BEHAVIORAL SOLUTIONS

BEHAVIORAL SERVICES REQUEST & CONSENT FORM

Patient Name:	Facility:	Room #	Referring Physician:	Staff Requesting Service:

1: 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 Six) Date

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

3: Is the referral currently in a Part A Stay? ☐ No ☐ Yes (Expires _____)

4: Is the referral Urgent? (can't wait until next visit) ☐ No ☐ Yes
(If referral is urgent please contact our office at 414-220-9990 in addition to sending this referral)

5: (Choose the Service You Want)

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

6: Complete only if the service will be paid privately:

Name of Payor	Address	Phone Number

7: (Indicate the Purpose of the Evaluation):

Problem:	Symptoms (Circle):
Behavioral Disorder	Striking Out Inappropriate Behavior Yelling Wandering Refusing Care
Cognitive Impairment	Confusion Disorientation Memory Loss Other:
Depression	Sadness Crying Withdrawn Not Eating Suicidal Thoughts Hopelessness
Anxiety	Nervousness Frightened Shaky Sweating Sleep Problems Agitated
Adjustment Issues	Grief Losses Poor Coping Angry Longing for Home
Psychosis	Paranoid Delusional Hallucinations Bizarre Behavior

☐Assessment of Cognitive Capacity ☐Other (specify): _____

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