OPTIMUM BEHAVIORAL HEALTH, INC
Edward Amos, Ph.D.
Clinical Psychologist

Fist name M.I.	Last name	Social Sec. #	Birthdate	Age	Sex	Marital status
Street address	City	State	Zip	Phone	Wk/cell phone	

Primary Insurance Information

Subscribers name	Social Security #	Date of birth	Relationship to patient
Street address	City	State	Zip	Phone
Insurance Co. Name	Insurance ID#	Group #	Insurance phone#/address	Employer

Secondary Insurance Information

Subscribers name	Social Security #	Date of birth	Relationship to patient
Street address	City	State	Zip	Phone
Insurance Co. Name	Insurance ID#	Group #	Insurance phone #/address	Employer

Insurance Agreement

My signature below indicates that I have been informed of the policies and payment arrangements of Optimum Behavioral Health, Inc. I understand that I may request clarification or additional information about the policies and payment arrangements, and may request a copy of this document at any time.

I authorize payment of my medical benefits to Optimum Behavioral Health, Inc. for partial payment for professional services provided. In order to obtain insurance reimbursement, I authorize the release of any information pertinent to my case to my insurance company, managed care agent, or adjuster. A photocopy of this assignment is considered as effective and valid as the original.

_____ I choose to use my insurance as partial payment for psychological services

_____ _____
Signature Date

_____I choose to pay in full for psychological services and I do **NOT** wish for my insurance company to be billed.

_____ _____
Signature Date

OPTIMUM BEHAVIORAL HEALTH, INC.

MEDICAL REVIEW FORM

Name: _____ Date: _____

Family Physician: _____ Height: _____

Last Examination Date: _____ Weight: _____

Have you ever been treated for or been diagnosed with one of the following? (Please circle applicable items.)

A. High blood pressure, anemia or any other blood disorder.

B. Chest pains, shortness of breath, heart attack, any history of cardiac illness.

C. Diabetes or other endocrine disorders.

D. Any disorder of the kidney, bladder, prostate, breast or reproductive organs.

E. Ulcer, chronic indigestion, intestinal bleeding, hepatitis, colitis, or diarrhea.

F. Asthma, tuberculosis, bronchitis, emphysema, or other disorders of the lungs.

G. Fainting, convulsions, tension or migraine headaches, paralysis, epilepsy, memory loss or confusion, or any disorders of the brain or nervous system.

H. Arthritis, gout, back pain or other disorders of the muscles, bones or joints.

I. Do you use any tobacco products? How often? _____

J. Do you use any type of alcohol products? How often? _____

Have you noticed any recent changes in your vision, hearing, coordination, balance, strength, speech, memory or thinking, changes in energy, sleeping, eating, elimination, menstrual cycle, sexual activity?

Please list any psychiatric, psychological, or mental health treatment history

_____

_____

Please list all medications you are taking:

_____

_____

Please list any medication, food, pollens, or other substances you are allergic to:

_____

OPTIMUM BEHAVIORAL HEALTH, INC.
MEMPHIS, TENNESSEE
OLIVE BRANCH, MISSISSIPPI

Authorization for Therapist to Collaborate with Patient's Physicians

I, _____, authorize **Optimum Behavioral Health, Inc** to provide my physician,

Physician's name: _____

Office location: _____

Phone number: _____

Information about my symptoms, my diagnosis, and the course of my treatment.

I also authorize my physician _____ to provide Optimum Behavioral Health, Inc., information/records of my medical conditions and treatments.

This authorization will expire 90 days from today, or at any time I choose to revoke the authorization.

_____ _____
Patient's Signature Date

_____ _____
Witness' Signature Date

Client Rights & Privacy Policy

Confidentiality: Communication with the psychologist is confidential, which means it is private and can only be shared with others (such as the referring physician or other healthcare provider) with your written consent. There are some exceptions:

Dangerous behaviors (including serious thoughts of self-harm or someone else, information about child or elder abuse) are not protected by your right to confidentiality. By law, these behaviors are reported to appropriate authorities to keep you and others safe.

If you are involved in legal actions of any kind, you may be waiving a right to keep records confidential. You may wish to discuss this with your attorney before consenting to psychological services.

Most third party payers (e.g. health insurance companies, Medicare, Tenncare, EAP, Disability services, Workman's comp) require psychologists to provide information regarding symptoms, diagnosis, place and dates of service, treatment plan and other related information. If you wish for your health insurance company or other payers listed above, you are authorizing the psychologist to disclose required information. If you do not want this, you may elect to pay for services yourself, which eliminates this issue.

Informed Consent: You have the right to both agree and refuse psychological services. You have the right to consent to release of records if you want someone else to be informed about services here. You may ask the psychologist for information about training and credentials. Further information about state provisions for your rights can be obtained from the Tennessee Board of Examiners in Psychology at (615) 357-6791.

We require cancellation of appointments 24 hours in advance. Failure to do so will result in a charge of $50.00, which is not billed to your insurance company and will affect any future appointments with this office.

Patient notification of privacy rights: The Health Insurance Portability and Accountability Act (HIPPA) created new protections around health information. This applies to all health care providers. We do have a copy of this document in the office. By law we are required to secure your signature that you have had this offered to you. Please simply ask the psychologist for a copy if desired. It is important to know what patient protections are offered by HIPPA. At OBH, we do all we can to protect the privacy of your records. Paper copies are held for 7 years after service, then destroyed. Charts are held in a secure facility only accessible by OBH staff.

My signature below indicates I have been informed of my rights and information about policies and that I understand this information. Signature also indicates understanding that I have been offered the opportunity to review HIPPA policies with a copy provided to me if desired. It is my responsibility to ask the psychologist for further explanation about fees, privacy concerns, confidentiality and HIPPA issues.

_____ _____

Patient Signature Date

_____ _____

Psychologist Signature Date