# Berkshire Psychiatric & Behavioral Health Services, P.C.

**716 N. Park Road, Wyomissing, PA 19610** **1800 N. 12th Street, Reading, PA 19604**
**610-375-0544 FAX 610-378-9779** **610-816-5728 FAX 610-816-5710**

## ***BIOGRAPHICAL INFORMATION FORM***

DATE: _____

PATIENT NAME: _____
ADDRESS: _____
_____CITY_____ZIP _____
E-MAIL 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 INSURED:_____RELATIONSHIP TO PATIENT:_____
NAME OF INSURANCE:_____
ID#:_____GROUP #:_____PHONE#:_____
SECONDARY INSURANCE:_____
PLACE OF EMPLOYMENT/SCHOOL:_____
EMERGENCY CONTACT PERSON/PHONE#:_____
PCP/FAMILY PHYSICIAN:_____
REFERRING PHYSICIAN/THERAPIST:_____

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 Psychiatric and Behavioral Health Services, P.C. I also authorize Berkshire Psychiatric and Behavioral Health Services, P.C. 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 minor) Date

RELEASE OF INFORMATION: PCP/Family Physician
I authorize for my clinician at Berkshire Psychiatric & Behavioral Health Services, P.C. to collaborate with my PCP/Family Physician _____ regarding my symptoms and/or diagnosis in order to obtain or release pertinent information regarding my care.

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

RELEASE OF INFORMATION: Clinical
My clinician may discuss my symptoms or diagnosis with his/her colleagues at Berkshire Psychiatric & Behavioral Health Services, P.C. for clinical purposes. Other discussion with referring clinicians or with family members require signed consent.

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

***(ASSIGNMENT AND/OR RELEASE SIGNATURE(S) EXPIRES ONE YEAR FROM DATE SIGNED)***

 Patient Name_____

INFORMED CONSENT FOR TREATMENT:

I agree and consent to participate in behavioral health care services offered and provided by a Berkshire Psychiatric & Behavioral Health Services, P.C. provider. 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.

_____ _____

Patient Signature (***Patients 14 yrs or older must sign themselves)*** Date

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.

_____ _____

Parent/Guardian Signature (if under 14yrs old or as necessary) Date

PATIENT RIGHTS AND RESPONSIBILITIES:

I have been given a copy of Berkshire Psychiatric & Behavioral Health Services, P.C. Patient Rights and Responsibilities and am aware of the Grievance and Appeal Procedures contained in this Notice. This Notice is also posted in the waiting room. I am aware that I may request an additional copy of Berkshire Psychiatric & Behavioral Health Services, P.C.'s Patient Rights and Responsibilities at any time.

_____ _____

Patient Signature (Parent/Guardian if necessary) Date

**PRACTICE PRIVACY POLICY / NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS**

Berkshire Psychiatric & Behavioral Health Services, P.C. is required by law to maintain the privacy of your health information and not discriminate on the basis of race, color, age, sex, national origin, language, or disability. We will only release patient information related to treatment, payment and health care operations as Federal HIPAA regulations and/or State law allow. We will provide aids and services to patients with disabilities and/or those whose primary language is not English. A signature below signifies you have been given a copy of our "Notice of Privacy Practices and Non-discrimination and Accessibility Requirements." This Notice is also posted in our waiting room and available upon request. 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

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

_____

_____

Patient Signature (Parent/Guardian if necessary) Date

Text messages may be sent to my cellular phone *(standard message and data rates may apply from your wireless carrier)*
_____YES _____NO

I have been informed of the Notice of Privacy Practices and Non-Discrimination and Accessibility Requirements:

_____ _____

Patient Signature (Parent/Guardian if necessary) Date

 Patient Name_____

PERSONAL INFORMATION BACKGROUND

PRESENT PROBLEM FOR WHICH YOU ARE SEEKING EVALUATION AND TREATMENT:

_____

_____

_____

_____

PRESENT SOCIAL CIRCUMSTANCES/SUPPORT:

1) MARITAL STATUS _____Married _____Separated _____Divorced
_____Widowed _____Single

2) # of CHILDREN_____ Ages_____

3) PARENTS LIVING? Mother _____Yes _____No # of SIBLINGS_____
Father _____Yes _____No

4) DO YOU HAVE A SUPPORT SYSTEM OF FAMILY AND/OR FRIENDS LIVING CLOSE BY?
_____Yes _____No
_____

5) ORGANIZATION(S)/CHURCH _____

PRESENT MEDICAL HEALTH:

1) PLEASE LIST ANY CURRENT MEDICAL CONDITION FOR WHICH YOU ARE SEEKING TREATMENT ELSEWHERE
_____
_____

2) TREATING PHYSICIAN_____

3) MEDICATIONS TAKEN (PRESCRIBED) _____
_____

MEDICATIONS (OVER THE COUNTER) _____

4) USAGE: a) COFFEE _____ b) SMOKING _____ c) ALCOHOL _____

GOALS – WHAT WOULD YOU LIKE TO RESULT FROM THIS EVALUATION AND TREATMENT RECOMMENDATION?

_____

_____

_____