Berkshire
WELLNESS CENTER
of Reading
A Proud Member of Oceans Healthcare

BIOGRAPHICAL INFORMATION FORM

DATE: _____

PATIENT LEGAL NAME: _____
NAME USED/PREFERRED: _____ GENDER: _____
ADDRESS: _____
CITY: _____ ZIP: _____ EMAIL ADDRESS: _____
PHONE#:(HOME) _____ (WORK) _____ (CELL) _____
DATE OF BIRTH: _____ SOCIAL SECURITY#: _____
RACE: White ____ Black ____ Hispanic ____ Native American ____ Asian/Pacific Islander ____ Other _____
PARENT NAME (If patient is under 18): _____
PARENT ADDRESS (If different from patient): _____
PARENT PHONE#:(HOME) _____ (WORK) _____ (CELL) _____
PARENT DATE OF BIRTH: _____ SOCIAL SECURITY#: _____
SPOUSE NAME (If applicable): _____
SPOUSE DATE OF BIRTH: _____ SOCIAL SECURITY#: _____
NAME OF INSURANCE: _____
NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____
ID#: _____ GROUP #: _____ PHONE#: _____
SECONDARY INSURANCE: _____
PLACE OF EMPLOYMENT/SCHOOL: _____
EMERGENCY CONTACT PERSON/PHONE#: _____
PCP/FAMILY PHYSICIAN: _____
REFERRING PHYSICIAN/THERAPIST: _____

As permitted by law, this office may contact patients to notify them of future appointments or schedule changes by telephone at their residence, or by leaving a message on an answering machine or with an adult at their residence. Messages may also be left on a cellular phone voice mail or via text message, or at a workplace, but only if that number is given as the contact number. ***Please note our courtesy reminders do not alleviate the patient/guardian from the responsibility of keeping appointments, nor any fees assessed if the reminder is not received.*** When contacting a patient by phone, office staff uses a standard practice of simply identifying ourselves as "your doctor's office". If you are a patient of a therapist, the therapist's name only (not title) would be used. **If you do not wish for this office to leave a message to be delivered to you regarding an appointment or other office issue, you may indicate below. PLEASE NOTE: Although HIPAA allows reasonable use of phone messages, we make every effort to respect your request.**

Voice messages may be left at my residence: _____ Yes _____ No

Voice messages may be left at my workplace: _____ Yes _____ No

Voice messages may be left at on my cellular phone: _____ Yes _____ No

Text messages may be sent to my cellular phone: _____ Yes _____ No
(standard message and data rates may apply from your wireless carrier)

I grant permission for the following individuals to make or change appointments on my behalf:

_____

_____ _____
Patient Signature (Parent/Guardian if necessary) Date

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Patient name:_____ DOB:_____

(ASSIGNMENT AND/OR RELEASE SIGNATURE(S) EXPIRES 12 MONTHS FROM DATE SIGNED)

INFORMED CONSENT FOR TREATMENT:
I agree and consent to participate in behavioral health care services offered and provided by Berkshire Wellness Center of Reading. Berkshire Wellness Center is an outpatient department of Haven Behavioral Hospital of Eastern Pennsylvania. I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral care providers directly supervising the services received by the patient.

If the patient is under the age of fourteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____
Patient Signature (Parent/Guardian if necessary) Date

PATIENT RIGHTS AND RESPONSIBILITIES:
I have been made aware of Berkshire Wellness Center of Reading Patient Rights and Responsibilities posted in the waiting room. I have also received a copy of Berkshire Wellness Center of Reading's Patient Rights and Responsibilities.

_____ _____
Patient Signature (Parent/Guardian if necessary) Date

ACCOUNT RESPONSIBILITY, BENEFITS ASSIGNMENT & INSURANCE RELEASE OF INFORMATION:
I understand that I am the party responsible for payment of professional services rendered. If insurance is applicable, I authorize payment directly to Berkshire Wellness Center of Reading. I also authorize Berkshire Wellness Center of Reading to release to my insurance company medical information necessary to process my claim(s). I understand I am responsible for any co-pays, co-insurances, deductibles, late cancellations (cancellations with less than 24 hours notice) or missed appointment fees, and/or any and all unpaid balances incurred.

_____ _____
Patient Signature (Parent/Guardian if necessary) Date

PRACTICE PRIVACY POLICY/NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS
I have read and understand Berkshire Wellness Center of Reading' s Privacy Policies and Non-Discrimination and Accessibility Requirements.

_____ _____
Patient Signature (Parent/Guardian if necessary) Date

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Patient name:_____ DOB:_____

RELEASE OF INFORMATION: Clinical
My clinician may discuss my symptoms or diagnosis with his/her colleagues at Berkshire Wellness Center of Reading for clinical purposes. Other discussions with referring clinicians or with family members require signed consent(s).

_____ _____
Patient signature (Parent/Guardian if necessary) Date
□ Patient declined to provide consent for Clinical Release

_____ _____
Witness of Consent/Signatures-Berkshire staff Date

*Due to telehealth services and/or physical limitations, the patient/guardian was unable to sign this form. Verbal consent with the understanding and agreement for each of the above listed consents has been obtained and witness by two Berkshire Wellness Center of Reading employees.

_____ _____
2nd Witness of Consent/Signatures-Berkshire staff Date

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Revoke Date:_____

Signature of Patient:_____ Date: _____

Signature of Berkshire Staff:_____ Date:_____