

Patient Information/OTR

SECTION I				PATIENT INFORMATION			
Employer & Location (City & State):			Division/Department:		Authorization #:		
Patient Name:			Employee SS#:		Patient Date of Birth:		
1. Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone: ()		Work Phone: ()			
2. Home Address:			City:		State:		Zip:
3. Case Status:		4. Ethnic Origin:		5. Marital Status:		6 Education: (highest completed)	
<input type="checkbox"/> New <input type="checkbox"/> Reopened <input type="checkbox"/> Last Time Seen at CAI: <hr/> <input type="checkbox"/> Same Problem <input type="checkbox"/> New Problem		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced		<input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> Technical <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
7. Information Source:		8. Referral Source:		9. Employee's Job Category:		10. Employee Status:	
<input type="checkbox"/> Home Mailing <input type="checkbox"/> Brochure/Poster <input type="checkbox"/> Training Session <input type="checkbox"/> Family Member <input type="checkbox"/> Supervisor <input type="checkbox"/> Co-Worker <input type="checkbox"/> Other		<input type="checkbox"/> Self Referral <input type="checkbox"/> Supervisory Referral <input type="checkbox"/> Suggestion <input type="checkbox"/> Required <input type="checkbox"/> Family Initiated <input type="checkbox"/> Company Wellness/Medical Department		<input type="checkbox"/> Executive Management <input type="checkbox"/> Professional/Technical <input type="checkbox"/> Sales/Marketing <input type="checkbox"/> Clerical <input type="checkbox"/> Maintenance <input type="checkbox"/> Labor Manufacturing		<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Downsized <input type="checkbox"/> Terminated <input type="checkbox"/> Voluntarily Left Company Date: _____ Length of Service: Years ____ Months ____	

SECTION II						MEMBER INFORMATION					
Name:		Relationship to Employee:		SS#:		D.O.B./Age:		Ethnicity (see#4)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Home Address:				City:		State:		Zip:			
Case Status: <input type="checkbox"/> New <input type="checkbox"/> Reopened/Last Time Seen at CAI: _____						Problem (if reopened): <input type="checkbox"/> New <input type="checkbox"/> Same					

SECTION III				PROVIDER USE ONLY			
Outpatient Treatment Plan				Problem Classification			
New Auth. Date:		Counselor Name:		(Select and Indicate <u>one</u> Primary (1) and <u>one</u> Secondary (2) problem.)			
Date of Last Visit:				___ 1. Emotional ___ 2. Drugs ___ 3. Alcohol ___ 4. Relationship Problems ___ 5. Familial ___ 6. Traumatic Event or Loss ___ 7. Occupational ___ 8. Legal ___ 9. Financial ___ 10. Other: _____			
Axis I:				<u>Case Disposition</u>			
Axis II:				1. Date of Closing _____			
Axis III:				2. TX Provided: (Check/Complete all that apply)			
GAF (current):				___ a. EAP EAP Treatment Successfully Completed? Yes ___ No ___ ___ b. Outpatient Psych Tx, Therapist Name/Co. _____ ___ c. Outpatient CD Tx, Agency Name _____ ___ d. Inpatient Psychiatric Treatment, Agency Name _____ ___ e. Inpatient CD Treatment, Agency Name _____ ___ f. Community Resources (e.g. self-help, elder care, etc.) _____ ___ g. Other: _____			
Symptoms: (description and severity)				3. Referred to CAI Managed Care? Yes ___			
Risk Assessment	SI: intent plan hx of harming self HI: intent plan hx of harming others			___ MC Department Verbally Informed ___ EAP Referral Form Completed No ___			
Medication (s) (indicate frequency and dosage)				4. Did Client receive a Satisfaction Survey Form? Yes ___ No ___			
Sessions used							
Sessions requested							
Treatment Goals:	1. 2. 3.						

SECTION IV**STATEMENT OF UNDERSTANDING****FEES**

Cameron and Associates, Inc. (CAI) is a private EAP/Managed Behavioral Health Care firm offering consulting, assessments, referrals for long-term counseling, in-patient admissions and confidential short-term counseling to employees and their eligible dependents. EAP counseling services are offered to eligible members at no cost. The EAP benefit has been prepaid by your employer, _____ and offers up to a maximum of _____ counseling sessions per primary problem. Clients are seen by appointment. However, only face-to-face sessions will be reimbursed. No-shows will not be reimbursed by CAI.

Referrals to outpatient and in-patient counseling may be recommended to resolve problems that are not covered under the EAP. Any costs involved for these services outside of the EAP are the client's responsibility. There may be coverage for these outside services under your medical benefit plan.

PRIVACY

Information concerning the use of CAI services is not given to anyone outside of Cameron and Associates, Inc. (CAI) without your permission, unless it is required by law. Certain states require that CAI staff assume the responsibility for reporting to appropriate parties when a person is in danger to him or herself, to others, or when child or adult abuse/neglect is involved.

SELF-REFERRAL

If an employee or family member initiates a request for assistance, the contact will remain confidential, unless there is individual written permission.

SUPERVISOR REFERRAL

If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive drug screening, the supervisor will be notified whether or not the employee has kept the appointment(s).

VOLUNTARY PARTICIPATION

Use of CIA's services is voluntary. It is the client's decision to use, or not to use, the services available. In some cases, as noted above, your employer may require assessment and follow through with the recommendations made by staff as a condition of employment, or as a part of the company's substance abuse policy.

SECTION V**ACKNOWLEDGEMENT OF PRIVACY POLICIES**

- I have received a copy of Cameron and Associates, Inc.'s Notice of Privacy Policies.

SECTION VI**PATIENT AGREEMENT FOR COMMUNICATIONS**

- I understand that as part of my Mental Health Care, CAI may need to contact me for the purpose of confirming an appointment or giving me additional information.
- I understand that CAI will use the minimum necessary information needed when they communicate with me. I understand that I can revoke or amend this agreement at any time. Any revocation or changes will not apply to communications already complete.
- I hereby authorize CAI to contact me in the following manner:

Please choose one:

Home: _____ Mobile: _____ Office: _____ Email: _____

ACKNOWLEDGEMENT

By signing the **Patient Information/OTR Form**, I understand and acknowledge its content beginning with sections I-II and sections IV-VI, which includes the "Statement of Understanding", "Acknowledgement of Receipt of Privacy Practices" and "Patient Agreement for Communications".

(Please print Employee/Member name)

(Employee/Member Signature)

(Parent/guardian if under 16 years of age)

(Date)

PROVIDER INFORMATION/INSTRUCTIONS

Please submit this Patient Information/OTR Form along with a **HCFA 1500 Claim Form for billing. (CAI no longer accepts CAI invoices or personal invoices). Mail forms to:

CAMERON AND ASSOCIATES, INC., ATTN: CLAIMS DEPT., 6100 LAKE FORREST DR., SUITE 550, ATLANTA, GA 30328

**** Claims must include the authorization number. (Prior Authorization is required for all Services)**

Please give all clients the following forms**: Satisfaction Survey Form Notice of Privacy Policies Brochure

**** These forms are not required for submission of payment, but are required to be given to the member(s).**

All Providers will need to submit a Patient Information/OTR form after the initial 3 authorized sessions to request additional sessions and/or date of closing. Please fax the completed form to (404) 459-7147 or mail to CAI. You will be notified in writing of approval or denial of additional sessions within 72 hours of submitting the completed Patient Information/OTR form.

For further information, assistance or Authorization please Contact CAI at: **(404) 843-3399/ (800) 334-6014.**