

BEHAVIORAL SERVICES REQUEST & CONSENT FORM

Patient Name:	Facility:	Room #	Referring Physician:	Staff Requesting Service:
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Step One: (Obtain Patient Consent to Evaluation/Treatment) The following is a consent for treatment, authorization for parties to release information for treatment/billing purposes and a summary of how your health information may be disclosed: BSI may use my health care information to provide treatment, coordinate with my treatment team and provide alternatives, obtain payment, conduct health care operations, to contact me or my POA, to report abuse, neglect or violence, administrative oversight, or in judicial proceedings, as legally required. I have a right to request restrictions to my health care information, receive confidential and private communications, inspect my record, amend my health care information and request an accounting of disclosures. I acknowledge that the facility in which I reside has contracted with BSI to provide behavioral health services to the facility's residents. I willingly admit myself for all treatment consistent with the treatment program, patient rights, and billing procedures as will be explained to me by the behavioral consultant.

I understand that BSI will bill Medicare and/or other insurance or through an agreement with the facility for the services rendered. All charges not covered by Medicare, other insurance or the facility are the responsibility of me, the undersigned (resident's POA, guardian and/or trust.) In cases where it is medically necessary and appropriate to bill other payors, I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to BSI for services furnished me by that provider, and I hereby assign medical reimbursement rights to BSI and authorize such insurance providers to make payments for services rendered directly to BSI. I understand that I am financially responsible to the provider for all co-insurance charges or other fees not covered by my health care plan. This Authorization and Consent are provided throughout my care with BSI, but may be revoked at any time by written notification. A copy of this consent shall be considered as valid as the original.

Resident Signature (or legal representative named in Step Four) _____
Date

Step Two: (Obtain Primary Physician's Order)

Please Attach: Copy of Current Face Sheet with Payor Information
 Copy of MD Order "Psychological/Psychiatric Consultant to evaluate and provide treatment as necessary."

Step Three: (Choose the Service You Want)

- Behavioral Eval/Plan/Therapy If Covered Insurance go to Step Five, if not go to Step Four
- Psychiatry/Med Eval If Covered Insurance go to Step Five, if not go to Step Four
- Guardianship Evaluation If Medicaid go to Step Five, if not go to Step Four
- Incapacity Evaluation If Medicaid go to Step Five, if not go to Step Four
- Other: Describe: _____

Step Four: Complete if the service will be paid privately:

Name of Payor	Address	Phone Number

Step Five: (Indicate the Purpose of the Evaluation):

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| <p><input type="checkbox"/> Problem:</p> <ul style="list-style-type: none"> Behavioral Disorder Cognitive Impairment Depression Anxiety Adjustment Issues Psychosis Alcohol/Drugs | <p><input type="checkbox"/> Symptoms (Circle):</p> <ul style="list-style-type: none"> Striking Out Innappropriate Behavior Yelling Wandering Refusing Care Confusion Disorientation Memory Loss Other: Sadness Crying Withdrawn Not Eating Suicidal Thoughts Hopelessness Nervousness Frightened Shaky Sweating Sleep Problems Agitated Grief Losses Poor Coping Angry Longing for Home Paranoid Delusional Hallucinations Bizarre Behavior Intoxication Craving Hx of Use/Abuse Drug/Alcohol Seeking |
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Assessment of Cognitive Capacity
 Other (specify): _____

Step Six: Fax to 414-221-0001 with payor info and MD order