

PRIMARY CARE PHYSICIAN AND BEHAVIORAL HEALTH PROVIDER
COMMUNICATION FORM

Health Plan Member Consent for Oakland Psychological Clinic Provider and Primary Care Physician to Exchange Information
OAKLAND PSYCHOLOGICAL CLINIC

2222 S. LINDEN RD., STE. J
FLINT, MI 48532
Telephone (810) 732-0560 Fax (810) 732-6351
NPI # 1538356282

Health Plan _____ Date _____

I, (Please Print Client Name) _____

Date of Birth _____ Social Security Number _____

Authorize (Client or Guardian Signature) _____

Do Not Authorize (Client or Guardian Signature) _____

This signature indicates that the Beacon Health Coordination of Care Member Tip Sheet was given to clients who have Beacon Health insurance.

My Primary Care Physician _____ NPI # _____

Address _____

Phone Number _____ Fax Number _____

To exchange information regarding my Mental Health/Substance Abuse Treatment and Medical Health Care for coordination of care purposes as may be necessary for the administration and provision of my Health Care coverage. The information exchanged may include information on Mental Health Care or Substance Abuse Care and/or Treatment such as Diagnosis and Treatment Plan. I understand that this authorization shall remain in effect for One Year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above Behavioral Health Care Provider. I also understand that it is my responsibility to notify my Behavioral Health Care Provider if I choose to change my Primary Care Physician.

Stop Here

Witness _____ Date _____

DSM IV Diagnosis Code and Name _____

Risk Disposition: Emergent Urgent Routine

Modality of Treatment: CBT SFBT IOT Other _____

Treatment Plan Type (Circle One: Individual, Family, Group, Medication Reviews, Other) _____

Frequency of Behavioral Health Treatment (Circle One: Weekly, Bi-Weekly, Monthly, Other) _____

Estimated Length of Behavioral Health Treatment _____

Therapist Name _____ Type II (Therapist) NPI# _____

Referred to Psychiatrist ___ YES ___ NO Psychiatrist Name _____

Medications Prescribed _____

IF THERE IS A NEED TO COMMUNICATE ABOUT AN URGENT OR EMERGENCY SITUATION, PLEASE CALL THE HEALTH PRACTITIONER IN ADDITION TO SENDING OR FAXING THIS FORM.

___ Conclusion of Mental Health/Substance Abuse Treatment: Yes _____ No _____

___ Date of Last Session _____ Treatment Completed? Yes _____ No _____

___ Notification of Prescription or Change in Medications _____

___ Other _____

Clinician Signature and Credentials _____

PLEASE SEND A COPY OF THIS FORM TO PRIMARY CARE PHYSICIAN. FILE THE ORIGINAL IN MEMBER'S CHART. IF THIS FORM IS SENT BY FAX, PLEASE ATTACH PRINTED CONFIRMATION FORM THAT FAX HAS BEEN SENT.

Date Sent _____ Sent By (initial) _____ Fax _____ Mail _____

FOR BCN CLIENTS, PLEASE ALSO FAX FORM TO 877-287-9056

Updated June 2019