

Optimae Behavior Health Services

Customer Demographic

Client Name: _____ **Date:** _____
Address: _____ **City:** _____ **State:** _____ **ZIP:** _____
Home/Cell Phone: _____ **May we leave a message?** Yes No

Email: _____
Date of Birth: _____ **Social Security #:** _____
Legal Gender: _____ **Preferred Gender Identity/Expression:** _____
Primary Language: _____ **Interpreter Needed?** Yes No

Parent/Guardian (if applicable): _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Emergency/Alternate Contact: _____ **Phone:** _____

Do you have Medicaid Services: Yes No **Medicaid #:** _____
MCO: Wellpoint Iowa Total Care Molina **MCO ID #:** _____

Primary Insurance Information:

Insurance Company: _____ **Insurance ID#:** _____
Policyholder's Name: _____ **Relationship to Customer:** Self Spouse Child Other
Policyholder's Date of Birth: _____ **Social Security #:** _____
Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Policyholder's Home/Cell Phone: _____ **Policyholder's Employer:** _____

Is Policyholder Responsible for Payment of this bill: Yes No

If No, please give Name & Address of Responsible Person:

Secondary Insurance Information:

Do you have secondary policy: Yes No **If Yes, Insurance Company:** _____

How would you rate the urgency of your need on a scale of 1 – 10 (1 = no urgency, 10 = high urgency):

Are services needed due to a court committal? Yes No

Additional information you would like to share:



Individual's name:

Date of Birth:

Title XIX:

I understand, agree to all items, and acknowledge that I have been offered a copy of the following:

- Optimae Service Description describing the services being offered (Form 42)
- Optimae Informed Consent, Rights and Responsibilities (Form 7)
- Optimae Notice of Privacy Practices (Form 67)
- Frequently Asked Questions about Advance Directives (Form 136)
- Optimae Formal Appeals Process (Form 8)
- Payment Responsibilities Policy/"No Show" Policy (Form 144)
- Informed Consent, Rights and Responsibilities for Telepsychiatry and Teletherapy (Form 166)
- Med Consent (Form 120)
- Controlled Substances Agreement (Form 184)
- Non-Recording Agreement (Form 213)
- Consent for Use of Note Taking Assistant (Form 218)

Pharmacy Name:

Phone:

I also authorize the release of any medical or other information necessary to process claims. I request payment of government benefits to myself or to the party who accepts assignment below. I authorize payment of medical benefits to the undersigned physician or supplier for services described in claims.

Individual's Signature

Date

Guardian's Signature (if applicable)

Date

Optimae LifeServices
AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose: ___ Treatment ___ Payment ___ Health Operations

INDIVIDUAL: _____ SOCIAL SECURITY# _____

INDIVIDUAL ADDRESS: _____

TITLE XIX # _____ (If Applicable) BIRTH DATE: _____

I the undersigned, hereby authorize Optimae staff to release and/or obtain verbal, electronic, or written information indicated below, regarding the above named individual with:

Name of Person or Agency: _____

Complete Mailing Address: _____

Description of each purpose(s):

- | | |
|--|---|
| <input type="checkbox"/> Referral for new services | <input type="checkbox"/> Coordination of Services |
| <input type="checkbox"/> Establishing eligibility for services | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Planning & implementation of Service Plan | |

INFORMATION TO BE DISCLOSED FROM OPTIMAE:

- Yes No ANNUAL REVIEW
- Yes No DISCHARGE SUMMARY
- Yes No FINANCIAL INFORMATION
- Yes No SERVICE/TREATMENT PLAN
- Yes No MEDICAL-HEALTHCARE INFORMATION
- Yes No PROGRESS SUMMARY
- Yes No SOCIAL HISTORY
- Yes No VOCATIONAL INFORMATION
- Yes No INCIDENTS _____
- Yes No OTHER (specify) _____

INFORMATION TO BE OBTAINED FROM AGENCY LISTED ABOVE:

- Yes No DISCHARGE SUMMARY
- Yes No FINANCIAL INFORMATION
- Yes No SERVICE/TREATMENT PLAN
- Yes No MEDICAL-HEALTHCARE INFORMATION
- Yes No PROGRESS SUMMARY
- Yes No SOCIAL HISTORY
- Yes No VOCATIONAL INFORMATION
- Yes No EDUCATIONAL PLANS
- Yes No OTHER (specify) _____

Description of specifics: _____

To Be Disclosed By Mental Health Services:

- Yes No PSYCHIATRIC ASSESSMENT/REPORT
- Yes No PSYCHOLOGICAL EVALUATION

To Be Obtained From Originating Source:

- Yes No PSYCHIATRIC ASSESSMENT/REPORT
- Yes No PSYCHOLOGICAL EVALUATION

1. I understand that the Provider cannot guarantee that the Recipient will not disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. I also understand that I may review the disclosed information and ask questions by contacting the Privacy Officer at 226 W. Main Ottumwa, Iowa 52501 or (641)777-9852.

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Optimae except when I am (i) receiving research-related treatment or (ii) receiving healthcare solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at 226 W. Main Ottumwa, Iowa 52501 or (641)777-9852.

4. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (**initial any category NOT to be released**):

Substance Abuse** _____

Mental Health _____

HIV-related Information _____

Genetic tests/info*** _____

** Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR 42 CFR Part 2 prohibits unauthorized disclosure of these records). ***Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

5. This document is valid for one year unless otherwise specified. This document is valid until _____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to Mental Health:

Individual Signature _____ Date _____

Guardian Printed Name _____ Guardian Signature _____ Date _____

Date copy given to Individual or Guardian: _____ Check if customer or guardian declines to receive a copy

Send information to: _____

Optimae LifeServices
AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose: ___ Treatment ___ Payment ___ Health Operations

INDIVIDUAL: _____ SOCIAL SECURITY# _____
INDIVIDUAL ADDRESS: _____
TITLE XIX # _____ (If Applicable) BIRTH DATE: _____

I the undersigned, hereby authorize Optimae staff to release and/or obtain verbal, electronic, or written information indicated below, regarding the above named individual with:

Name of Person or Agency: _____

Complete Mailing Address: _____

Description of each purpose(s):

- | | |
|--|---|
| <input type="checkbox"/> Referral for new services | <input type="checkbox"/> Coordination of Services |
| <input type="checkbox"/> Establishing eligibility for services | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Planning & implementation of Service Plan | |

INFORMATION TO BE DISCLOSED FROM OPTIMAE:

- Yes No ANNUAL REVIEW
 Yes No DISCHARGE SUMMARY
 Yes No FINANCIAL INFORMATION
 Yes No SERVICE/TREATMENT PLAN
 Yes No MEDICAL-HEALTHCARE INFORMATION
 Yes No PROGRESS SUMMARY
 Yes No SOCIAL HISTORY
 Yes No VOCATIONAL INFORMATION
 Yes No INCIDENTS
 Yes No OTHER (specify) _____

INFORMATION TO BE OBTAINED FROM AGENCY LISTED ABOVE:

- Yes No DISCHARGE SUMMARY
 Yes No FINANCIAL INFORMATION
 Yes No SERVICE/TREATMENT PLAN
 Yes No MEDICAL-HEALTHCARE INFORMATION
 Yes No PROGRESS SUMMARY
 Yes No SOCIAL HISTORY
 Yes No VOCATIONAL INFORMATION
 Yes No EDUCATIONAL PLANS
 Yes No OTHER (specify) _____

Description of specifics: _____

To Be Disclosed By Mental Health Services:

- Yes No PSYCHIATRIC ASSESSMENT/REPORT
 Yes No PSYCHOLOGICAL EVALUATION

To Be Obtained From Originating Source:

- Yes No PSYCHIATRIC ASSESSMENT/REPORT
 Yes No PSYCHOLOGICAL EVALUATION

1. I understand that the Provider cannot guarantee that the Recipient will not disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. I also understand that I may review the disclosed information and ask questions by contacting the Privacy Officer at 226 W. Main Ottumwa, Iowa 52501 or (641)777-9852.

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Optimae except when I am (i) receiving research-related treatment or (ii) receiving healthcare solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at 226 W. Main Ottumwa, Iowa 52501 or (641)777-9852.

4. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (**initial any category NOT to be released**):

Substance Abuse** _____ Mental Health _____
HIV-related Information _____ Genetic tests/info*** _____

** Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR 42 CFR Part 2 prohibits unauthorized disclosure of these records). ***Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

5. This document is valid for one year unless otherwise specified. This document is valid until _____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to Mental Health:

Individual Signature _____ Date _____

Guardian Printed Name _____ Guardian Signature _____ Date _____

Date copy given to Individual or Guardian: _____ Check if customer or guardian declines to receive a copy

Send information to: _____