



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 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

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

NOTE: If the patient is a minor, please bring immunization records.

QCI STAFF

Processed by (name) _____

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 not 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: _____