Optimae LifeServices Inc.
Behavioral Health Face Sheet Tool

Client Name: ____ **Date:** ______ / ______ / ________

Address: ___________________________**City:** _____________________**State:** ______ **ZIP:** _____________

Home/Cell Phone: __________________________ **May we leave a message? Yes__ No__**

Email: ____

Date of Birth: _____ / ____ / ________ **Social Security #:** ________ - ______ - ___________

Emergency/Alternate Contact: ____________________________________ **Phone:** ____________________________

Parent/Guardian: ____ **Phone:** ____________________________

Legal Gender: ___________________________ **Preferred Gender Identity/Expression:** ________________________

Primary Language: __________________________________ **Interpreter Needed? Yes___ No____**

Medicaid #: ________________________**(if applicable)**

MCO ID #: ________________________________ **MCO:** ☐ **Amerigroup** ☐ **Iowa Total Care** ☐ **Molina**

Is Client Responsible for Payment of this bill?: Yes ___ No ___ If No, give Name & Address of Responsible Person:

____

Pharmacy: ____ **Phone:** ________________________

Address: ____

Court Committal? Yes___ No___

Insurance Information

Policyholder's Name: ___________________________________ **Policyholder's Date of Birth:** _____ / ____ / ________

Social Security #: _________ - ______ - ___________ **Relationship to Client: self ___ spouse____ child____ other_____**

Address: ____ **City:** ________________________________

State: ________ **ZIP:** _______________ **Policyholder's Home/Cell Phone:** ________________________________

Policyholder's Employer: ____________________ **Is Policyholder Responsible for Payment of this bill?: Yes ___ No ___**

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

Insurance Company: ____ **Insurance ID#:** ____________________________

Secondary Insurance Information

Policyholder's Name: ___________________________________ **Policyholder's Date of Birth:** _____ / ____ / ________

Social Security #: _________ - ______ - ___________ **Relationship to Client: self ___ spouse____ child____ other_____**

Address: ____ **City:** ________________________________

State: ________ ZIP: _______________ Policyholder's Home/Cell Phone: ______________________________________

Policyholder's Employer: ____________________ Is Policyholder Responsible for Payment of this bill?: Yes ___ No ___

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

Insurance Company: ____ Insurance ID#: ______________________________

Additional Insurance Information

Policyholder's Name: ______________________________________ Policyholder's Date of Birth: _____ / ____ / ________

Social Security #: _________ - ______ - ___________ Relationship to Client: self ___ spouse____ child____ other_____

Address: ____ City: __________________________________

State: ________ ZIP: _______________ Policyholder's Home/Cell Phone: ______________________________________

Policyholder's Employer: ____________________ Is Policyholder Responsible for Payment of this bill?: Yes ___ No ___

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

Insurance Company: ____ Insurance ID#: ______________________________

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)

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

Name: Today's Date:
DOB:
ID Number:

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.

Individual's Signature Date

Guardian's Signature (if applicable) Date

OPTIMAE BEHAVIORAL HEALTH SERVICES

MEDICATION CONSENT FORM

I give my voluntary consent to Optimae Behavioral Health to treat my psychiatric symptoms. I authorize Optimae's licensed medical providers to prescribe and/or administer medications for my care. I understand that such treatment involves regular appointments, and that my provider may order laboratory testing, counseling, group meetings, and other clinical services that they feel will benefit my care.

1. **UNDERSTANDING MY MEDICATIONS AND DIAGNOSIS:** I understand that if I am not sure about a diagnosis or treatment option, the behavioral health nurses and provider are available to answer my questions. I realize that it is my right to know why medications are prescribed and what all side effects I may experience when starting a new medication. I also understand that taking prescribed medications and following through with other recommended treatments is my choice. However, I do realize that I must work with my provider in order to stay a patient with Optimae Behavioral Health.

2. **SIDE EFFECTS: I understand that I should use my best judgement, and go to the closest Emergency Room if I have any severe side effects.** Examples of this would be tongue and throat swelling, significant drowsiness or dizziness, and suicidal ideations. If I have side effects that are not a risk to my safety, I will contact the behavioral health nurse to report the side effects. I also agree to contact the Optimae nurse if I feel that my condition is worsening, or if I have any problems or concerns with a treatment plan, including prescriptions. I understand that the behavioral health nurse will notify my provider of the situation.

3. **MEDICAL CONDITIONS:** I understand that to provide the best care, my provider must know about all of my current medical conditions, not just my psychiatric symptoms. I realize that if I experience a significant health change, I should notify the behavioral health nurses so that the provider may have a chance to adjust medications, if needed. **It is recommended that women who are pregnant or breast feeding discuss this with their primary care provider or obstetrician before taking any medications.**

4. **MEDICATION LISTS:** I understand that to provide the best care, my provider must know every medication and supplement that I am taking. I agree to bring a list of my medications, vitamins, and herbal supplements to my appointments whenever there is a significant change.

5. **SCHEDULING APPOINTMENTS:** I agree to work with my Behavioral Health Provider at the end of every appointment to determine a time frame for the next appointment. I understand that not scheduling and attending appointments in the agreed upon time frame may cause a lapse in my prescriptions. And, I realize that not attending appointments for a span longer than six months may cause me to be discharged from Optimae Behavior Health services.

--------THIS DOES NOT EXPIRE--------

MEDICATION INFORMATION

Name DOB Title 19/MCO

Date Completed

☐ CUSTOMER REPORT ONLY

Please include all medications you take:

- Prescription drugs, regardless of what kind of prescriber has ordered them or whether you get them from mail order, your local pharmacy or the internet.
- Over-the-counter medications (like aspirin, Tylenol, cough syrups, vitamins, homeopathic and herbal products)
- Anything that you may be taking from a provider of alternative therapies.
- Any medications (prescription or otherwise) that you take that belong to other family members, friends, co-workers, strangers, etc.

Contraindications:		Allergies:		
Medication taken: (check one)	Independently	Monitored	Staff Administered	
Name/Type (Prescribed and Non-prescribed)	**Dosage and Frequency**	**Physician Title**	**Date Prescribed Decreased, Changed**	**Date Discontinued**

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):

☐ Referral for new services
☐ Establishing eligibility for services
☐ Planning & implementation of Service Plan
☐ Coordination of Services
☐ Other_______________________________

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 **(<u>initial</u> any category <u>NOT</u> 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:____