# ORION
## BEHAVIORAL HEALTH NETWORK

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**

**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***

**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, Step Parent, Adoptive Parent, Foster Parent, and Guardian)*

Name: _____

Date of Birth: _____

Address: _____

_____

Contact Number: _____

SSN: _____

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): _____**

**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 a Release of Information form.**

## Household Information

**Mothers Full name: _____**

**Fathers Full Name: _____**

**Who has legal custody? _____**

**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?**