17025 Snowmobile Ln Eagle River, AK 99577

Telephone: (907)-696-7466 Fax: (907)726-0332

Email: Info@obhn.org

Patient Name: _____ Date of Birth: _____ Gender: M / F

Refer to patient as_____

Guardian Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Guardian Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Primary Address:_____

City: _____ State: _____Zip:_____

EMAIL (REQUIRED): _____

Need at least one email address for Guardian of patient

Preference for Reminder Messages: Text Message ____ Email____ Both____ None____

Emergency Contact (Other than Guardians) _____

Relationship: _____ Phone: _____

Parents are asked to *check- in at least 15 minutes* prior to an appointment. This allows for collection of insurance information and time for Nurse / Medical Assistant to check-in the child, a process which may include weight, height measurement, and blood pressure measurement.

Primary Insurance (Type): _____

Subscribers Name: _____ DOB: _____

Subscribers SSN #: _____

ID/Policy Number: _____ Group Number: _____

Secondary Insurance (Type): _____

Subscribers Name: _____ DOB: _____

Subscribers SSN #: _____

ID/Policy Number: _____ Group Number: _____

(Please Provide a copy of the Front and back of card before initial visit)

OBHN is no longer accepting Medicaid for talk therapy. If you have a private insurance with Medicaid secondary, you likely will have a co-pay for therapy services that will be your responsibility

School Information

Current School: _____

Grade: _____

Difficulties in school:

___ None ___ Frequent Suspension __ Detention ___Learning Problems __Poor Attendance

Is the patient on an IEP/504 Plan __YES __NO

Special Education ___ YES ___ NO

OTHER SCHOOL SERVICES_____

Guarantor Information

Relationship to Patient: _____
(Example: Biological Parent, Adoptive Parent, OCS and/or Guardian)

Name: _____

Date of Birth: _____

Address: _____

_____

Contact Number: _____

SSN(required):_____

Email Address: _____

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.

Signature: _____ Date: _____

Reason for Medical Evaluation

___ MOOD ___ Aggression ___Inattention ___Hyperactivity/Impulsivity ____Anxiety ___ Other

SERVICES PATIENT IS RECEIVING

___ SPEECH Office/Provider _____ Phone Number_____

___ OT/PT Office/Provider_____ Phone Number_____

___ Therapist Office/Provider_____ Phone Number _____

___ ABA Office/ Provider _____ Phone Number _____

___ Other Office/Provider _____ Phone Number _____

Medical History

Primary Care Provider (Office & Doctor): _____ Phone: _____

Current Medications: _____ Dose _____

_____ Dose _____

_____ Dose _____

_____ Dose _____

Any Allergies? (if yes please explain): _____

Household Information

Mothers Full name: _____

Fathers Full Name: _____

Who has legal custody? _____

Who has medication consent? _____

Employer of Father_____ Employer of Mother_____

Employer Address:_____ Employer Address: _____

Employer Phone Number:_____ Employer Phone Number: _____

Who lives in the home with the patient?

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Trauma History

Has this patient experienced any of the following?

____ YES ____NO ____SUSPECTED Emotional Abuse?

____ YES ____NO ____SUSPECTED Sexual Abuse?

____ YES ____NO ____SUSPECTED Physical Abuse?

____ YES ____NO ____SUSPECTED Neglect?

____ YES ____NO ____ N/A If in OCS custody, lived in multiple foster homes?