Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Last Name: _____First Name: _____ MI:_____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security No.: _____ Date of Birth: _____/_____/_____ Email: _____

Primary Language: English Spanish Other:_____

Please check all the appropriate boxes below:

Gender: ☐Male ☐Female ☐Transgender ☐ _____ ☐ Decline **Pronoun Preferences**: _____

Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ _____ ☐ Decline

Marital status: ☐Married ☐Divorced ☐Separated ☐Single ☐Widowed Other: _____

Race: ☐ Black ☐Asian/ Pacific Islander ☐ White ☐Hispanic/ Latino ☐Native American Other: _____ ☐Decline

Living situation: ☐Alone ☐Family ☐Personal Care Home ☐Group Home ☐Homeless Other: _____

**Demographics information above is required for state and insurance statistics reporting and will not affect your ability to receive services*

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Retired ☐Self-Employed ☐Disabled ☐Student ☐Volunteer

Employer: _____ Address: _____ City/State/Zip: _____

Emergency Contact: _____Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Relationship: _____

Primary Insurance: _____

Insurance ID: _____ **Group/Policy#:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

Relationship: _____ **Effective Date:** _____

Subscriber Employer: _____

Secondary Insurance: _____

Insurance ID: _____ **Group/Policy#:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

Relationship: _____ **Effective Date:** _____

Subscriber Employer: _____

Primary Care Doctor: _____ Practice Name: _____ Practice Phone: _____

Allergies/Medical Condition: _____

Assignment and Release: By signing below, I authorize payment of insurance benefits including Medicare, if I am a Medicare beneficiary, be made on my behalf to Penn Psychiatric Center/Collegeville Psychological Center for any services provided to me by the organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the organization, the Centers for Medicare/Medicaid Services, my insurance carrier, or other medical entity. I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy.

Missed Appointments: By signing below, I understand Penn Psychiatric Center/Collegeville Psychological Center's policy on Missed Appointments. I understand that if I demonstrate a pattern of cancellations seen as three consecutive missed appointments without 36 hour notice or three missed appointments within a two month period I may no longer be able to receive treatment. I understand that if I miss an appointment, my psychiatrist is not responsible for calling in medications to my pharmacy as an alternative to an appointment.

Client Signature: _____ Date: _____

Client's Representative/Guarantor Signature: _____ Date: _____

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-9390
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Consent to E-mails Text Messages/Phone Calls

This communication request form pertains to appointment reminders, quality of service feedback, and general health reminders and information only. Personal Protected Health Information will not be transmitted via text or unsecure email.

_____ **(Client Initials)** I consent to receive calls, voicemails and/or text messages from the practice at my **cell phone number** and any number forwarded or transferred to that number.

The **cell phone number** that I authorize to receive calls/voicemails/text message for appointment reminders, feedback, and general health reminders/information is:

Cell Phone Number: _____

_____ **(Client Initials)** I consent to receive calls and voicemails from the practice at my **home phone number** and any number forwarded or transferred to that number.

The **home phone number** that I authorize to receive calls/voicemails for appointment reminders, feedback, and general health reminders/information is:

Home Phone Number: _____

_____ **(Client Initials)** I consent to receive e-mails from the practice at the email address listed below.

The e-mail that I authorize to receive e-mail message for appointment reminders and general health reminders/ feedback/information is:

Email Address: _____

I understand that text/email communication is not always secure. Electronic messages can be intercepted and for this reason, we do not communicate personal health information through this method. PPC cannot guarantee but will use reasonable means to maintain security and confidentially of information sent.

My signature below indicates that I authorize that I am the person legally responsible for use of all the accounts, that I am of legal age for consent, and that I agree to all terms and conditions of use for the text messaging/ electronic communication services. I understand that this authorization can only be revoked in writing.

_____

Printed Name

_____ _____

Signature **Date**

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

CONSENT FOR RELEASE OF INFORMATION– Emergency Contact/Family Contact

Name of Client: _____ DOB: _____

Address: _____

I, _____ hereby authorize **Penn Psychiatric Center/Collegeville Psychological Center**

☐ To Release Information to: ☐ To Obtain Information from:

☐ via verbal ☐ via fax/ written

Name: _____Relationship to Client_____

Address: _____

Phone: _____ FAX:_____

Check Personal Health Information to be released for: ☐ All Treatment dates or ☐ Treatment dates from: _____ to: _____

☐ **Psychiatric Evaluation**	☐ **Summary of Treatment to Date**	☐ **Lab Reports**
☐ **Medications**	☐ **Medical History**	☐ **Other:** _____
☐ **Biopsychosocial History**	☐ **Communication and Treatment Plan**	☐ **Other:** _____
☐ **Discharge Summary**	☐ **Academic/School Records**	

Upon signing below, I consent to the disclosure of my protected Mental Health information as indicated above for the specific purpose of EmergencyContact/Family Contact for Continuity of Care. Information to be released shall be forwarded to the attention of Emergency/Family Contact and/or Penn Psychiatric Center/Collegeville Psychological Center.

I have been informed that I may revoke this authorization by written or verbal communication. I have also been informed of my right (subject to Section 5100.3-39 of the regulations promulgated under the Mental Health Procedures Act of 1976) to inspect the information to be released. Furthermore, I consent to the disclosure of information relating to my alcohol and/or drug dependency provided that disclosure is limited, (pursuant to the Pennsylvania Drug and Alcohol Abuse Act of 1972) to medical personnel for the purpose of further treatment and government or other officials for the purpose of obtaining benefits.

This consent to release information is effective from: _____ to:_____
(not to exceed one year)

_____ **Date of Signature:** _____
Signature of Client

_____ **Date of Signature:** _____
Signature of Witness (If Patient is physically unable to sign)

_____ **Date of Signature:** _____
Signature of Office Staff

(The Information enclosed is confidential. The law prohibits further copying without written consent of the person to whom it pertains. Disclosure of this information is strictly prohibited and may be subject to civil liability)

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

CONSENT FOR RELEASE OF INFORMATION– General

Name of Client: _____ DOB: _____

Address: _____

I, _____ hereby authorize **Penn Psychiatric Center/Collegeville Psychological Center**

☐ To Release Information to: ☐ To Obtain Information from:

☐ via verbal ☐ via fax/ written

Name: _____Relationship to Client_____

Address: _____

Phone: _____ FAX:_____

Check Personal Health Information to be released for: ☐ All Treatment dates or ☐ Treatment dates from: _____ to: _____

☐ **Psychiatric Evaluation**	☐ **Summary of Treatment to Date**	☐ **Lab Reports**
☐ **Medications**	☐ **Medical History**	☐ **Other:** _____
☐ **Biopsychosocial History**	☐ **Communication and Treatment Plan**	☐ **Other:** _____
☐ **Discharge Summary**	☐ **Academic/School Records**	

Upon signing below, I consent to the disclosure of my protected Mental Health information as indicated above for the specific purpose of EmergencyContact/Family Contact for Continuity of Care. Information to be released shall be forwarded to the attention of Emergency/Family Contact and/or Penn Psychiatric Center/Collegeville Psychological Center.

I have been informed that I may revoke this authorization by written or verbal communication. I have also been informed of my right (subject to Section 5100.3-39 of the regulations promulgated under the Mental Health Procedures Act of 1976) to inspect the information to be released. Furthermore, I consent to the disclosure of information relating to my alcohol and/or drug dependency provided that disclosure is limited, (pursuant to the Pennsylvania Drug and Alcohol Abuse Act of 1972) to medical personnel for the purpose of further treatment and government or other officials for the purpose of obtaining benefits.

This consent to release information is effective from: _____ *to:*_____
(not to exceed one year)

_____ **Date of Signature:** _____
Signature of Client

_____ **Date of Signature:** _____
Signature of Witness (If Patient is physically unable to sign)

_____ **Date of Signature:** _____
Signature of Office Staff

(The Information enclosed is confidential. The law prohibits further copying without written consent of the person to whom it pertains. Disclosure of this information is strictly prohibited and may be subject to civil liability)

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

CONSENT FOR RELEASE OF INFORMATION– Primary Care Physician

Name of Client: _____ DOB: _____

Address: _____

☐ **I refuse to release/ Do not have a Primary Care Physician**

I, _____ hereby authorize **Penn Psychiatric Center/Collegeville Psychological Center**

☐ To Release Information to: ☐ To Obtain Information from:

☐ via verbal ☐ via fax / written

Name (Person, Agency, Medical Practice): _____

Address: _____

Phone: _____ FAX:_____

Check Personal Health Information to released for: ☐ All Treatment dates or ☐ Treatment dates from: _____ to: _____

☐ **Psychiatric Evaluation**	☐ **Summary of Treatment to Date**	☐ **Lab Reports**
☐ **Medications**	☐ **Medical History**	☐ **Other:** _____
☐ **Biopsychosocial History**	☐ **Communication and Treatment Plan**	☐ **Other:** _____
☐ **Discharge Summary**	☐ **Academic/School Records**	

Upon signing below, I consent to the disclosure of my protected Mental Health information as indicated above for the specific purpose of Primary Care Physician for Continuity of Care. Information to be released shall be forwarded to the attention of Primary Care Physician and/or Penn Psychiatric Center/Collegeville Psychological Center.

I have been informed that I may revoke this authorization by written or verbal communication. I have also been informed of my right (subject to Section 5100.3-39 of the regulations promulgated under the Mental Health Procedures Act of 1976) to inspect the information to be released. Furthermore, I consent to the disclosure of information relating to my alcohol and/or drug dependency provided that disclosure is limited, (pursuant to the Pennsylvania Drug and Alcohol Abuse Act of 1972) to medical personnel for the purpose of further treatment and government or other officials for the purpose of obtaining benefits.

This consent to release information is effective from: _____ to:_____
(not to exceed one year)

_____ **Date of Signature:** _____
Signature of Client

_____ **Date of Signature:** _____
Signature of Witness (If Patient is physically unable to sign)

_____ **Date of Signature:** _____
Signature of Office Staff

(The Information enclosed is confidential. The law prohibits further copying without written consent of the person to whom it pertains. Disclosure of this information is strictly prohibited and may be subject to civil liability)

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Penn Psychiatric Center / Collegeville Psychological Center encourages our consumers to be knowledgeable about policies and practices related to their continued quality care. All policies, procedures, and informational packets are available to be printed upon request, and most pertinent consumer information is posted in the waiting rooms.

By initialing and signing below, you as the consumer are agreeing that you have read/understand the following practices:

Please **initial** all that apply:

_____ I have read and understand Penn Psychiatric Center/Collegeville Psychological Center's **Bill of Rights** and **Notice of Privacy Practices**.

_____ I have read and understand all information outlined in the **Patient Orientation** which includes Penn Psychiatric Center/ Collegeville Psychological Center's **Financial Responsibility Policy** and **Replacement Prescription Policy** posted in the waiting room.

_____ I have read and understand the agency's notice of **Assignment and Release** and the agency's **Missed Appointment Policy** outlined on the Client Information Sheet.

_____ I have read and understand the agency's **Civil Rights Compliance** Information posted in the waiting room.

_____ I have read and understand Penn Psychiatric Center/Collegeville Psychological Center's **Freedom of Choice Notification**. I agree that I have entered into treatment voluntarily and have the choice to obtain mental health services from any provider that I choose.

_____ I understand that Penn Psychiatric Center/Collegeville Psychological center treats all consumers without regard to race, religious creed, national origin or political affiliation.

_____
Consumer Name (Printed)

_____ _____
Consumer Name (Signature) Date

_____ _____
Witness (If consumer is unable to sign) Date

_____ _____
PPC Staff Signature (Witness) Date

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Pennsylvania as with the rest of the country has increased vigilance on prescribing practices for controlled substances. As a result Penn Psychiatric Center is required to be more vigilant as well. As per state requirements PPC will complete a mandatory search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for each client every time a controlled substance is prescribed.

The controlled substance prescription policy is as follows:

- Penn Psychiatric Center will only provide a prescription for Benzodiazepines and Stimulants only **one** month at a time.
- An appointment is needed to obtain a monthly prescription. Calling in controlled substance prescriptions is not allowed.
- Penn Psychiatric Center **WILL NOT** provide a prescription for **Benzodiazepines** with contraindicated medications including the following:
    - ***Methadone***
    - ***Suboxone-Subutex***
    - ***All Narcotic/Opioids Analgescis (Oxycodone, Oxycontin, Percocet, Percodan, etc.)***
    - ***All CNS stimulant medications (ADD treatment medications)***
- Penn Psychiatric will not provide a prescription for **Benzodiazepines** or **CNS stimulants** if there is a history of substance abuse or dependence.
- In the case of an emergency situation, **a maximum of a five day supply** of a controlled substance prescription may be prescribed and the prescription picked up in the office during business hours. This emergency supply will then be subtracted from the patient's next thirty day or monthly prescription.
- **We will not be able to provide a replacement for any controlled substance prescriptions (*Klonopin, Ativan, Adderall, etc.*) if they are lost, stolen or destroyed.**

Please sign below to acknowledge receipt of this policy.

_____

Consumer Name (Printed)

_____ _____

Consumer Name (Signature) Date

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Medication and Symptom Review

Client Name: _____ Date: _____

Please check all current medications and medications previously prescribed: No Medication History ☐

☐ Abilify	☐ Cymbalta	☐ Haldol	☐ Luvox	☐ Provigil	☐ Trilafon	☐ Tegretrol
☐ Ativan	☐ Depakote	☐ Invega	☐ Melaril	☐ Prozac	☐ Trazadone	☐ Trileptal
☐ Ambien	☐ Effexor XR	☐ Invega Sustenna	☐ Methadone	☐ Remeron	☐ Trintellix	☐ Valium
☐ Adderall	☐ Elavil	☐ Klonopin	☐ Neurontin	☐ Restoril	☐ Saphris	☐ Viibryd
☐ Buspar	☐ Equetro	☐ Lamical	☐ Nuvigil	☐ Risperdal	☐ Seroquel	☐ Vyvanse
☐ Celexa	☐ Fanapt	☐ Latuda	☐ Pamelor	☐ Risperdal Consta	☐ Stelazine	☐ Wellbutrin
☐ Clozapine	☐ Fetzima	☐ Lexapro	☐ Paxil	☐ Ritalin	☐ Straterra	☐ Xanax
☐ Cogentin	☐ Focalin	☐ Lithium	☐ Pristiq	☐ Rozerem	☐ Suboxone	☐ Zoloft
☐ Concerta	☐ Geodon	☐ Lunesta	☐ Prolixin	☐ Thorazin	☐ Symbyax	☐ Zyprexa

Other medication prescribed: _____

History of psychiatric medications that have ***HELPED*** the most:

Medication Name:	Dosage:	Length of Use:	Result:	Reason Stopped:

History of psychiatric medications that ***WERE NOT HELPFUL*** or ***STOPPED DUE TO SIDE EFFECTS***:

Medication Name:	Dosage:	Length of Use:	Result:	Reason Stopped:

Current & Past Symptoms - Past Symptom **(P)** Current Symptom **(C)**, *Please check all that apply*

P	C	Symptom
☐	☐	Loss of All Interest
☐	☐	Easily Irritated
☐	☐	Feeling Lonely
☐	☐	Feeling Hopeless/ Helpless
☐	☐	Feeling Worthlessness
☐	☐	Appetite Change
☐	☐	Reclusive and Withdrawn
☐	☐	Feeling Down/Depressed
☐	☐	Concentration Problems
☐	☐	Tired/ No Energy
☐	☐	Insomnia
☐	☐	Excessive Sleep
☐	☐	Guilt Feeling
☐	☐	Feeling Overwhelmed
☐	☐	Decrease Sexual/ Difficulties
☐	☐	Crying Spells
☐	☐	No Motivation
☐	☐	Indecisive
☐	☐	Death Wishes
☐	☐	Suicidal / Homicidal Thoughts

P	C	Symptom
☐	☐	Anxiety Worried
☐	☐	Phobias/ Fears
☐	☐	Trembling / Dizziness
☐	☐	Hyperventilation/ Perspiration
☐	☐	Panic Attacks
☐	☐	Chest Pain
☐	☐	Avoidance
☐	☐	Eating Disorder (Anorexia/Bulimia)
☐	☐	Obsessive Compulsive Behavior
☐	☐	Sick Frequently—Medical
☐	☐	Suspicious/ Not Trusting Others
☐	☐	Being Watched
☐	☐	People Talk about/ Laugh at me
☐	☐	People Can Read my Mind
☐	☐	Receiving Message from TV/Radio
☐	☐	Pacing at Night
☐	☐	Hearing God Talking to you
☐	☐	Hallucinations (auditory/visual)
☐	☐	Mental Telepathy
☐	☐	Delusions
☐	☐	Confused / Disoriented

P	C	Symptom
☐	☐	Uncontrollable Anger / Aggression
☐	☐	Racing Thoughts
☐	☐	Memory Concentration Problems
☐	☐	Mood Swings
☐	☐	Elevated Mood—Euphoria
☐	☐	Shopping Sprees
☐	☐	Sleeping Less
☐	☐	Increased Sexual Desire
☐	☐	Increased Energy, Especially at Night
☐	☐	Talkative / Interrupting Others
☐	☐	Not Finishing Tasks before Starting Another
☐	☐	Increase Goal Directed Activity
☐	☐	Thoughts Disorganized
☐	☐	Self-Mutilation / Cutting
☐	☐	Violent Behavior
☐	☐	Fire Setting

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Informed Consent for Treatment

Name: (Last Name) (First Name) (MI)

I, _____, the undersigned, hereby attest that I have voluntarily given my consent for treatment or the treatment of the minor or person under my legal guardianship mentioned above, at Penn Psychiatric Center, Inc., hereby referred to as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or nurse in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Center encourages that this decision be discussed with the treating clinician(s). This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights and HIPAA pamphlets and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the HIPAA Privacy Officer.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Center non-voluntarily, if any or all occur: A) the client exhibits physical violence, threatening behaviors, verbal abuse or aggression, carries weapons, or engages in illegal acts at the Center, B) the client refuses to comply with stipulated program rules or treatment recommendations, or does not make payment or payment arrangements in a timely manner, C) the client exhibits behavior that compromises the safety or confidentiality of clients or the Center staff. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Center Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by Federal and/or State law and regulations. As a rule, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as a mental health consumer unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is to medical personnel in a medical emergency, or to qualified personnel for audit, insurance payee requests or program evaluation.

Violation of confidentiality regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the Center, or about any threat to commit such a crime. Law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported to appropriate State or Local authorities. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients under the age of 14 have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

Attendance Policy: PPC is dedicated to providing the most effective treatment to all those who seek services. In order to do this it is important for clients to attend all scheduled appointments. Additionally, individuals who demonstrate a pattern of cancelled or missed appointments may no longer be able to receive treatment with the Center.

Payment: I hereby authorize any insurance benefits to be paid directly to the Center and I understand that I am financially responsible for non-covered services. I also authorize the Center to release any information required in the processing of this claim.

I consent to this treatment and agree to abide by the above stated policies and agreements with Penn Psychiatric Center, Inc.

Client/Parent/Guardian Signature: _____ Date: _____

Witness Signature : _____ Date: _____

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA19426
Phone: (610)489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA19460
Phone: (610) 917-2200
Fax: (610) 917-2360

Thank you for choosing us as your behavioral health provider. Understanding your financial responsibilities is an essential element to your care and treatment. Please read this document, and sign in the space provided. We are happy to answer any questions you may have regarding these policies.

ALL PAYMENT IS DUE AT TIME OF SERVICE

Co-Payments, Deductibles and Fees

- All co-payments, insurance deductibles and fees for services not covered by insurance must be paid at time of service. We will give you our best estimate of what the copay should be for each visit. The only way we can confirm what the co-pay should be exactly is reading the Explanation of Benefits we receive after the session is billed and paid. If your co-pay is higher than what was collected, you are responsible for paying the difference. If it should have been lower than what was paid by you, we will give you a refund or credit.
- We accept cash and credit cards (Visa, Mastercard). Payments are accepted in person, by phone or by mail.

Insurance

- It is your responsibility to know and understand the provisions, limits and the requirements of your individual benefit(s) plan. Please contact your insurance company with questions you may have regarding your coverage.
- We participate with most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at time of service. If you are insured with a plan that we do business with, but do not have an up to date insurance card, payment in full is expected at each visit until we can verify your coverage.
- As a service to you, we will submit your claims to your insurance company; however, we cannot guarantee benefits or payment. Please be aware that you are responsible for the balance of your claim should your claim be denied by your insurance company. ***You remain financially responsible for all services provided by this office***. Your insurance benefit is a contract
  with you and your insurance company; Penn Psychiatric Center is not a part of this contract.
- Please be aware that some or possibly all services you receive may be non-covered, considered not necessary or unreasonable by insurers. You are financially responsible to pay for these services at the time of service or within 20 days of the billing statement.
- Please bring your insurance card to each visit. Please notify our staff of any changes in insurance prior to your next visit. If you fail to notify us of insurance changes in a timely fashion, you may be responsible for your entire bill.

Minors and Patients with Divorced Parent

- The parent/guardian that accompanies a minor to his/her appointment is expected to bring payment at time of service.
- For separated or divorced parents, payment is expected from the parent bringing the child in for treatment. We will not bill another parent for payments due at time of service; regardless of which parent is responsible for the insurance.

Penn Psychiatric Center

Billing Statements

- The balance of your statement is due within 20 days of receipt.
- If the balance is not paid in full by the due date, or other arrangements are not made with our office, a penalty rate of 6% may be applied to your outstanding amount.
- Payment may be made in person, by phone or mail. In addition to the acceptable forms of payment listed previously, we also accept checks for statement balance payments. There is a $35 charge for all returned checks.

Past Due Accounts

- If your account is overdue by 30 days or more, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless payment plan is negotiated.
- If you have a balance on your account exceeding $100, you are responsible for paying a minimum 50% of monies owed prior to being able to schedule any further appointments, and arrangement must be made for the remaining balance. If you have future appointments scheduled, and payment is not received, they will be cancelled.
- If your account balance is overdue by 45 days, with no attempt to pay, all future appointments will be cancelled, and you will not be able to schedule a new non-emergent appointment until payment is made.
- If your account must be sent to a collection agency, you will be responsible for all fees incurred from the collection agency and/or attorney.
- All payment plan arrangements are made at the discretion of Penn Psychiatric Center.
- Financial non-compliance may result in discharge from the practice.

Missed and Late Cancel Appointments

- If applicable, there is a $50 fee for missed appointments or cancellations made less than 36 hours in advance of the scheduled appointment. This fee is not covered by insurance and must be paid prior to your next appointment.
- Patients who arrive more than 5 minutes past their appointment time may need to be rescheduled and will incur a late cancellation fee.
- Appointment reminder calls are made prior to your appointment as a courtesy and are not guaranteed. You are responsible for your scheduled appointment time even if you do not receive a reminder call from us.

Our practice is committed to providing quality care to our patients. Please let us know if you have any questions or concerns.

I have read the financial policy and agree to abide by its guidelines. I also understand that such terms may be amended or subject to change.

_____

Patient or Responsible Party Name (Printed)

_____ _____

Patient or Responsible Party (Signature) Date

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

TELEHEALTH CONSENT FORM

Client Name:_____

Date of Birth: _____ Phone Number: _____

Email Address: _____

The purpose of this consent form is to obtain your consent to participate in telehealth sessions with your provider and/or clinician. By signing the consent form you agree to participate in telehealth sessions with Penn Psychiatric Center.

Please check the services you consent to receive via telehealth:

☐ Outpatient Services ☐ Peer Support Services ☐ CommonGround Services ☐ IBHS
☐ Partial Hospitalization Program (PHP)

All existing laws regarding you access to treatment information apply during telehealth sessions. The telehealth sessions will not be recorded or stored. Reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telehealth services and all existing confidentiality protections under federal and state laws apply to information disclosed during all telehealth sessions.

The system that will be used during telehealth sessions is in compliance with HIPAA, however, it is your responsibility as the client to be in a private environment in order to ensure that your information is protected.

The provider/clinician has the right to refuse completing the telehealth session if they feel the surrounding environment is not appropriate for the session or private enough in order to protect the privacy of the client.

Please note, if the provider/clinician is concerned for your safety and a safety plan is not established, local law enforcement can be dispatched for a welfare check. Communication to other medical centers or crisis centers can also occur if the situation is deemed necessary.

The provider/clinician has the right to discontinue telehealth if they feel it is not clinically appropriate.

When services are being delivered through telehealth to children depending on the age of the child a caregiver must participate and/or observe during the provision of services.

I choose to engage in telehealth sessions. By signing this form, I certify that I have read or had this form explained to me, agree to participate in telehealth sessions and agree to abide by the rules identified in this form.

Client Signature: _____ Date:_____

Staff Signature:_____ Date:_____

DBT Questionnaire

Name_____**DOB**_____

Question:	Please circle one:	
1. I have shifts in mood that last only a few hours at a time	YES	NO
2. I have anger that is inappropriate, intense, or uncontrollable	YES	NO
3. Self-destructive acts, such as self-mutilation or suicidal threats And gestures that happen more than once (in the last year)	YES	NO
4. I have two potentially self-damaging behaviors (circle below)	YES	NO
• Alcohol and other drug abuse		
• Compulsive Spending		
• Gambling		
• Eating disorders		
• Shoplifting		
• Reckless driving		
• Compulsive Sexual Behavior		
5. I have trouble identifying who I am… I have confusion about (circle below)	YES	NO
• Self-image		
• Long-term goals		
• Friendships		
• Values		
• What I think		
6. I feel consistently empty inside, like I have a "hole inside"	YES	NO
7. I have a pattern of unstable, chaotic, or intense relationships (circle below)	YES	NO
• No middle ground – people are either the best or worst		
• Alternate clinginess and feeling suffocated		
• Great difficulty trusting		
• Feeling of "needing" someone else to survive		
• Heavy need for affection and reassurance		
8. Feeling "out of it," not being able to remember what you said or did – especially because of severe stress	YES	NO
9. I notice, or people tell me, that I am extremely sensitive (circle below)	YES	NO
• Ability to sense how others are feeling		
• Overly sensitive to criticism or rejection		
• Tire people out with my extreme reactions		
• A "little" thing to other people is a big thing to me		
10. I have been through multiple years of therapy or several therapists without meaningful change taking place	YES	NO

**Adapted from Marsha Linehan, as annotated on www.palace.net (Borderline Personality Disorder)

Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200

Life Event Checklist - Trauma Screening Tool

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or Explosion					
3. Transportation accident (examples: car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (Examples: dangerous chemicals, radiation)					
6. Physical assault (Examples: attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (Examples: shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (Examples: kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (Examples: homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience *Please explain:* _____					

SAMHSA Life Event Checklist: Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995

Printed Name: _____ Signature: _____

Date: _____

Witness Signature: _____ Date: _____