

**Optimae LifeServices Inc.
Behavioral Health Face Sheet**

Client Information	<p>Client Name: _____ Date: ____ / ____ / ____</p> <p>Address: _____ City: _____ State: _____ ZIP: _____</p> <p>Home/Cell Phone: _____ May we leave a message? Yes ___ No ___</p> <p>Emergency/Alternate Contact: _____ Phone: _____</p> <p>Gender: Male ___ Female ___ Date of Birth: ____ / ____ / ____ Social Security #: _____ - _____ - _____</p> <p>Title XIX #: _____ (if applicable)</p> <p>MCO ID #: _____ MCO: <input type="checkbox"/> Amerigroup <input type="checkbox"/> Iowa Total Care</p> <p>Is Client Responsible for Payment of this bill?: Yes ___ No ___ If No, give Name & Address of Responsible Person: _____</p>
Insurance Information	<p>Policyholder's Name: _____ Policyholder's Date of Birth: ____ / ____ / ____</p> <p>Social Security #: _____ - _____ - _____ Relationship to Client: self ___ spouse ___ child ___ other ___</p> <p>Address: _____ City: _____</p> <p>State: _____ ZIP: _____ Policyholder's Home/Cell Phone: _____</p> <p>Policyholder's Employer: _____ Is Policyholder Responsible for Payment of this bill?: Yes ___ No ___</p> <p>If No, give Name & Address of Responsible Person: _____</p> <p>Insurance Company: _____ Insurance ID#: _____</p>
Secondary Insurance	<p>Policyholder's Name: _____ Policyholder's Date of Birth: ____ / ____ / ____</p> <p>Social Security #: _____ - _____ - _____ Relationship to Client: self ___ spouse ___ child ___ other ___</p> <p>Address: _____ City: _____</p> <p>State: _____ ZIP: _____ Policyholder's Home/Cell Phone: _____</p> <p>Policyholder's Employer: _____ Is Policyholder Responsible for Payment of this bill?: Yes ___ No ___</p> <p>If No, give Name & Address of Responsible Person: _____</p> <p>Insurance Company: _____ Insurance ID#: _____</p>
Office Use	<p>Date of Eligibility Call: _____ Diagnosis Code: _____</p> <p>Office Visit Co-Pay Amount: \$ _____ Deductible Amount: \$ _____</p> <p>Communication Restriction: Yes ___ No ___ HIPAA Privacy Notice Date: ____ / ____ / ____</p> <p>Parent/Guardian: _____ Date of Birth: _____ Social Security #: _____</p>



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)
- _____ Provider Collaboration (Form 131)

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

Provider/Clinician

Date

Name:
DOB:
ID Number:

Today's Date:

Optimae LifeServices Behavioral Health Provider Collaboration

Optimae LifeServices routinely communicates with your Primary Care Physician and/or Case Manager/IHH (Integrated Health Home) in order to provide the best care for you.

Please complete the following:

I want my PCP notified of Optimae involvement in my care.

I do not want my PCP notified of Optimae involvement in my care at this time.

I do not have a PCP.

I want my Case Manager/IHH notified of Optimae involvement in my care.

I do not want my Case Manager/IHH notified of Optimae involvement in my care at this time.

I do not have a Case Manager/IHH.

Please inform the following other professionals about Optimae involvement in my care:

Personal health information will not be shared with any providers without a signed release of information.

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: _____