent, you will be responsible for any and all charges incurred as a result of the collection process. If temporary financial problems arise, please contact the office at 520-771-6782 so that an adequate payment plan may be arranged.

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PRESCRIPTION POLICIES

• Before requesting a refill, please check your bottle to see if there are any refills left. Please make sure to call at least 7 days prior to running out of medications. When you call, please provide your name, date of birth, name of medication and your pharmacy number.

• There will be a $30.00 charge for the following: Each lost prescription replacement for any medication A rewrite for a partially filled prescription A refill request when overdue for an appointment Rewrite for prescriptions that cannot be transferred. Rewrite for new prescription not on formulary or too expensive

• It is often helpful to bring all your prescription bottles with you on your first appointment or early in your treatment to review your medication and what will need to be refilled. We may not be able to refill new medications in between appointments.

• Make sure you inform us of your pharmacy to send prescriptions to at the time of the appointment. Genoa is our in-house pharmacy; they can facilitate prior authorizations and delivery of medications to your home or schedule a time for you to pick up at our office.

• If the prescription is for a controlled medication, please call the pharmacy first as there should be a prescription waiting for you.

• If you have not missed or canceled any appointments, Make sure there are medication refills to last until your next appointment.

• Please keep in mind the policies you were shown on your first appointment about when we have to charge for refills.

• Unless previously arranged, You are required to be seen every 3 months to continue to refill medication.

PRIOR AUTHORIZATION POLICIES

• Prior authorization forms are unfortunately time consuming, please allow up to 72 hours or more depending on medication and/or pharmacy.

I hereby acknowledge that I have been presented with a copy of DSBH fee, financial. Prescription, and prior auth policies.

_____ _____

Patient parent/guardian signature **Date**

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Dear patient,

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 Act of 1996 (HIPAA). This practice is dedicated to maintaining the privacy 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:

• To public health authorities and health oversight agencies that are authorized by law to collect information.
• Lawsuits and similar proceedings in response to a court or administrative order.
• If required to do so by law enforcement official. 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 able to help prevent the threat.
• If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
• To federal officials for intelligence and national security activities authorized by law.
• To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
• For Workers Compensation and similar programs.

Your rights regarding your health information

• 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 work. We will accommodate reasonable requests.
• 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 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.
•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 Desert Sage Behavioral Health.
•You may ask 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 Desert Sage Behavioral Health. **You must provide us with a reason that supports your request for amendment.**
•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.

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•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. Contact the U.S. Department of Health and Human Rights, by mail at 200 Independence Ave, S.W. Washington D.C. 20201 or at HHS.Mail@hhs.gov. The complaint to the Secretary must be filled with 180 days of when the complainant knew or should have known that the act of omission complaint occurred. To file a complaint with our practice, contact the office. All complaints must be submitted in writing.
•You will not be penalized for filing a complaint. 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 the receptionist at Desert Sage Behavioral Health.

I hereby acknowledge that I have been presented with a copy of Desert Sage Behavioral Health's Notice of Privacy Practices/Disclosure of Protected Health Information.

Printed Name: _____

Signature: _____

Date: _____

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FINANCIAL RESPONSIBILITY

Please read each statement below and initial to indicate agreement:

Initials _____	**PAPERWORK FOR OUTSIDE AGENCIES** Paperwork for outside agencies (ex. Medical leave, disability, time-of-work paperwork, etc.) I agree to pay a fee of $75 out-of-pocket charge per report, as these **are not** covered by insurance.
Initials _____	**PAYMENT FOR SERVICES** I agree to provide payment/co-pay/co-insurance for both the initial evaluation and for subsequent services prior to my appointment. • Payment for services is expected at the time services are rendered • If I have an outstanding balance of $100 or more, I understand that I must make payment arrangements before scheduling my next appointment.
Initials _____	**MISSED APPOINTMENTS AND LATE CANCELLATIONS** • With a few exceptions, I understand that I am responsible for the full fee ($75/$100), for missed appointments/late cancellations (less than 24 hours' notice). For example- a Monday 1 pm appointment must be canceled prior to 1 pm the previous Sunday. • Insurance does not cover missed appointments. If there is no answer when you call to cancel, leave a message. If voicemail is full, send email. Please understand that these options provide time stamps for when appointments are canceled.
Initials _____	I fully understand that if my insurance denies payment for any services defined as a non-covered service, or if my account becomes delinquent due to missed appointments, late cancellations, or returned check fees, then I will be responsible for **ANY AMOUNT DUE**. I further understand that if my account gets referred to or placed with our collection agency, I will be **FULLY RESPONSIBLE** for **ALL FEES** assessed with collections and/or attorney/court costs.

I agree with the statements above and have initiated each space.

Patient, or authorized Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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MEDICATION AGREEMENT & INFORMATION

Initials _____	• Before requesting medication refills, check the bottle to see if there are any refills left. • If in need of medication refill before the next appointment, notify **DSBH ONE WEEK** prior to running out of medication. This allows enough time to refill medication and ensure that you do not go without. In some cases, pharmacies may bridge medication until the office reopens. • To receive medication refills, I understand that I'm REQUIRED to attend follow-up appointments at **least every 3 months.**
Initials _____	If I'm prescribed a BENZODIAZEPINE (alprazolam, clonazepam, diazepam, Initials: lorazepam) for longer than 3 months, I agree to attend anxiety groups as offered by DSBH.
Initials _____	I understand that I must provide a copy of an EKG completed within the past year **BEFORE** being prescribed a stimulant for ADHD (amphetamine, dexmethy|phenidate, dextroamphetamine, methylphenidate, or Vyvanse). I understand that my medication will **NOT** be filled until an EKG within 1 year has been completed AND the results have been read by provider,
Initials _____	If I'm prescribed a controlled medication (benzodiazepine or stimulant) • I agree to **RANDOM DRUG SCREENINGS**. I Understand that failure to complete in a timely manner (72 hours) or testing positive for substances not prescribed to me will result in instant discharge of all controlled medications. (Tapering off certain medications may be offered if deemed medically appropriate). • I understand that if my medication is LOST or STOLEN, **I must file a report with the local police department. A Copy of the police report must be sent to DSBH and a follow up appointment must be scheduled BEFORE another script is filled**. DSBH will determine outcomes on a case-by-case basis.
Initials _____	I Agree to not drive under the influence of any alcohol and/or illegal substance, or After receiving Spravato/Ketamine. These actions may put providers at liability and are **NOT** tolerated. **YOU WILL BE DISCHARGED AS PATIENT**. I understand that staff will set up transportation to/from appointments (at my expense) to ensure the safety of myself and/or the public.
Initials _____	**CONSENT FOR TREATMENT AGREEMENT** I agree to receive psychiatric treatment, which may include medication management and/or other psycho-therapeutic interventions as clinically indicated. This treatment is in accordance with standard practice, laws, and regulations regarding psychiatric treatment in Arizona. I understand that DSBH's treatment recommendations represent the options they believe will benefit me most. I am aware that I am free to either consent to this/these treatments(s) ot refuse without affecting any other treatment I may be receiving.

I acknowledge that I have read and understand the above information.

Patient, or authorized Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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FINANCIAL POLICY

AGREEMENT FOR PAYMENT FOR SERVICES:
Full Payment for services is at the time of service and collected at the beginning of each appointment. Any insurance co-payments are due at time of service. You must provide your insurance card and identification-at-each visit, which is subject for verification prior to your appointment time. DSBH reserves the right to cancel your appointment if proof of insurance cannot be verified or is not provided or require full visit fee be paid prior to your appointment.

CO-PAY:
A preset amount that is your responsibility at each visit. This is a flat rate that is subject to change each time your policy is renewed.

Co-Insurance: Percentage of your visit which will be calculated on the amount your insurance discount allows for the type of service you are receiving. This amount may change from visit to visit depending on the complexity of your appointment and or additional services rendered during your appointment.

SELF-PAY:
When you do not have an insurance discount plan, paying cash for your visit, you will be quoted a typical visit amount for your reason for visit and length and payment will be required prior to your visit. This amount may increase depending on the type of service you actually receive along with any additional services rendered during the visit.

SCHEDULING AGREEMENT: For DSBH staff to schedule you in a timely manner and allow for timely follow-up appointments, it is your responsibility to communicate when you are unable to keep your appointment not only as a courtesy to your provider and other patients, but also for administrative purposes as our staff prepares for each and every patient visit. Please be advised that 3 no shows for any provider will result in discharge from the practice. 24-hour notice must be provided to cancel an appointment or a no-show fee of $75 for 30 min appointment and $100 for hour long or longer appointment will be charged to your account, and you may not be able to reschedule the missed appointment for 30 days or until fee is paid. No show fee and same day cancellation rate is $75/$100 (if this is recurring you will not be able to set up an appointment for 30 days and/or be discharged as a patient).

UNDERSTANDING YOUR COSTS:
While DSBH staff strives to make sure all your financial obligations for services are clearly explained to you prior to your visit, it is your responsibility as a patient to understand what your insurance covers and does not. DSBH recommends you contact your insurance company by calling the number listed on your insurance card and inquire about your mental health benefits allowing you to be aware of any costs that may become your responsibility as part of your treatment with DSBH. I also understand and acknowledge that I am personally responsible to pay DSBH in full for services that my health insurer will not cover due to nonpayment of my health insurance premiums. Financial Policy

I acknowledge that I have read and understand the above information.

Patient, or authorized Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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OUTSTANDING BALANCES: If your patient responsibility balance becomes greater than $100.00 at any time, DSBH requires payment agreements be made and followed in order to continue treatment. If at any time it is determined that good faith payments are not being made on any account, DSBH reserves the right to deny services till accounts are paid in full. Not fulfilling financial obligations to DSBH is also grounds for discharge from the practice. If there is a credit balance on your account at any time and you are still receiving treatment, please note that the credit will be applied to future fees incurred. Overpayments on accounts will be refunded if no longer receiving services within a period of six months.

Other Costs: Any returned check for insufficient funds will result in an additional fee of $35.00. Medical Records Release to patient, cost starts at $35 for the first 30 pages and is $0.25 for any pages over 30. Medical record releases requested by other providers on your behalf are at no charge to you. Complex forms requested to be filled out by your provider on your behalf may also incur additional fees depending on time required for completion. This does not pertain to insurance prior authorizations. Please present your documents and then DSBH staff can assess whether fees will be incurred.

MEDICATION REFILL POLICY: Prescriptions should be obtained at your regularly scheduled physician appointments. It will be necessary for you to make an appointment for any prescription changes as this will not be done over the phone. There are times when you may have prescription needs between appointments, please be aware that no prescriptions will be refilled after normal business hours. Please allow 72 hours for processing of any prescription request. In the event a prescription is not effective, do not discard medication. Please bring in any unused medication at your next visit and DSBH staff will properly dispose of it. Please note that some prescriptions require prior authorization from insurance companies and allow DSBH staff 72 hours to complete necessary forms and follow-up on your behalf. DSBH will not replace lost or stolen prescriptions unless a police report is provided. A $30.00 fee will be your responsibility if your physician must replace the prescription after the police report is provided to the DSBH.

STATEMENTS: Each month you will receive a statement for your portion of any bill that is due within 30 days of receipt. You will be asked at your next appointment for any outstanding balance payment in full unless prior arrangements for payments have been made.

COMMUNICATION: If you ever have questions about bills that you receive or you have the need to make payment arrangements due to hardship, loss of insurance, job, or other, please contact our billing department and we will be happy to assist you in your options for continuing your care. Please retain this document for your records

BILLING FOR LAB SERVICES: Most diagnostic tests (labs) performed in conjunction with your medical visit will be an additional charge that is billed separately to your mailing address and/or insurance. If you receive a Lab bill that you find in error, please call them directly at the number provided on the bill.

I acknowledge that I have read and understand the above information.

Patient, or authorized Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

GENERAL MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Primary Care Physician (or NP or PA)

Name: _____ Phone: _____

Address: _____ Fax: _____

Other Physicians/Specialists/Therapists

Name: _____ Specialty:_____ Phone: _____

Name: _____ Specialty:_____ Phone: _____

Medical History: Do you have or have you ever had (check the ones that apply to you)

	Yes	No		Yes	No		Yes	No
Chronic pain	[ ]	[ ]	Hair/nail changes	[ ]	[ ]	Heart attack	[ ]	[ ]
Loss of appetite	[ ]	[ ]	Hair loss	[ ]	[ ]	Heart disease	[ ]	[ ]
Increase in appetite	[ ]	[ ]	Diarrhea	[ ]	[ ]	Hepatitis	[ ]	[ ]
Weight gain	[ ]	[ ]	Constipation	[ ]	[ ]	High blood pressure	[ ]	[ ]
Weight loss	[ ]	[ ]	Persistent nausea	[ ]	[ ]	High cholesterol	[ ]	[ ]
High energy	[ ]	[ ]	Persistent vomiting	[ ]	[ ]	Triglycerides	[ ]	[ ]
Low energy	[ ]	[ ]	Heartburn	[ ]	[ ]	HIV	[ ]	[ ]
Night sweats	[ ]	[ ]	Urine frequency	[ ]	[ ]	Irritable bowel syndrome	[ ]	[ ]
Not enough sleep	[ ]	[ ]	Urine retention	[ ]	[ ]	Stroke	[ ]	[ ]
Too much sleep	[ ]	[ ]	Chest Pain	[ ]	[ ]	Hyperthyroidism	[ ]	[ ]
Dizziness	[ ]	[ ]	Heart palpitations	[ ]	[ ]	Hypothyroidism	[ ]	[ ]
Memory problems	[ ]	[ ]	Swollen hands/feet	[ ]	[ ]			
Frequent headaches	[ ]	[ ]	Arthritis	[ ]	[ ]			
Muscle spasms	[ ]	[ ]	Asthma	[ ]	[ ]	Other medical Conditions:		
Tremors	[ ]	[ ]	Bleeding/clotting	[ ]	[ ]			
Muscle weakness	[ ]	[ ]	Cancer	[ ]	[ ]	_____		
Swelling of joints	[ ]	[ ]	Diabetes	[ ]	[ ]	_____		
Joint pain/stiffness	[ ]	[ ]	Epilepsy/seizures	[ ]	[ ]	_____		
			Fibromyalgia	[ ]	[ ]			
			GERD/acid reflux	[ ]	[ ]	_____		
			Glaucoma	[ ]	[ ]			

Date last blood work completed: _____

Date last EKG completed: _____

Medications and doses (include supplements, herbals, birth control).

_____

_____

_____

Medication allergies: _____

Pharmacy (include name and cross streets): _____

For women: Are you currently pregnant? Yes [ ] No [ ] Unsure [ ] If yes, how many weeks?_____

Are you currently on birth control? Yes [ ] No [ ] Have you gone through menopause? Yes [ ] No [ ]

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ARIZONA HIPAA MEDICAL RELEASE FORM

Authorization for use or disclosure of health information

I authorize **Desert Sage Behavioral Health** to **disclose** the following information from the health records of:
Patients name: _____ Date of birth: _____ / _____ / _____
Phone Number: (____) _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize the following **persons or business** to **receive** my protected health information:
Name of business/person _____
Address: _____
City: _____ State: _____ Zip: _____
Information to be released (check if applicable:

[ ] Allergy Records [ ] Consultations [ ] Developmental/Behavioral
[ ] Drug/Alcohol Treatment [ ] Genetic testing [ ] HIV/AIDS
[ ] Hospital records & reports [ ] Immunizations [ ] Surgical reports
[ ] Prescriptions [ ] Psychiatric [ ] Sexual Assault
[ ] Treatment or tests [ ] X-Ray reports [ ] Other communicable disease
[ ] Discharge summary **[ ] ENTIRE MEDICAL RECORDS**
[ ] Other (specify):_____

For the following dates: FROM: _____ TO: _____

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws. I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organizations) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization. I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

Printed Name: _____

Signature: _____ Date: _____

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ARIZONA HIPAA MEDICAL RELEASE FORM

Authorization for use or disclosure of health information

I authorize **Desert Sage Behavioral Health** to **Receive** the following information from the health records of:
Patients name: _____ Date of birth: _____ / _____ / _____
Phone Number: (____) _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize the following **persons or business** to **Disclose** my protected health information:
Name of business/person _____
Address: _____
City: _____ State: _____ Zip: _____
Information to be released (check if applicable:

[ ] Allergy Records [ ] Consultations [ ] Developmental/Behavioral
[ ] Drug/Alcohol Treatment [ ] Genetic testing [ ] HIV/AIDS
[ ] Hospital records & reports [ ] Immunizations [ ] Surgical reports
[ ] Prescriptions [ ] Psychiatric [ ] Sexual Assault
[ ] Treatment or tests [ ] X-Ray reports [ ] Other communicable disease
[ ] Discharge summary **[ ] ENTIRE MEDICAL RECORDS**
[ ] Other (specify):_____

For the following dates: FROM: _____ TO: _____

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws. I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organizations) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization. I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

Printed Name: _____

Signature: _____ Date: _____

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Communication Consent Form

Patient Information

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____

Consent

I, the undersigned patient, hereby authorize Desert Sage Behavioral Health to:

• **Contact me via text message** regarding my treatment and appointment reminders.

Consent for Text Messages:

Signature: _____

Date: _____

• **Send and receive emails** regarding my medical information and treatment plans.

Consent for Email Communication:

Signature: _____

Date: _____

• **Communicate with me** regarding my care and treatment through voice messages.

Consent for Phone Communication:

Signature: _____

Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE - 9
(PHQ-9)

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	☐ **1**	☐ **2**	☐ **3**	☐ **4**
2. Feeling down, depressed, or hopeless	☐ **1**	☐ **2**	☐ **3**	☐ **4**
3. Trouble falling asleep or staying asleep, or sleeping too much	☐ **1**	☐ **2**	☐ **3**	☐ **4**
4. Feeling tired or having little energy	☐ **1**	☐ **2**	☐ **3**	☐ **4**
5. Poor appetite or overeating	☐ **1**	☐ **2**	☐ **3**	☐ **4**
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐ **1**	☐ **2**	☐ **3**	☐ **4**
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ **1**	☐ **2**	☐ **3**	☐ **4**
8. Moving or speaking so slowly that people would have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐ **1**	☐ **2**	☐ **3**	☐ **4**
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ **1**	☐ **2**	☐ **3**	☐ **4**

Add each column _____+_____+_____+_____

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

General Anxiety Disorder 7-item (GAD-7) Scale

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. Feeling nervous, anxious, or on edge	☐ 1	☐ 2	☐ 3	☐ 4
2. Not able to stop or control worrying	☐ 1	☐ 2	☐ 3	☐ 4
3. Worrying too much about different things	☐ 1	☐ 2	☐ 3	☐ 4
4. Trouble relaxing	☐ 1	☐ 2	☐ 3	☐ 4
5. Being so restless that it's hard to sit still	☐ 1	☐ 2	☐ 3	☐ 4
6. Becoming easily annoyed or irritable	☐ 1	☐ 2	☐ 3	☐ 4
7. Feeling afraid as if something awful might happen	☐ 1	☐ 2	☐ 3	☐ 4

Add each column _____+_____+_____+_____

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

Mood Disorder Questionnaire

Name: _____ Date: _____

Instructions: Mark the answer that best applies to you. Please answer each question as best as you can.

1. Has there ever been a period of time when you were not your usual self and…	Yes	No
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
...you felt much more self-confident than usual?		
...you got much less sleep than usual and found you didn't really miss it?		
...you were much more talkative or spoke faster than usual?		
...thoughts raced through your head or you couldn't slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating o r staying on track?		
...you had much more energy than usual?		
...you were much more active or did many more things than usual?		
...You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
...spending money got you or your family in trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time ? Please check 1 response only.		
3. How much of a problem did any of these cause you – like being able to work; having family. Money, or legal problems; getting into arguments or fights? ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

Adult ADHD Self Report Scale (ASRS-v1.1) Symptoms Checklist

Patient Name: _____ Date: _____

Instructions: Mark the answer that best applies to you. Please answer each question as best as you can.

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an Xin the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Very often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?				
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?				
3. How often do you have problems remembering appointments or obligations?				
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?				
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?				
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?				

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?				
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?				
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?				
10. How often do you misplace or have difficulty finding things at home or at work?				
11.How often are you distracted by activity or noise around you?				

Continued on the next page…

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an Xin the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Very often
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?				
13. How often do you feel restless or fidgety?				
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?				
15. How often do you find yourself talking too much when you are in social situations?				
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?				
17. How often do you have difficulty waiting your turn in situations when turn taking is required?				
18. How often do you interrupt others when they are busy?				