

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

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

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? _____
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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

Notice of Privacy Practices – Short Version

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This pamphlet is a shorter version of the full, legally required NPP which you may request for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If we obtain information that requires us by law to report suspected child abuse.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the office receptionist or Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer:

Paul E. Delfin, Ph.D.,
DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610

Phone: 610-378-9601

The effective date of this notice is December 1, 2015.

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 December 31, 2014.

Signature (patient or authorized representative):

Date:

Relationship/authority
(if signed by authorized representative):

DGR Policies

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.

Please review and keep for your records.

FRAGRANCE POLICY

This is a fragrances-free workplace. Thank you for not wearing any of the following during your visit: cologne, after shave lotion, perfume, perfumed hand lotion, fragranced hair products, and/or similar products. Our chemically-sensitive co-workers and clients thank you.

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