COMMUNITY STRONG LLC
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Behavioral Health Integration (BHI) & Remote Patient Monitoring (RPM)

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Address: _____

Referring Provider Information

Provider Name: _____

NPI #: _____

Phone: _____

Fax: _____

Clinic/Facility Name: _____

Clinic Email: _____

Care Team Contacts (Optional – for coordination of care)

1. Name: _____ | Email: _____

2. Name: _____ | Email: _____

3. Name: _____ | Email: _____

2. Qualifying Diagnosis

A. BHI Qualifying Diagnosis (Check all that apply)

□ Major Depressive Disorder (F32.0- F32.9 / F33.0 - F33.0)
□ Generalized Anxiety Disorder (F41.1)
□ Post-Traumatic Stress Disorder (PTSD) (F43.10)
□ Bipolar Disorder (F31.0–F31.9)
□ Schizoaffective Disorder (F25.0–F25.9)
□ Substance Use Disorder (F10–F19 with appropriate codes)
□ Adjustment Disorder (F43.20–F43.29)
□ Other : _____

B. RPM Qualifying Diagnoses (Check all that apply)

□ Hypertension (I10)
□ Heart Failure (I50.20–I50.9)
□ Chronic Obstructive Pulmonary Disease (COPD) (J44.0–J44.9)
□ Diabetes Mellitus (E08–E13)
□ Chronic Kidney Disease (N18.1–N18.9)
□ Obesity / BMI ≥ 30 (E66.01–E66.9)
□ Sleep Apnea (G47.33)
□ Other: _____

C.Ketamine Clinic Qualifying Diagnoses (Check all that apply)

□ Treatment-Resistant Depression (F32.2 / F33.2)
□ PTSD (F43.10)
□ Severe Anxiety Disorder (F41.1)
□ Bipolar Depression (F31.81)
□ Chronic Pain with Associated Depression (G89.4 + F32.9)
□ Suicidal Ideation (R45.851)
□ Other: _____

3. RPM Devices Assignment

□ Blood Pressure Monitor
□ Pulse Oximeter
□ Weight Scale
□ Glucometer
□ Peak Flow

Duration of Time: 0-99 months_____.

Monitor how many times a day: _____.

Other (write-in ICD-10 or clinical reason): _____

_____.

4. Purpose of BHI + RPM + Ketamine Monitoring

I understand that these services are designed to: Monitor my mental and physical health before, during, and after treatment. Track vital signs, symptoms, and mood changes. Allow my care team to communicate and respond promptly to concerns. Support treatment safety and effectiveness. **I understand these services do not replace emergency care in urgent situations, I will call 911.**

5. Consent for Service:

I consent to: Participation in Behavioral Health Integration services and Remote Patient Monitoring using assigned devices, Coordination with my ketamine treatment provider (if applicable) and Communication of my health between authorized providers.

HIPAA Compliance & Authorization to Bill

I acknowledge that I have been informed of my rights under the Health Insurance Portability and Accountability Act (HIPAA). I consent to the secure collection, transmission, and use of my health information for medical monitoring, treatment, and billing purposes.

I authorize Community Strong LLC and its billing partners to submit claims to my health insurance for Remote Patient Monitoring (RPM) services rendered and to receive direct payment for these services. I understand that my insurance may be billed monthly for monitoring services and I may be contacted by a health coach or clinician.

Patient Consent
Verbal Consent Given (initial by provider: _____
Patient Signature: _____ Date: ____ / ____ / _____
Provider Signature: _____Date: ____ / ____ / _____