## Patient Record Update

**Patient Information**

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Cell Phone:_____

**Guarantor Information - if different from self**

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Relationship:_____

**Employer Information**

Name:_____ Occupation:_____

Add1:_____

City:_____

State:_____ Zip:_____

**Insurance Information: Please provide copies of cards to the receptionist**

**Primary Insurance Information**

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

**Insurance Information: Please provide copies of cards to the receptionist**

**Secondary Insurance Information**

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature: Date:

**FINANCIAL POLICY**

Thank you for choosing our doctors and therapists to meet your needs. The following is a statement of our Financial Policy, which we ask you to read and sign prior to treatment.

Psychiatric and psychological services have already been handled differently by insurance companies than medical/surgical services; therefore we ask you to become as knowledgeable as possible about your particular insurance plan.

YOUR PORTION OF PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AND MASTERCARD.

**MEDICARE**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to_____ _____ for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**INSURANCE**

Your insurance policy is a contract between you and your insurance company. If you have given us all the required information, we can submit the mental health services to the insurance companies with which we participate. We must have current policy, group, ID, and claim numbers. We will make a copy of your insurance card. Please be aware that some services may be "non-covered" services according to your policy. You are still responsible for payment of these services.

Many of us are members of "provider panels" of certain companies. If this is true for your insurance, then part of the payment will come directly to us from the company. You will need to pay a "co-payment" at each visit, the amount of which is determined by *your insurance company* (not be us). You will need to call your insurance carrier to learn what you co-payment will be. You may also need to be in touch with them from time to time in order to make sure that your claims are being paid and that your coverage is still authorized for our services.

If you are covered by an insurance carrier that requires precertification, it is your responsibility to call the company for authorization prior to your first appointment. If you do not have authorization, you will be billed for the services.

We accept the approved amount for some major insurance companies and some HMO and PPO programs, however please have the employer name, claim number, and address of where the claim should be sent. We require written preauthorization from the insurance carrier for all auto insurance and Workers' Compensation cases.

Please note we do not participate in Medical Assistance.

**COMMERCIAL INSURANCE**

I hereby authorize the release of information necessary to file a claim with my insurance company and *assign benefits otherwise payable to me to the physician indicated on the claim.*

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature_____ Date_____

**MINOR PATIENTS (UNDER 18 YEARS OF AGE)**

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, we will bill our participating insurances, but the parent who brings the child in for services is ultimately the responsibility party.

**FORENSIC EVALUATIONS**

Forensic Evaluations are usually not covered by insurance and are paid in full prior to the evaluation unless alternative arrangements are made.

**BILLING**

A Billing statement covering your services will be mailed to you each month. We expect payment to be made on a timely basis. A past due account will be turned over to our collection agency if no payment has been made.

I have read, understand, and agree to this Financial Policy.

_____ _____

Signature of Patient of Responsible Party Date

DGR BEHAVIORAL HEALTH ELECTRONIC COMMUNICATIONS POLICY

E-mail is only for scheduling or for a clinical reason that we can discuss ahead of time.

E-mail is not a substitute for discussions that should take place face-to-face.

E-mails should never be used for emergencies.

Do not e-mail your provider if you expect a quick response, as we only check e-mail occasionally.

We do not follow patients' blogs, follow patients on Twitter, Google them, friend them, or communicate by texting.

Cell phones should be off (or in silent mode) during sessions. Secret recording of sessions is not permitted.

To protect your privacy and respect that of others, please do not have cell phone conversations in the waiting room.

**CLIENT INFORMATION QUESTIONNAIRE**
All Information Confidential

**General Information** Date_____

Name_____Age_____Sex_____DOB_____

Address_____State_____Zip_____County_____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Maiden name_____

Occupation_____Education_____

Employer name and address_____

Referring individual or agency_____Phone_____

List family members and all others in the home

| Name | Age/Date of Birth | Relationship | Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you have a Mental Health Care Advance Directive? ____Yes ____No

If yes, please provide us with a copy to keep on file.

Do you have a Mental Health Power of Attorney? ____Yes ____No

If yes: Name_____

Address_____

_____

Phone_____

To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

| | | |
|---|---|---|
| Nervousness | Depression | Fears |
| Shyness | Sexual Problems | Suicidal Thoughts |
| Separation | Divorce | Finances |
| Drug Use | Alcohol Use | Friends |
| Anger | Self-Control | Unhappiness |
| Sleep | Stress | Work |
| Relaxation | Headaches | Tiredness |
| Legal Matters | Memory | Ambition |
| Energy | Insomnia | Making Decisions |
| Loneliness | Inferiority Feelings | Concentration |
| Education | Career Choices | Health Problems |
| Temper | Nightmares | Marriage |
| Children | Appetite | Stomach Trouble |
| Bowel Troubles | Being a Parent | My Thoughts |

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Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.

1. With what ethnic/cultural/racial group do you identify?_____
2. What is your religious affiliation?_____
3. What role does your religion/spirituality play in your life?_Positive_Negative_Neutral
4. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment?_____Yes_____No If yes, please identify?_____

_____

## DIET, SUBSTANCE USE AND LIFE STYLE ISSUES

1. Are you on a special diet? ☐No ☐Yes
   Describe_____

2. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, Etc)? ☐No ☐Yes
   Amount_____

3. Do you take Over The Counter (OTC) medications, herbal preparations, dietary supplements, etc? ☐No ☐Yes Type_____

4. Do you drink alcohol? ☐No ☐Yes
   Type_____Amount_____Last Drink_____

5. Have you ever had a problem with alcohol? ☐No ☐Yes
   Describe_____

6. Do you use any illicit drugs, e.g. marijuana, cocaine, hallucinogens, etc? ☐No ☐Yes
   Type_____Amount_____Last Used_____

7. Have you ever had a problem with substance abuse (other than alcohol)? ☐No ☐Yes
   Describe_____

8. Have you ever experienced unprotected sex, needle sharing, or blood transfusion?
   ☐No ☐Yes Describe _____

9. Do you use tobacco in any form?
   ☐No ☐Yes Describe _____

10. Have you ever received mental health or substance abuse treatment? ☐None
    ☐Inpatient ☐Outpatient
    Place/Provider_____Year(s)_____Reason_____
    Place/Provider_____Year(s)_____Reason_____
    Place/Provider_____Year(s)_____Reason_____
    Place/Provider_____Year(s)_____Reason_____
    Place/Provider_____Year(s)_____Reason_____

11. When were you last seen by a mental health professional?
    _____ ☐N/A

12. Please list your family doctor and any other physicians or therapists involved in your care.
    _____
    _____
    _____

13. Do you have any health problems? ☐No ☐Yes
Please list:

14. Have you had any major, non-psychiatric hospitalization? ☐No ☐Yes

| Place | Year | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

15. Have you any drug allergies or sensitivities? ☐No ☐Yes
Please list:

| Drug | Symptom |
|---|---|
| | |
| | |
| | |
| | |

16. Have you any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc)
☐No ☐Yes Describe

17. Do you take any medications, currently? ☐No ☐Yes

| Drug | Dose | Frequency | Duration | Reason |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

18. In the past, have you ever been on medication for anxiety, depression, insomnia, etc?
☐No ☐Yes
If yes,

| Drug | When | How Long | Effectiveness | Side Effects | Why Discontinued |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

19. Do you have any family history for mental illness or substance abuse? ☐No ☐Yes
Describe _____

20. Do you have any family history for medical problems, including diabetes, heart disease, cancer, Alzheimer's, asthma, etc? ☐No ☐Yes
Describe _____

_____ _____
Signature Date

DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610
Telephone (610) 378-9601
Fax (610-378-9061

# PENNSYLVANIA NOTICE FORM

## Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health care record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would when we consult with another health care provider, such as your family physician or another provider.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Use and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection that PHI. (Please see Section VI for further explanation.) We will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this notice.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to the Pennsylvania Department of Public Welfare.

- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and we determine that you are likely to carry out the threat, we must take reasonable

measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- **Worker's Compensation:** If you file a worker's compensation claim, we will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

- **Coroner's and Funeral Directors:** We may disclose health information about you to a coroner if that information is pertinent to the coroner's duties, such as identifying a decedent or determining the cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

- **Food and Drug Administration (FDA):** We may disclose health information about you to the FDA or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug you are taking or a medical device you are using. Medical devices are rarely used in psychiatry but medications are.

- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – you have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect and obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in your record. We may deny access to your PHI in under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket* – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- *Right to Be Notified if There is a Breach of Your Unsecured PHI* – You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise the policies and procedures, we will post the revision in our waiting rooms, and you may request a copy from our Privacy Officer.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the following person: Privacy Officer, DGR Behavioral Health, LLC, Wyomissing, PA 19610; phone: 610-378-9601.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Psychotherapy Notes

In the course of your care with us, you may receive treatment from a mental health professional (such as a psychiatrist) who keeps separate notes documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session. These notes, known as "psychotherapy notes," are kept apart from the rest of your medical record and typically do not include basic information such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, or your test results. Summaries of your diagnosis, condition, treatment plan, symptoms, prognosis, or treatment progress, although they may be contained within those psychotherapy notes, typically are not protected as psychotherapy notes when they appear in other sections of your records.

We will not disclose psychotherapy notes to others unless you have given written authorization to do so, subject to narrow exceptions (e.g. to prevent harm to yourself or others and to report child abuse/neglect.). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment or to enroll in a health plan. If you have any questions, feel free to discuss this subject with your therapist.

Please note that we may deny you access to psychotherapy notes if we determine that disclosure of specific information will constitute a substantial detriment to your treatment; or we will reveal the identify of persons or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality. In very limited circumstances we may also deny you access to other portions of the records. These circumstances include when information was obtained from others under a promise of confidentiality and access would likely reveal the source of the information; and when we determine that access is reasonably likely to endanger the life or physical safety of either you or another person.

VII. Effective Date of Privacy Policy

This notice will go into effect on October 1, 2013.

DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610
Telephone (610) 378-9601
Fax (610) 378-9061

## Acknowledgment of Receipt of Notice of Privacy Practices

**Patient Name:** _____

**Birth Date:** _____

**Maiden or other name** (if applicable):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of DGR Behavioral Health, LLC, effective October 1, 2013.

**Signature** (patient or authorized representative):

_____

**Date:**

_____

**Relationship/authority**
(if signed by authorized representative):

_____

# Consent to use and disclose your health information

This form is an agreement between you, _____ and DGR Behavioral Health. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.**

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative | Date

_____ _____

Printed name of client or personal representative | Relationship to the client

_____

Description of personal representative's authority

## CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set-aside for you and no one else. Consequently, unlike other doctors' offices, we do not double or triple book patients. However, in order to do this, we must charge a fee for all appointments not cancelled within 24 hours of the appointment. If your appointment falls on a Monday, you may leave a message with the answering service over the preceding weekend.

| | |
|---|---|
| Cancelled Appointments: | No charge will be made for any appointment cancelled with at least 24 hours advance notice. |
| Missed Appointments: | An appointment cancelled on less than a 24-hour notice, or an appointment missed without a notice of cancellation, will be billed a cancellation fee. This fee will not be charged to insurance, and is your responsibility to pay in full. |
| Exception: | Same-day cancellations because of serious medical/family emergencies or dangerous road conditions (snow and ice) will not be charged, as long as a telephone call is received in the office before the scheduled appointment time. |

We will try to give you a reminder call if you have requested one. However, you are responsible for the appointment whether or not you receive that call.

I am aware of the cancellation policy and agree to the terms.

_____ _____

Signature Date

_____

Parent Signature if appropriate