

Orion Behavioral Health Network – Annual Demographics Update

Demographics:

Patient Name: _____ Patient Date of Birth: _____
Address: _____ City: _____ Zip Code: _____
Home Phone #: _____ Best contact method for reminders: ___ Text ___ Email (Please check one)
Cell Phone #: _____ Name of parent/guardian: _____
Cell Phone#: _____ Name of parent/guardian: _____
Work Phone #: _____ E-mail: _____
Emergency Contact: _____ Number: _____
Preference for contact from clinic to schedule: Email _____ Text Message _____ Phone Call _____

**By providing OBHN your phone number for SMS, please note that messaging and data charges may apply and that you can opt-out at any time by replying STOP. By providing a telephone number and submitting this form you are consenting to be contacted by SMS text message. Message & data rates may apply. You can reply STOP to opt-out of further messaging. <https://www.obhn.org/privacy-a-policy>

Insurance:

Primary Insurance (Type): _____

Subscribers Name: _____ **DOB:** _____

Subscribers SSN #: _____ **Relationship to Patient:** _____

Address of Subscriber: _____

ID/Policy Number: _____ **Group Number:** _____

Secondary Insurance (Type): _____

Subscribers Name: _____ **DOB:** _____

Subscribers SSN #: _____ **Relationship to Patient:** _____

Address of Subscriber: _____

ID/Policy Number: _____ **Group Number:** _____

Custody: Who has legal custody of the patient? _____

No Show/Late Cancel Policy: A \$50 fee may be assessed for appointments that are No Showed or are cancelled within 48 hours of appt.

The Alaska state medical board has issued a directive that the treating physician during a telemedicine encounter request that the patient consent to sending a copy of the records to the patient's primary care provider. OBHN is requesting this of you on their behalf. Any release of your records is voluntary and at your discretion. If you choose to release information to your primary care physician, please provide an Release of Information form.

Guarantor Information:

Relationship to Patient: _____

(Example: Biological Parent, Step Parent, Adoptive Parent, OCS/Guardian)

Name: _____ Contact Number: _____

Date of Birth: _____ SSN: _____ Email: _____

Address: _____ City: _____ St: _____ Zip: _____

Guarantor responsibility: Payment for all professional services rendered is the responsibility of the patient, parent, or guardian. When the patient has insurance that is reasonably expected to contribute toward payment for services, Orion Behavioral Health Network will assist in the preparation and submission of insurance claims. However, the Guarantor is responsible for all fees regardless of insurance coverage. Payment for all services, is due when services are rendered. Payment of coinsurance and deductible is done based on reasonable estimate. If additional funds are required after the insurance claim has been processed, any balance will be billed to the Guarantor. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the Guarantor. If insurance issues arise, it is the responsibility of the Guarantor to contact the insurance company, group plan administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier.

HIPAA Annual Signature:

I hereby acknowledge receipt of Orion Behavioral Health Network's Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

Parent/Guardian Signature (if patient under 18)

Date

Patient Signature (if 18 or older)

Date