BEHAVIORAL HEALTH AND PRIMARY CARE PHYSICIAN (PCP) COORDINATION OF CARE FORM

***BEHAVIORAL HEALTH PRACTITIONER INSTRUCTIONS:** Please have your patient complete the patient section of this form. If your patient consents to the release of information, then please complete the practitioner section of this form, retain a copy for your records and HAI/Magellan audit purposes. Mail the completed form to the patient's PCP. If your patient refuses to consent to the release of information, then do not complete the practitioner section of this form, but retain a copy of this form for your records. Incomplete or illegible forms will be returned for correction.*

PATIENT SECTION

Patient Name:____________________ Patient Birth Date:__________

Patient Address, City, State, Zip:____________________

Name of Patient's Primary Care Physician (PCP):____________________

PCP's Address. City, State, Zip:____________________

Phone #:__________ Fax #:__________ PCP Office # (listed on member's ID card) (Aetna Members Only) __________

Name of Behavioral Health Practitioner: Lesli K. Johnson, Ph.D. License Type: Psychologist

BH Practitioner's Address, City, State, Zip: 17 Blue Line Drive Athens Ohio 45701

Phone #: (740)592-5689 Fax #: (740)593-7166

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

I authorize the release/exchange of confidential information between my behavioral health practitioner and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care. I understand that this consent is automatically renewable each year and that the confidential information that is exchanged will be kept by the recipient until such time as state law allows destruction of my patient record. I further understand that this authorization may be revoked by me, in writing, at any time, except to the extent that any action has been taken in reliance thereon. I understand that I, and/or my legal representative, are entitled to a copy of this form. I give my permission for release of the following information:

☐ Diagnosis and Medications ________ initial ☐ Behavioral Health Information ________ initial

*Patient/Legal Guardian Signature:*____________________ *Date:*________

***Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.

OR

I refuse to authorize the release/exchange of any behavioral health and medical information between my behavioral health practitioner and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care.

*Patient/Legal Guardian Signature:*____________________ *Date:*________

***Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.

BEHAVIORAL HEALTH PRACTITIONER SECTION

Dear Primary Care Physician: I have seen the above named patient for outpatient behavioral health treatment. The following information about the patient's behavioral health care may be helpful for you in managing the patient's medical care:

The patient has been seen on the following dates *(specify dates)*:____________________

The patient's behavioral health diagnosis is:____________________

The patient is taking the following medications *(list medications and dosage)*:____________________

Behavioral Health Clinical Information *(attach additional sheets if necessary)*:____________________

PCP INSTRUCTIONS: Please provide any medical information that may relate to this patient's behavioral health care to the behavioral health practitioner listed above. Examples of information that may relate to a patient's behavioral health care include: current and/or chronic medical conditions, current medications and dosages, sensitivities to medications and/or psychosocial stressors (e.g. loss of job, injuries, financial stress, parenting problems, etc.). Please call me if you wish to discuss this patient's care further or if you need additional information. Thank you.

Notice to Recipient of Information: This information has been disclosed to you from records protected by Federal and State laws regarding confidentiality. In accordance with Federal and State laws, the information received pursuant to this document is confidential and the recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal law restricts the use of this information to criminally investigate or prosecute members who are being treated for substance abuse.

Original - Mail to PCP (only if patient consents) **Copy - BH Practitioner**

Lesli K. Johnson, Ph.D.
Licensed Psychologist
17 Blue Line Drive
Athens, Ohio 45701-2325
740-592-5689 – FAX 740-593-7166

CONSENT FOR LIMITED AVAILABILITY OF PROTECTED HEALTH INFORMATION

I/We acknowledge that clinical files of clients at 17 Blue Line Drive are not made available to anyone but the independent practitioner who is delivering services. You have given Ms White, as the Billing Accountant and first receiver of your Protected Health Information (PHI,) access to all necessary data to bill for services and exchange information as necessary with insurance companies or other payment or manage care agencies on behalf of clients.

With the following signature, I/we authorize Karen White, Billing Accountant and Receptionist at Offices of Blue Line Drive to enter our first name and/or initials in an office scheduling book which maintains awareness of office and appointment time availability.

I/We acknowledge that private practitioners in the office may assist Ms White or the office, in her absence or when she's busy, by answering the phone or taking messages off the answering machine and delivering them as appropriate to Ms White or other practitioners. This might mean phone callers names and phone numbers might be taken from the machine periodically when Ms White is not in the office in order to guarantee timely delivery of messages.

I/We acknowledge that our PHI will be made available via our counselor's Professional Will to a designated mental health provider, who will notify us, in the event of our counselor's unexpected illness or death, and will manage our files to maintain protection of our confidential health information.

Signature of Client(s) ______________________ Date

LESLI JOHNSON, LISW, PH.D.
BILLING INTAKE INFORMATION

PATIENT'S NAME: ______________________________ TODAY'S DATE: ______
ADDRESS: ______________________ CITY: __________ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (WORK): _______________ (HOME): _______________
SOCIAL SECURITY NUMBER: __________________ DATE OF BIRTH: _______
ARE YOU EMPLOYED? YES: _________ NO: _________
IF YES, NAME OF EMPLOYER: ____
____

DO YOU HAVE INSURANCE COVERAGE? YES: ________ NO: ____________
IF YES, NAME OF INSURANCE COMPANY: ______________________________
ADDRESS OF INSURANCE COMPANY: __________________________________
NAME OF POLICYHOLDER: _____________________ DATE OF BIRTH: _______
RELATIONSHIP TO PATIENT: ________________ GROUP NUMBER: __________
I.D. OR SOCIAL SECURITY NUMBER OF POLICYHOLDER: _______________
ARE YOU COVERED BY A SECOND INSURANCE COMPANY? YES___ NO___
IF YES, NAME AND ADDRESS OF SECOND INSURANCE COMPANY: ________
____
NAME OF POLICYHOLDER: ____________________ DATE OF BIRTH: ________
RELATIONSHIP TO PATIENT: _______________ GROUP NUMBER: __________
I.D. OR SOCIAL SECURITY NUMBER OF POLICYHOLDER: _______________
WHO REFERRED YOU TO THIS OFFICE? _______________________________

IN ORDER TO SECURE PAYMENT FOR MY TREATMENT THROUGH MY INSURANCE COMPANY, I AUTHORIZED **LESLI K. JOHNSON, LISW, PH.D.** TO COOPERATE WITH MY INSURANCE COMPANY'S CLAIMS AND MANAGED CARE PROCEDURES, INCLUDING RELEASING SUFFICIENT CLINICAL INFORMATION (FOR EXAMPLE, DIAGNOSIS, SYMPTOMS, AND TREATMENT PLANS) TO ANSWER THEIR SPECIFIC QUESTIONS. I UNDERSTAND THE INSURANCE/MANAGED CARE COMPANY IS OBLIGATED TO MAINTAIN THIS INFORMATION CONFIDENTIALLY. I AUTHORIZE THE AFOREMENTIONED INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO **LESLI K. JOHNSON, LISW, PH.D.** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE AND THAT THE ENTIRE BILL IS MY RESPONSIBILITY REGARDLESS OF MY INSURANCE COVERAGE.

SIGNATURE: ______________________

____
SIGNATURE OF RESPONSIBLE PARTY
(If patient is under 18 years old)