ARIZONA BEHAVIORAL HEALTH CENTER

2600 N. 44th Street Suite B-104, PHOENIX, AZ. 85008
(602) 343-8232 Office (602) 323-8233 Fax

SERVICE INFORMATION

Form 20.004a

Patient Information:

Name_____ Age_____ Gender_____ Martial Status _____
Social Security Number_____ Date of Birth_____ Telephone _____
Address_____ City_____ Zip _____
E-Mail_____
Occupation_____ Employer or School_____
Business/School Address_____ Telephone _____

Spouse or Parent Information:

Name_____ Date of Birth_____
Address_____ Telephone_____
Occupation_____ Employer_____
Business address_____ Business Phone_____

In case of Emergency contact (person outside of your household):
Name/Relationship:
_____ Telephone_____
Address_____

Reason for requesting consultation_____
Referring physician/source of referral_____

Insurance Information:

Insurance Company_____ Mental Health Network_____
Insured's Name_____ Telephone No._____
Insured's Date of Birth_____ Relationship to patient_____
Insured's Employer _____ Employer's
No._____
Social Security Number of Insured_____ Authorization No._____
Policy#_____ Insurance Company's Telephone No._____

MEDICAL INSURANCE & FEE POLICY: Payment Due at Time of Service

If you have medical insurance coverage, you are directly responsible for payment. The insurance contract exists between you and your insurance company. We will be happy to assist you by filling the appropriate insurance forms. Counseling on the phone will be charge based on a quarter hour minimum.

[redacted]

I AUTHORIZE TREATMENT FOR THE PATIENT NAMED ABOVE AND ACCEPT RESPONSIBILITY FOR THE CHARGES INCURRED IN THIS OFFICE.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PROVIDER-PATIENT SERVICE AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPPA NOTICE FORM DESCRIBED IN THE PROVIDER-PATIENT SERVICE AGREEMENT.

Signature _____ Date_____

Acknowledgement of Admission

20.004b

Revised 2/15/2018

CONFIDENTIALITY

_____ I understand all information between AzBHC staff and client is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self or others.
3. Child/elder abuse/neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

_____ I understand I was given the "Client's Rights Program Agreement" handbook and the "HIPPA" guidelines as a client.

FINANCIAL TERMS

_____ I understand all information between AzBHC staff and client is held strictly confidential unless:

- Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for your sessions. Your Provider will be paid directly by the carrier. The client will be responsible for any applicable deductibles and copayments. If your insurance determines you are not eligible for services provided and you choose to proceed with service, you are responsible for full payment.
- For those without health plan/insurance coverage, payment arrangements should be made prior to your first visit.
- In the event of default of payment, the balance of the account is due in full. The client will be responsible for any reasonable court cost, attorney fees and/or collection fees incurred.
- **As of Jan. 2017, all past due amounts will be charged at 15% interest, plus every month after that until bill is paid in full.**

CANCELLED/MISSED APPOINTMENTS

_____ I understand a scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours' notice, client will be billed according to the scheduled fee of $80.00. An insurance company does generally not pay this fee.

APPEALS AND GRIEVANCES For those with managed care health plans:

_____ I understand and acknowledge my right to request reconsideration in the case that outpatient care (number of visits) is denied certification. I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also understand that should I choose to continue treatment without authorization by my health plan my Appeal is denied, I will be responsible for payment of sessions not approved.

CONSENT FOR TREATMENT

_____ I understand, and I further authorize and request that **Arizona Behavioral Health Center PC** carry out behavioral health diagnostic procedures to assist in determining level of care. I understand that the purpose of the procedures will be explained to me upon my request and are subject to my agreement. I also understand that my course of treatment is designed to be helpful. (It may at times be difficult and uncomfortable)

_____ **RELEASE OF INFORMATION**

I understand that I authorize the release of information for claims, certification/case management/quality improvements, and other purposes related to the benefits of my Health Plan. (Releases of information to providers, family, etc. require a separate form.)

_____ I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED.

_____ **I understand and agree to all of the above information.**

Client: signature	**Date:**	**Client: name printed**	**Date:**
Client or (Parent/Guardian) signature	**Date**	**Client or (Parent/Guardian) name printed**	**Date:**

01/01/2016

Attention: Arizona Behavioral Health Center Clients:

Please note that a scheduled appointment means that the time is reserved only for you. If you are unable to attend your scheduled appointment, it is your responsibility to cancel 24 hours in advance. **If you fail to cancel 24 hours in advance**, you will be charged with an **$80.00 No Show and/or Late Cancellation Fee.** This fee is not covered by insurance. This policy is clearly stated in the Acknowledgement of Admission paperwork that every client signed in the initial intake interview.

It is also the policy of Arizona Behavioral Health Center PC to turn over unpaid balances to a collection agency if payment arrangements are not made to bring an overdue account current.

If you have any questions, please call the office at 602-343-8232.

Signature: _____ Date: _____

Arizona Behavioral Health Center, P.C.

2600 N. 44th Suite B-104
Phoenix, Arizona 85018-2778
◆ Ph. (602) 343-8232 ◆ Fax (602) 343-8233

Client Handbook Receipt

I have received a copy of the Arizona Behavioral Health Center PC Handbook.

Client Printed Name: _____

Client Signature: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

A copy of this receipt must be placed in the Patient's Clinical Chart.

Arizona Behavioral Health Center, P.C.

Telemental Health Informed Consent

Form 20.032B
05/2020

I, _____, hereby consent to participate in telemental health with Arizona Behavioral Health PC Lakshmi R. Nolletti, LCSW, LISAC Clinical Director and other staff, as part of my behavioral health services identified through my treatment plan. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including, but not limited to, disruption of transmission by technology failure, interruptions and/or breaches of confidentiality by unauthorized persons, and/or limited abilities to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and required by law.
4. I understand that privacy laws that protect the confidentiality of my protected health information(PHI) also apply to telemental health unless an exception to confidentiality applies(i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Initial_____

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my

emergency contact person's name, address, and phone: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

2600 N 44th Street Suite B-104 ♦ Phoenix, Arizona 85008 Phoenix, AZ. ♦ Ph.(602) 343-8232 ♦ Fax (602) 343-8233

Name: Date:

The Trauma Screening Questionnaire[1] (TSQ) is a brief 10-item self-report measure designed to screen for posttraumatic stress disorder (PTSD). Each item is derived from the DSM-IV[2] criteria and describes either a reexperiencing symptom of PTSD (items 1 through 5) or an arousal symptom of PTSD (items 6 through 10). Avoidance and numbing symptoms, though also listed in the DSM-IV criteria, were not included in the TSQ in keeping with the authors' goal of creating a useful screening instrument that was "short and contain[ed] the minimum number of items necessary for accurate case identification."[1] The lead author states that "what the TSQ gains in simplicity and clarity more than compensates for the absence of symptoms that may be difficult to understand and judgements that may be difficult to make."[3] Preliminary psychometric data[1] from 2 samples (rail crash survivors and crime victims) indicate that, for PTSD screening purposes, the TSQ enables excellent levels of prediction (see Scoring and Interpretation, below).

Tranma Screening Questionnaire

Your Own Reactions Now to the Traumatic Event

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened a few weeks ago. Please indicate whether or not you have experienced any of the following AT LEAST TWICE IN THE PAST WEEK:

	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		

Scoring and Interpretation: The authors suggest administering the TSQ at least 3 weeks after the traumatic event "to allow for natural recovery processes." An optimal cutoff point was found to be a YES response to *at least* 6 reexperiencing or arousal symptom items, in any combination. A PTSD diagnosis was present in 86% of individuals in the rail crash survivors sample and 91% of those in the crime victims sample who made a YES response to *at least* 6 reexperiencing or arousal symptom items, in any combination. A PTSD diagnosis was *not* present in 93% of individuals in the rail crash survivors sample and 92% of those in the crime victims sample who made a YES response to *fewer than* 6 reexperiencing or arousal symptom items, in any combination.

[1]Brewin CR, Rose S, Andrews B, Green J, Tata P, McEvedy C, Turner S, & Foa EB. Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, 181:158-162, 2002.

[2]*Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV), Washington DC: American Psychiatric Association, 1994.

[3]Brewin CR. *British Journal of Psychiatry*, 181:535, 2002. [Correspondence]

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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	_____

A2663B 10-04-2005

(ACE) Questionnaire
Finding your ACE Score

NAME_____ DATE:_____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

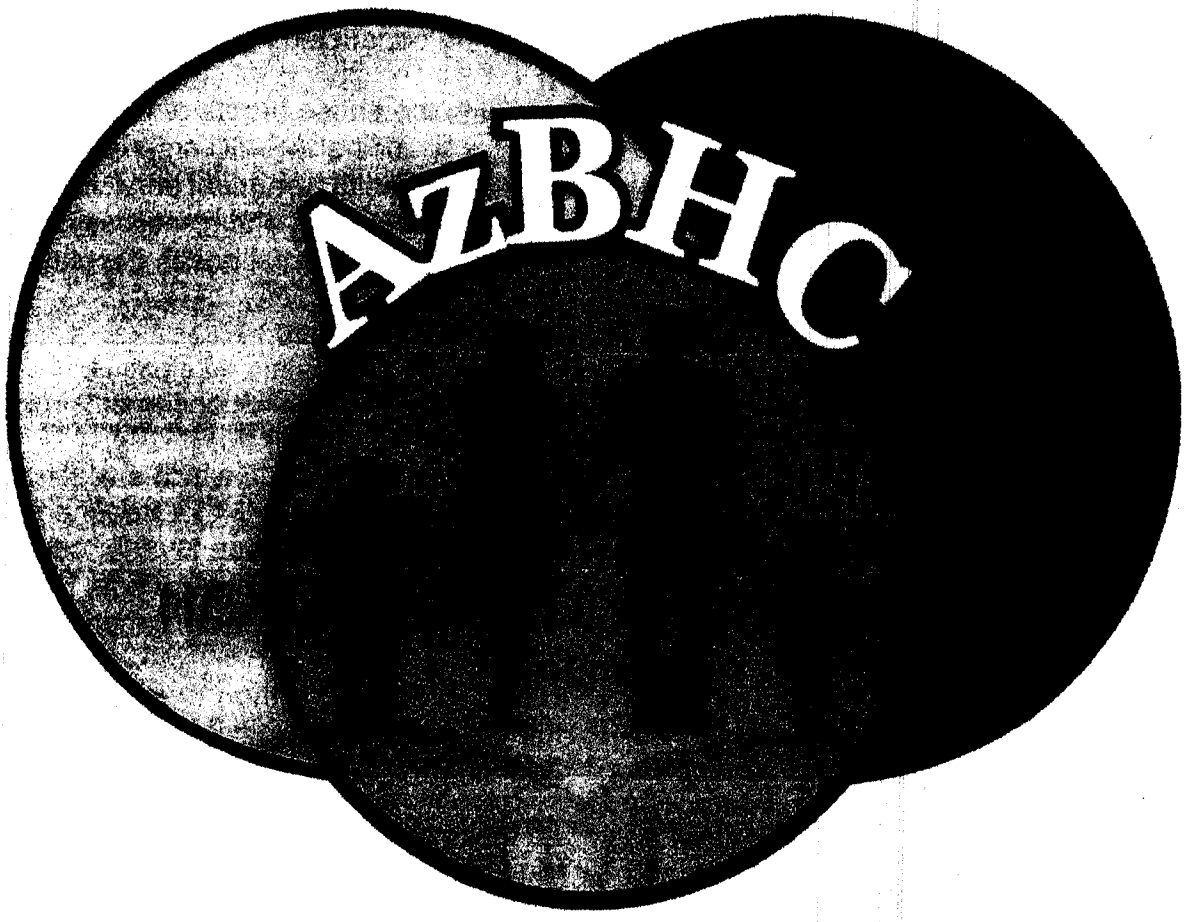
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

ARIZONA BEHAVIORAL HEALTH CENTER HANDBOOK

English



Client's Rights
Program & Fee Agreement
Client Refunds Policy and Procedure
Grievance Policy and Procedure

O: 01/2010 R: 02/2018

An **Arizona Behavioral Health Center** client has the following **CLIENT RIGHTS:**

1) AzBHC is an "Outpatient Clinic" subclass of behavioral health agency in Arizona.
2) An Outpatient Clinic is defined as a facility where only outpatient counseling/therapy for ambulatory clients sufficiently stable for outpatient counseling/therapy is undertaken. No residential or inpatient treatment is offered and no medications are prescribed or dispensed by AzBHC.
3) The AzBHC program provides Structured Outpatient Substance Abuse and Mental Health treatments services to English speaking adults, (from age 18 - 75). When appropriate collaborative/family counseling will be conducted in relationship to prescribe treatment.
4) Criteria for admission and re-admission to substance abuse programming are in accordance with American Society for Addiction Medicine (ASAM) criteria for outpatient Level II treatment. Admission for mental health treatment services are in accordance with admissions and re-admission assessments and re-assessments; along with methods of best practice for working with the mental health population.
5) Programs goals for AzBHC are as follows:
6) Achieve mental health stability/sobriety/family understanding.
7) Build and maintain internal commitment to a healthy and balanced lifestyle.
8) Educate, stabilize, and address the family dynamics to establish and maintain long-term mental health stability and/or substance abuse sobriety
9) To date the AzBHC has not had a waiting list. In the instance in which a waiting list might become necessary clients would be placed on a waiting list for treatment services when the client and or referral agency requests it, or due to other certain conditions in which the client completes the intake but has medical or legal issues that prohibit the start of program. All new clients will have an intake assessment scheduled within 1 week of AzBHC receipt of their referral.
10) Waiting lists will be utilized on a temporary basis of no more than 2 weeks. If the AzBHC is unable to provide services to the referred client within 2 weeks; the client will be referred to another agency for treatment services.
11) Criteria for referral to another agency is as follows: determination by the Clinical Administrative Director or his/her designee that treatment at AzBHC may not be effective as elsewhere, further determination by the administrator of his/her designee that another placement exists that is in the client and family's best interest, contact with the referral source, confirmation of availability at any identified placement site, agreement, if possible, with the client with this referral, communication of the referral to the client along with documentation whether or not the client accepted the referral.
12) Criteria for discharge from substance abuse programming are in accordance with American Society for Addiction Medicine (ASAM) criteria for outpatient Level II treatment. Discharge from health treatment services are in accordance with methods of best practice for working with the mental health population.
13) Criteria for transferring to another agency are as follows: determination by the Clinical Administrative Director or his/her designee that treatment at AzBHC may not be effective as elsewhere, further determination by the administrator of his/her designee that another placement exists that is in the client and family's best interest, contact with the referral source, confirmation of availability at any identified placement site, agreement, if possible, with the client with this referral, communication of the referral to the client along with documentation whether or not the client accepted the referral.

14) Criteria for declining to provide services: clients shall be denied services when they are judged by the Clinical Administrative Director or his/her designee to be a threat to themselves or others or documentation exist that the referral source is not a reliable payer, and that the likelihood exist that treatment will not be paid properly and the AzBHC organization would to be financially compromised.
15) Information regarding minimum requirements for knowledge, skills and training for AzBHC staff are as follows: Therapist will be licensed or certified by the Arizona Board of Behavioral Health as a Licensed Independent Substance Abuse Counselor (LISAC), Certified Professional Counselor (CPC, Licensed Psychologist, or Certified Masters Social Worker, or a high school diploma or GED and have at least four years' experience in a behavioral health related field in which two of these are in a substance abuse or mental health related capacity/ Any formal education obtained from a certified institution is verified by reference check. The Clinical Administrative Director will have a minimum of 5 years' experience in managing a mental health and or behavioral health treatment programming. AzBHC staff will demonstrate competency in the way in which they provide treatment (mental and behavioral health) services and shall pass a 90-day probationary period in any position to which they are assigned. Demonstrate skills include individual, group, marital/family/collaborative, chemical addiction, case management and proficiency in clinical documentation and record keeping.
16) It is the policy of AzBHC to refund money owed to a client due to pre-payment for services not yet rendered. Clients not continuing services at AzBHC due to one of the following factors: client is involuntarily discharged; client is voluntarily discharged or client is transferred to another program refunds are processed and distributed within 10 days of a request for refund being made. Refunds are issued in the form of a check and made payable to the client. Any charges incurred by the client will be clearly delineated on the treatment contract signed by the client on admission to AzBHC.
17) AzBHC does not offer services to Spanish speaking clients. AzBHC hopes to, at some time in the future, secure sufficient funds with which to hire qualified Spanish speaking therapist/counselor to make this option available.
18) The AzBHC offices are wheelchair accessible. We are, however, unable now to provide services for individuals with sensory impairments (i.e., sight or hearing). We hope to one day have the resources to provide services to this population.
19) AzBHC does not provide partial care residential care, residential care or inpatient treatment services.
20) A client or his/her formally designated agent/representative will receive written notice at least 30 days before AzBHC changes a fee the client is required to pay.

An AzBHC client has the following **CLIENT RIGHTS:**

1) To be treated with dignity, respect, and consideration
2) Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment
3) To receive treatment that a) Supports and respect's the client's individuality, choices, strengths, and abilities; b) Supports the client's personal liberty and only restricts the client's personal liberty per court order; or as permitted by A.A.C. Title 9, Chapter 20; c) Is provided in the least restrictive environment that meets the client's treatment needs.
4) Not be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights.

5) To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation
6) To have grievances to agency staff members and complaints to outside entities and other individuals with constraint or retaliation
7) To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense
8) To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights
9) If enrolled as an individual who is seriously mentally ill, to receive assistance from human rights advocates in understanding, protecting, or exercising the client's civil rights
10) To have the client's information and records kept confidential and released only as permitted by law
11) To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without consent, except: a) For photographing for identification and administrative purposes, as provided for by law; b) For a client receiving treatment according to A.R.S. Title 36, Chapter 37, or c) For video recordings used for security purposes that are maintained only on a Temporary basis
12) To review, upon written request, the client's own records during the agency's hours of operation or at a time agreed upon by the clinical administrative director, except as described by law
13) To review the following at the agency or at the Department of Health Services: a) A.A.C. Title 9 Chapter 20; b) The report of the most recent inspection of the premises conducted by the Department; c) A plan of correction in effect as required by the Department; d) The most recent report of any inspection conducted by any nationally recognized accreditation-agency, e) A plan of correction in effect as required by any nationally recognized accreditation agency.
14) To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health services, except for a behavioral health service provided to a client experiencing a crisis situation
15) To consent to treatment, unless treatment is ordered by a court of competent jurisdiction, after receiving a verbal explanation of the client's condition and the proposed treatment, including the intended outcome, the nature of the proposed treatment, any procedures involved in the proposed treatment, any risks or side effects from the proposed treatment, and any alternatives to the proposed treatment
16) To be offered or referred for treatment specified in the client treatment plan
17) To receive a referral to another agency if the agency is unable to provide the behavioral/mental health services the client request or that is indicated in the client's treatment plan
18) To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health
19) To be free from: a) abuse; b) neglect; c) exploitation; d) coercion; e) manipulation; f) retaliation for submitting a complaint to the Department or another entity; g) discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent; h) Treatment that involves the denial of (I) food, (II) the opportunity to sleep, or (iii) the opportunity to use the toilet, and I) restraint or seclusion, of any form, used as a means of coercion, discipline, convenience or retaliation

20) To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan.
21) To control the client's own finances except as provided by law
22) To participate or refuse to participate in religious activities
23) To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene
24) To be compensated according to state and federal law for that primarily benefits the agency and that is not part of the client's treatment plan
25) To participate or refuse to participate in research, or experimental treatment
26) To consent in writing, refuse to consent, or withdraw written consent to participate in research or treatment that is not a professionally recognized treatment
27) To refuse to acknowledge gratitude to the agency through written-statements, or other media, or speaking engagements at public gatherings
28) To receive behavioral health services in a smoke-free facility
29) To receive a written notice within 30 days of any change in any fee the client is required to pay.

PROGRAM and FEE AGREEMENT: AzBHC is committed to helping facilitate change in individual and families so that they can attain and maintain a mentally/emotionally and drug-free lifestyle. Towards this objective, we ask our participants to make a commitment to the treatment process by agreeing to the following:

1) Abstain from all drug use, including alcohol, while in the program (except those prescribed by a physician for mental/physical health reasons).
2) Come to all scheduled meetings. One unexcused absence will result in a written warning. Two unexcused absences can result in dismissal from the program.
3) "What is heard in group; stays in group." All information discussed in group is confidential.
4) Urine drug and alcohol testing is random. AzBHC may ask you to provide a urine sample on site and it will be sent to Norchem Laboratories, an outside provider service that we have a contract with, for analysis. The fee for this service is $ 25.00 and will be included in your monthly billing statement. When called for a sample, you will need to provide a sample that day. Failure to do so is interpreted as a test positive and will be addressed accordingly.
5) You will be assigned to a specific level of care by your therapist. The cost for treatment will be determined by the "Billing dept." As a participant of the AzBHC program, you are responsible to pay for services when they are rendered. You will start the program once you have signed the "AzBHC Inform Consent Agreement" with your therapist.
6) Your Co-Payment amount for your "aftercare" sessions will be $25.00 per visit. Insurance does not pay for "aftercare".
7) Your program will consist of a combination of individual and group sessions specific to your level of care, family/couples/collaborative sessions, and aftercare.
8) Your therapist will make referral recommendations to Self Help groups (eg: AA, NA, CA, CODA, Alanon & SA) and or any community organized workshop and activities that will be beneficial in your treatment.
9) There is a "no-show" fee of $ 80.00 for a client that does not appear for a scheduled individual session or who does not cancel at least 24 hours in advance of the scheduled appointment. There is no fee for missed group sessions.

CLIENT REFUNDS POLICY AND PROCEDURE: It is the policy of AzBHC to refund money owed to a client due to pre-payment for services not yet rendered.

1) Any charges incurred by the client will be clearly delineated on the treatment contract signed by the client.
2) The client can request a Summary of Charges statement from the office/business manager and receive this statement in the office in one business day or via US Postal Service within 10 business days.
3) Any discrepancy on a Client Statement/Summary of Charges can be disputed by the client and/or his agent or representative and a request made in writing for a clinical and administrative review and given to an AzBHC counselor or the office/business manager or the clinical administrative director.
4) The clinical administrative director has the responsibility to conduct and complete a clinical and administrative review to determine any fees to be refunded a client within 10 business days of the date of receipt of a client's written request.
5) Any fees due the client will be issued by check within 30 days from the date of outcome of the clinical and administrative review.
6) A client or his/her formally designated agent/representative will receive written notice at least 30 days before AzBHC changes a fee the client is required to pay.

GRIEVANCE POLICY AND PROCEDURE: A grievance may be submitted by a client and/or his/her agent/representative orally or in writing to the Arizona Behavioral Health Center. AZBHC Administration will review the grievance within two business days of receipt and arrange a meeting with the client to review and respond to the grievance. Accurate documentation of the grievance proceeding will be maintained by the AzBHC administration.

AND/OR

A grievance may be submitted by a client and/or representative orally or in writing to the Department of Health Services. The client is under no obligation to inform the Arizona Behavioral Health Center of his/her intentions to file a complaint. The grievance may be submitted directly to:

1. Arizona State Health Department, 150 N. 18th Avenue, 4th Floor, Phoenix, Arizona 85007, 602-542-1025
2. Arizona Dept. of Child Safety, PO Box 6030, S/C CH010-23A, Phoenix, Arizona 85005-6030 1-602-255-2500 or 1-888-767-2445 Secondary Phone: (1-888-SOS-CHILD) TDD 1-800-530-1831.
3. Division of Behavioral Health Services, 150 N. 18th Avenue, 2nd Floor, Phoenix, AZ 85007, (602) 364-4558,
   (602) 364-4570 Fax Toll-Free: 1-800-867-5808
4. DES Adult Protective Services, 4520 N. Central, Suite 410, Phoenix, Arizona 85012, 877-767-2385
   or
5. Office of Human Rights Advocates, 150 N. 18th Avenue, #210, Phoenix, Arizona 85007, 602-364-4585.

AzBHC is prohibited from discharging or discriminating in any way against any client by whom, or on whose behalf, a complaint has been submitted to the Office of Behavioral Health Licensure Department (OBHL), or who has participated in a complaint investigation process.