QCI Referral & Initial Paperwork
Medicare, Commericial/Private Insurance, Other
03/13/2019
2 Pages + ROI

QCI STAFF
Processed by (name)_____
Date received_____
Date of 1st appt_____

QCI Behavioral Health

Referral for Services:

Please fill in all questions to expedite referral process.

Patient Information Form (Medicare, Commercial/Private Insurance or Other Benefit Plan)

Please indicate which County you are requesting services in:

___Washington County ___Prince George's County ___Charles County ___Calvert County ___St. Mary's County

Does the patient speak English? ____Yes ____No *NOTE: QCI only provides services for English speaking patients at this time. QCI will attempt to point non-English speaking individuals, and those requiring sign language translation, to appropriate resources to the best of our ability.*

Referral source: Self: ___Yes ___No Other:_____

Patient Name: (First, Last, Middle Initial) _____ **Referral Date:** _____

Patient Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Patient Phone #: _____ **Patient Date of Birth:** _____

Patient Gender: ___Female ___Male Social Security Number: _____

Race: ___American Indian/Alaskan Native __Asian ___Black/African American ___Native Hawaiian/Other Pacific Islander ___White

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Primary Insurance: _____ **Authorization Needed: ___Yes ___No**

Primary Insurance ID #: _____ **Policy or Group #:** _____

PAYOR ID #: _____ **Phone # on back of card:** _____

Patient Status: ___Single ___ Married ___Other ___Employed ___Full-time Student ___Part-Time Student

Primary Insurance Name of Insured: _____

Relationship to Patient: ___Self ___Spouse ___Child ___Other

Date of Birth of Insured: _____ **Gender of Insured: ___Female ___Male**

Employer's Name: _____ **Insurance Plan Name:** _____

Is there another insurance: ___Yes ___No

Name of other insurance: _____ **Other Insurance Policy or Group #:** _____

Other Insurance PAYOR ID #: _____ **Phone # on back of card:** _____

Name of Other Insured: (First, Last, Middle Initial) _____

Date of Birth of Other Insured: _____

Is there any other Benefit Plan? ___Yes ___No

Name & Phone # of Other Benefit Plan: _____

ID# of Other Benefit Plan:

Patient's Condition Related to:

Employment ___Yes ___No Auto Accident ___Yes ___No Other Accident: ___Yes ___No

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To best serve our patients:

- **If the patient is a minor, please bring immunization records to initial appointment.**
- **Has patient ever been diagnosed with Autism, Asperger's, Pervasive Developmental Disorder (PPD), or any other developmental disability?** ___Yes ___No
  - If yes, what was the diagnosis?_____
  - Is Patient under a doctor's care for the above mentioned? ___Yes ___No
    If yes, where_____
- **Does the patient have a history of court charges and incarcerations** (check where applicable):
  _____Drug-Related _____Theft _____Assault _____Weapons Possession
  _____Other (provide details):_____
  _____
  _____
  Is patient currently registered as a sex offender? _____yes _____no

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Date received_____

QCI Behavioral Health

Authorization to Disclose Health Information/Release of Information

Patient Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ DOB: _____

I authorize the use or disclosure of the above named individual's health information as described below:

A. The following individual or organization is authorized to:

_____release the information _____receive and use the information

Individual/Organization Name: _____

Address: _____

Phone: _____ Fax: _____

B. The following individual or organization is authorized to:

_____release the information _____receive and use the information

Individual Name/Organization Name: QCI Behavioral Health, LLC

9475 Lottsford Road, Suite 250 Largo, MD 20774 Ph: 301-636-6504 Fax: 301-636-6509	5010 Regency Place, Suite 203 White Plains, MD 20695 Ph: 240-427-3554 Fax: 240-419-2556	201 North Burhans Boulevard Hagerstown, MD 21740 Ph: 301-791-0032 Fax: 301-797-4760

C. The purpose(s) for which the information may be released:

_____At the request of the patient _____Continuation of care/consultation

_____Social Security/Disability Certification

_____To pass on message to the patient; determine the patient's location

_____To exchange information concerning the patient illness and treatment

_____Other: _____

D. If not previously revoked, this authorization will terminate on the earliest of the following dates:
One year from the signatures date below, or upon the following date, event, or condition:
_____
(For authorizations to terminate due to an event or condition, the parties authorized to release information above must be notified in writing upon occurrence of the event or condition to cancel authorization.)

What information is being released:
Items below may include information on substance abuse and HIV/AIDS status unless indicated otherwise here:

_____Do not disclose substance abuse information _____Do note disclose HIV information

_____Emergency Room Record _____Entire record except psychotherapy notes

_____Most Recent History and Physical _____Referral _____Immunization Record

_____Intake Interview _____Medication List _____Psychiatric Evaluation/Diagnosis

_____Discharge Summary _____Psychological/Educational Report _____History of Allergies

_____Psychosocial Assessment _____Pathology Report _____Verbal Communication

_____Diagnostic Test/Results (labs, x-rays, and other test results) _____Most Recent Physical Exam

_____Other: _____

_____Psychotherapy Notes (Due to the highly sensitive nature of psychotherapy notes federal law requires a separate authorization form for their disclosure.)

E. **Dates of information** (it applicable): From: _____ to _____

F. **In understand the following:**
A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. **Revocation:** I have the right to revoke this authorization at any time. If I choose to cancel the release of information/authorization, I must notify the person/company identified in Section B in writing that I revoke this authorization. The revocation will not apply to information that has already been released in response to this authorization. **Re-disclosure:** If this information is to be received by individuals or organizations that are not health care providers, health care clearing houses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed and no longer protected by federal privacy regulations. Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws. **Conditioning of eligibility:** QCI Behavioral Health will not withhold treatment from me if I refuse to sign this form.

G. **Signature: _____Date: _____**
Patient, Parent, Legal Guardian

Authorizations signed by a legal representative must include a copy of the Guardianship papers or a Power of Attorney.

Witness (if client is unable to sign):
Signature: _____Date: _____