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

1800 N. MILFORD RD., STE. 100
MILFORD, MI 48381
Telephone (248) 684-6400 Fax (248) 684-5973
NPI # 1417144031

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