Ohio Physicians Health Program

PARTICIPANT DEMOGRAPHIC & INTAKE FORM

DEMOGRAPHIC INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Degree/Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Mobile Phone Number: _____

Work Phone Number: _____

Presently Employed: ☐ Yes ☐ No Communication Preference: ☐ Home ☐ Work

Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Phone Number: _____

OTHER CONTACTS

Primary Care Physician: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Attorney: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Therapist: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

PROFESSIONAL LICENSE(S)

State: _____ Number: _____ Status: _____

State: _____ Number: _____ Status: _____

State: _____ Number: _____ Status: _____

Has your license or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing board? ☐ Yes ☐ No

PAST OR PRESENT TREATMENT INFORMATION (IF APPLICABLE)

Treatment Facility: _____

Contact Person: _____ Phone Number: _____

Admission Date: _____ Discharge Date: _____

Drug(s) of Abuse: _____ Sobriety Date: _____

Additional Treatment? ☐ Yes ☐ No Diagnosis: _____

Past Treatment Facility (if applicable): _____

Contact Person: _____ Phone Number: _____

Admission Date: _____ Discharge Date: _____

PRESCRIPTIONS

Please indicate below all current prescriptions and over the counter medications.

Medication/Dosage	Reason Taken	Prescribing Physician
Example: Fluoxetine, 40mg	*Depression*	*John Doe, M.D.*

REPORTING

Please indicate below the organization/person in which you authorize to receive information and/or updates from OPHP regarding your participation and/or compliance.

Name of Agency: _____

Contact Person: _____

Address: _____

Phone Number: _____ Fax Number: _____

E-mail Address: _____

Method of Delivery: ☐ Regular Mail ☐ Fax ☐ E-mail

OPHP CONFIDENTIALITY AGREEMENT

To abide by the Ohio Physicians Health Program (OPHP) confidentiality requirements and due to the sensitive nature of OPHP's work, we ask that you sign below acknowledging that all information and files will be kept within the OPHP offices. In signing this you are agreeing not to speak or write any of the above, per Code of Federal Regulations 42 CFR Part 1. Violation of this Agreement makes the signer subject to prosecution.

E-MAIL AUTHORIZATION

E-mail is a convenient form of communication that may be utilized between you and OPHP staff if desired. By signing this form you are authorizing OPHP to utilize your e-mail address for OPHP communication. Please acknowledge that due to HIPAA regulations, communications will be sent via encrypted e-mail. Although it is unlikely, information can still be intercepted and read by other parties besides the person to who it is addressed. By signing below you understand the inherent unsecured nature associated with this method of communication and therefore accept the risks of using it. You also understand that you are responsible for informing OPHP of any changes to your e-mail adddress.

SELF EVALUATION

Please decribe below, in detail, the primary reason or purpose for your referral to OPHP. Include in your response: any precipitating event(s); your primary stressors; your primary symptoms; and any other information you believe would be helpful for OPHP to know. Please use additional paper if needed.

Signature: _____ Date: _____

Printed Name: _____

FEES (AS APPLICABLE)

Non-Refundable Processing Fee.....$394

Monthly Administrative Fee.....$100

Urine Drug Testing (UDT) Fees.....$42 - $84

Alternative Testing Fees (blood, hair, nail, breath).....$129 - $600

UDT Collection Fee (at OPHP).....$20

Behavior Health Assessment.....$400

Return to Work Evaluation.....$389

By signing below, I agree to pay for all applicable services rendered. I understand that OPHP services will be at my own expense and will be discontinued, according to OPHP policy, for failure to pay in a timely manner.

PAYMENT INFORMATION

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____ Card Type: ☐ Visa ☐ MasterCard

Name on Card: _____

Expiration Date: _____ 3-Digit Code on Back of Card: _____

Signature: _____

Printed Name: _____ Date: _____