SAHARA BEHAVIORAL HEALTH

NEW PATIENT INTAKE PACKET

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

Preferred Name: _____ Date of Birth: _____ Social Security Number: _____

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

Home Phone: _____Cell Phone: _____ Email: _____

Marital Status: _____ Gender: Male ☐ Female ☐ Transgender ☐ Other: _____

Preferred Language: _____ Race/Ethnicity: _____

Occupation: _____ Employer: _____ Referred by: _____ Phone Number: _____

We utilize our In-House Pharmacy GENOA HEALTHCARE PHARMACY. If you prefer to use a different pharmacy, please indicate below.

Preferred Pharmacy: _____ Phone Number: _____ Pharmacy Address: _____

AUTHORIZED PERSONS TO DISCUSS YOUR ACCOUNT / TREATMENT / MEDICAL RECORDS

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Primary Care/PCP: _____ Phone #: _____ Fax #: _____

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 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.

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

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 #: _____

Card on File Authorization

Effective August 1, 2026, Sahara Behavioral Health (SBH) is requiring all patients to keep a debit or debit/credit card on file. Your signature in this form is to authorize charges to your debit/credit card through our e-payment system via e-clinical works for services rendered. Your card information will be stored securely in e-clinical works and charged only when there is a balance on your account. These charges will appear on your bank debit/credit card statement as Satinder S Purewal MD LLC. You have the right to request a paper copy of this document.

I authorize Sahara Behavioral Health to charge my debit/credit card. I also agree that my debit/credit card will be charged for any additional fees that I incur, including late cancellation/no shows for visits with my psychiatric provider, treatment visits, form fees, urine drug screens, and provider letters. **I authorize Sahara Behavioral Health to charge my debit/credit card the same day these fees are incurred. The fees are listed below:**

- **Missed-late cancelled follow-up psychiatry appointment $50.00**
- **Urine drug screen $25.00**
- **Form fee/FMLA/Disability (per packet) $50.00 1st page, $10.00 each additional page.**
- **Provider letters $50.00**

I understand that if I have a balance with SBH after my insurance company processes my claim, including deductible, coinsurance, and copays, the office will run my debit/credit card on file to settle this balance. I understand that it is my responsibility to contact the office and update my card on file or notify the billing office if I need to make other payment arrangements. SBH will not refund processed payments.

I understand that this authorization will remain in effect as long as I am a patient at Sahara Behavioral Health. I agree to notify SBH of any changes in my account information. I understand that I may not be able to start or continue services without an active card on file.

I certify that I am an authorized user of this debit/credit card and will not dispute these scheduled transactions with my bank or debit/credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that debit/credit card transactions could be linked to Protected Health Information.

I hereby authorize the below:

- **I authorized SBH to securely store my debit/credit card.**
- **I authorize SBH to charge administrative fees the same day they occur- these include missed appointments, urine drug screens, form, and letter fees.**
- **If I have a balance from my visit after my insurance processes, I understand that my card will be charged for this balance once the notice is received from the insurance company.**
- **I will call SBH to update my card on file should the funds not be available, the card is cancelled, or if I need to make other payment arrangements.**
- **I understand that SBH may decline to continue services if I violate this agreement.**
- **I understand SBH will not charge more than $500 to the card without permission regardless of larger balance.**
- **I understand if I choose to use a credit card I may be charged up to a 3% fee.**

By signing below, you certify that you are the person completing this form and that you understand and consent to the content therein.

Signature

Date

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
OFFICE POLICIES

1. All Medications will be refilled by Appointments only. Refills are not provided by phone, email, or outside of office hours.
2. 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. The insurance company will be notified of 2 or more "no show appointments" and the practice may not continue to provide services.
4. All co-pays, deductibles and balances owed are due at the time of your appointment.
5. 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. Inappropriate language, threats and/or behavior will not be tolerated, and will be grounds for dismissal from practice.
7. Absolutely no alcohol, illegal drugs, or weapons are allowed in the building.
8. The use of electronics for the purpose of recording or videoing is strictly prohibited in the building, including the patient lobby.

Office Policy Initials: _____

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 and agree to the following:

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.
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.
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.
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.
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.
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
7. **I understand that selling, trading, or giving a medication to another person is illegal.**
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.**
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.
10. **I give my permission for Sahara Behavioral to contact any pharmacy, physician, or hospital to specifically discuss my medications as necessary.** Understand that providers at Sahara Behavioral also check data on state prescription drug monitoring program.
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.

Controlled Drug Policy Initials: _____

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.

Client Informed Consent Initials: _____

I have read and understand and agree to the policies as stated above.

_____ _____

Signature **Date**

SAHARA BEHAVIORAL HEALTH
NOTICE OF HEALTH INFORMATION PRIVATY PRACTICES

This Notice of Health Information Privacy Practices or "Notice" describes how Sahara Behavioral Health may use and disclose your health information and how you can access this information. In this Notice, we use terms like "we," "us" or "our" or "Sahara Behavioral Health" to refer to Sahara Behavioral Health, and its affiliates. Please review this Notice carefully.

How and Why We Protect Your Privacy
We understand that information about you and your health is personal. By "health information," we mean protected health information as defined under federal law (the Health Insurance Portability and Accountability Act, or HIPAA, and its implementing regulations). Not only is it our legal obligation, but it is our business imperative to ensure the confidentiality of your health information. We continuously seek to safeguard your health information through administrative, physical, and technical means, and otherwise abide by applicable federal and state laws.

How We Collect and Maintain Your Health Information
The health information that we collect or maintain may include:

- Your name, age, date of birth, insurance policy information, email address, username, password, and other registration information.
- Health information that you provide us, which may include information or records relating to your medical or health history, health status and laboratory testing results, diagnostic images, and other health-related information.
- Health information about you prepared or obtained by the Healthcare Professionals(s) who provide clinical services through our electronic health record, such as medical and therapy records, treatment and examination notes, and other health-related information.
- Billing information that you provide us, such as credit card information, or that we receive from a health plan, employer or other provider of healthcare benefits on your behalf.

How We Use and Disclose Health Information
We use and disclose your health information for the normal business activities that the law sees as falling in the categories of treatment, payment, and healthcare operations. Generally, we do not need your permission for these disclosures under applicable laws. Below we provide examples of those activities, although not every use or disclosure falling within each category is listed:

1. Treatment – We keep a record of the health information you provide us. This record may include your test results, diagnoses, medications, your response to medications or other therapies, and information we learn about your medical condition through therapy or psychiatry services. We may disclose this information so that other doctors, nurses, and entities such as laboratories can meet your healthcare needs.
2. Payment – We document the services and supplies you receive when we are providing care to you so that you, your insurance company, or another third party can pay us. We may tell your health plan about upcoming treatment or services that require prior approval by your health plan.
3. Health Care Operations – Health information is used to improve the services we provide, to train staff, for business management, quality assessment and improvement, and for customer service. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you.
4. Marketing – By agreeing to our Privacy Policy, you authorize us to contact you with newsletters, educational materials, marketing, promotional materials, and other information we believe may be helpful to you.

We may also use and disclose your health information to:

- Comply with federal, state, or local laws that require disclosure.
- Assist in public health activities, such as tracking diseases or medical devices.
- Inform authorities to protect victims of abuse or neglect.
- Comply with federal and state health oversight activities, such as fraud investigations.
- Respond to law enforcement officers or court orders, subpoenas or other processes.
- Inform coroners, medical examiners and funeral directors of information necessary for them to fulfill their duties.
- Facilitate organ and tissue donation or procurement.

- Conduct research following internal review protocols to ensure the balancing of privacy and research needs.
- Avert a serious threat to health or safety.
- Assist in specialized government functions, such as national security, intelligence, and protective services.
- Inform military and veteran authorities if you are an armed forces member (active or reserve).
- Inform a correctional institution if you are an inmate.
- Inform workers' compensation carriers or your employer if you are injured at work.
- Recommend treatment alternatives.
- Tell you about health-related products and services.
- Communicate within our organization for treatment, payment, or healthcare operations.
- Communicate with other providers, health plans, or their related entities for their treatment or payment activities, or health care operations activities relating to quality assessment and improvement, care coordination, and the qualifications and training of healthcare professionals.
- Disclose health information to funeral directors, medical examiners, or coroners as required for their duties. After 50 years post-death, health information may be used or disclosed without restrictions.
- Provide information to other third parties with whom we do business, such as a record storage provider.
    - However, you should know that in these situations, we require third parties to sign a legal Business Associate Agreement (BAA) in order to attest that they will safeguard your information.
- We may also use or disclose your personal or health information for operational purposes. For example, we may communicate with individuals involved in your care or payment for that care, such as family or guardians, and send appointment reminders.
- All other uses and disclosures, not previously described, may only be done with your written authorization. You may revoke your authorization at any time; however, this will not affect prior uses and disclosures. In some cases, state law may require that we apply additional protections to some of your health information.

Our Healthcare Professionals' Responsibilities
We are required by law to:

- Maintain the privacy of your health information.
- Provide this Notice of our duties and privacy practices.
- Abide by the terms of the Notice currently in effect.
- Tell you if there has been a breach compromising your health information.
- We reserve the right to change our privacy practices and make the new practices effective for all the information we maintain.

Your Federal Rights
The law entitles you to:

1. Inspect and copy certain portions of your health information. We may deny your request under limited circumstances. You may request that we provide your health records to you in an electronic format.
2. Request amendment of your health information if you feel the health information is incorrect or incomplete. However, under certain circumstances we may deny your request.
3. Receive an accounting of certain disclosures of your health information made for the prior six (6) years, although this excludes certain disclosures for treatment, payment, and health care operations. (Fees may apply to this request).
4. Request that we restrict how we use or disclose your health information. However, we are not required to agree with your requests, unless you request that we restrict information provided to a payor, the disclosure would be for the payor's payment or healthcare operations, and you have paid for the health care services completely out of pocket.
5. Request that we contact you at a specific telephone number or address.
6. Obtain a paper copy of this notice even if you receive it electronically. We may ask that you make a request in writing.

How to File a Complaint
If you believe that your privacy has been violated, you may file a complaint with us or with the US Department of Health and Human Services. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

To file a complaint with us or receive more information contact:
Phone: 623-878-2100
Email: info@sbharizona.com

To file a complaint with the Secretary of Health and Human Services:
Phone: (800) 537-7697

To file an online complaint:
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Address: 200 Independence AVE, S.E., Washington, DC 20201

_____ _____
Client / Parent or Legal Guardian Signature **Date**

_____ _____
Client / Parent or Legal Guardian Name **Relationship to Client**

Sahara Behavioral Health

www.saharabehavioralhealth.com ◆ (623) 878-2100

Name: _____ Date of Birth: _____ Today's Date: _____

(This is a confidential record of your medical history and will be kept by this office. Please fill completely)

Previous Psychiatrist: _____ Office Phone Number: _____

Reason for Visit: _____

Are you <u>currently</u> having any of the following complaints? Please check the box if yes:

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

<u>PAST</u> Mental Health History. Please Check the boxes that apply:

Major Depression	☐	Drug addiction	☐
Anxiety	☐	Drug overdose	☐
Bipolar	☐	Seizure disorder	☐
Schizophrenia	☐	Diabetes	☐
ADHD or ADD	☐	High blood pressure	☐
Self-harm or cutting behavior	☐	Heart disease	☐
Suicide attempt	☐	Liver disease	☐
Alcoholism	☐	Kidney disease	☐

Past Medical History:

Past Surgical History:

Surgery	Date	Reason

Substance Abuse History. Please check current or past for all that apply:

Substance	Current	Past	Length of Use (in years)
Alcohol	☐	☐	
Opiates (prescription pain medication, heroin, etc.)	☐	☐	
Benzodiazepines (Xanax, Valium, Ativan, Klonopin, etc.)	☐	☐	
Cocaine	☐	☐	
Amphetamines (methamphetamine, Adderall, etc.)	☐	☐	
Any other illicit drugs (LSD, PCP, MDMA, etc.)	☐	☐	
Marijuana	☐	☐	
Tobacco	☐	☐	

If you are currently drinking alcohol, please answer the following questions:

1. How often do you have a drink containing alcohol?
   ☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
3. How often do you have six or more drinks on one occasion?
   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Personal and Social History:

Place of birth		Height	
Highest level of education		Present weight	
Occupation		Usual Weight	
Marital status		Recent significant weight change?	
Number of children		History of trauma or abuse?	
Who do you live with?		Any active or pending litigation?	

Family History. Please check all that apply:

Condition	Maternal	Paternal	Unknown
Mental health problems			
Alcoholism			
Drug addiction			
Heart disease			
Diabetes			

Review of Symptoms. Please check all that apply:

Headaches	☐	Palpitations	☐	Constipation	☐
Dizziness	☐	Chest pain	☐	Diarrhea	☐
Tremors	☐	Shortness of breath	☐	Sweats	☐
Weakness	☐	Back pain	☐	Urinary problems	☐
Falls	☐	Abdominal pain	☐	Sexual difficulties	☐
Hearing difficulties	☐	Nausea	☐	Pregnant	☐
Visual difficulties	☐	Vomiting	☐	On birth control	☐

Falls: In the last year, how many major falls have you suffered that have resulted in major injury?

☐ Zero ☐ One or two ☐ Three or four ☐ More than four

Advanced Directive: Please check all that apply:

☐ I do NOT have an Advanced Directive ☐ I do have an Advanced Directive ☐ I have a DNR

If you do have an Advanced Directive in place, please provide Sahara Behavioral with all relevant information so we can be better equipped to support you.

Medication:

Allergies:

Current Medications:

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

Previous Medications:

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

The information provided above is correct to the best of my knowledge and understanding.

_____ _____

Client / Parent or Legal Guardian Signature **Date**

_____ _____

Client / Parent or Legal Guardian Name **Relationship to Client**