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

16664 15 MILE RD.
FRASER, MI 48026
Telephone (586) 294-3030 Fax (586) 294-0805
NPI # 1770772436

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