Optimal Behavioral Health

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Dx _____

Check Benefits? Y N

Insurance Intake

This form is required for all clients who are covered by insurance or managed care benefits.

1. Client Name: _____ DOB: _____
   Gender: □ Male □ Female □ Other

   Address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   Alternate Contact: _____ Is it alright to leave confidential messages? □ Yes □ No

Email: _____ Email may not be a confidential form of communication. Your email will not be shared or solicited. Listing your email here constitutes permission to send protected health information via email.

2. Name of Primary Insured: _____ DOB: _____

   Relationship to insured: _____ Employer: _____

3. Insurance Company: _____ Phone: _____
   This policy is: □ Primary □ Secondary // Do you have another insurance? □ Yes □No
   (Please attach additional sheets for secondary insurance company information)
   Are you covered by the Oregon Health Plan? □ Yes □ No Medicare? □ Yes □ No

   ID#: _____ Group # _____
   Check one of the following: □ Health Insurance □ Worker's Compensation □ Auto Insurance

   Address: _____ City: _____ State: _____ Zip: _____
   Insurance Payer ID: _____

I have been given an opportunity to read the Notice of Privacy Practices, and I hereby authorize Optimal Behavioral Health and appointed billing agent(s) to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) _____ for the purpose of evaluating and processing claims for benefits.

I further authorize payment of medical benefits to Optimal Behavioral Health for services provided.

Signed: _____ Date: _____

Relationship to Client: □ Self □ Other: _____

Other Information: _____

For Office Use Only:

Ph _____ *Dt* ____/____/____ *Rep* _____ *Eff* ____/____/____

Ded _____ *m* _____ □ *Cal* □ *Plan:* _____ *Pd@* _____ *Co* _____ *UCR* _____

V Limit _____/_____ *MN* □ *Auth* □ *PEC Wait* □*Exempt* _____

OOP _____ *Met* _____ *Other:* _____

Eml ____/____/____ *Cl pt* ____/____/____ *@* ____:____ □*LM* □*Ph*