Emotional Wellness, LLC

3933 Perkiomen Avenue, Suite 102, Reading PA 19606 ~ 2481 Lancaster Pike, Shillington, PA 19607 ~ Wilson School District

Phone: 610-779-7272 **www.emwell.org** **Fax: 610-985-9100**

Biographical Information Form

Date: _____

Patient Name: _____Date of Birth_____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail Address: _____
Phone #: (Home) _____ (Work) _____
(Cell) _____ Text Message Reminders: Yes_____ No_____

Parent Name (If patient is under 18): _____
Parent Address (If different from patient): _____
Parent Phone #: (Home)_____ (Work)_____ (Cell)_____
Parent Date of Birth: _____
Spouse Name (if applicable): _____
Spouse Date of Birth: _____

Primary Insurance
Name of Insured: _____DOB_____ Relationship to Patient: _____
Address (If different from patient): _____
Name of Insurance: _____
ID #: _____ Group #: _____ Phone #:_____

Secondary Insurance
Name of Insured: _____DOB_____ Relationship to Patient: _____
Address (If different from patient): _____
Name of Insurance: _____
ID #: _____ Group #: _____ Phone #:_____

Place of Employment/School: _____
Emergency Contact Person: _____ Phone #:_____
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 Emotional Wellness, LLC. I also authorize Emotional Wellness, LLC, 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 or missed appointments, and/or any and all unpaid balances incurred.

_____ _____
Patient Signature (Parent/Guardian, if minor) Date

Release of Information: PCP/ Family Doctor
My clinician at Emotional Wellness, LLC, has my permission to communicate my symptoms and/or diagnosis with my family physician in order to obtain or release pertinent information regarding to my care.

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

 (Please complete reverse side)

Release of Information: Clinical

My clinician may discuss my symptoms or diagnosis with his/her colleagues at Emotional Wellness, LLC, 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)

Informed Consent for Treatment:

I agree and consent to participate in behavioral health care services offered and provided by an Emotional Wellness, LLC, 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. 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 Emotional Wellness, LLC's Patient Rights and Responsibilities posted in the waiting room. I am also aware that I may request a copy of Emotional Wellness, LLC's Patient Rights and Responsibilities at any time.

_____ _____

Patient Signature (Parent/Guardian if necessary) Date

Practice Privacy Policy

Emotional Wellness, LLC, is required by law to maintain the privacy of your health information. We will only release patient information related to treatment, payment and health care operations. This information will be released as Federal HIPAA regulations and/or State law allow. **"Please note this exception – In case of suspicion of harm to minors, suicidal/homicidal threats, your clinician is a mandated reporter."** A signature below signifies that you have been informed of our "Notice of Privacy Practices" outlining our privacy policy. This Notice is posted in our waiting room. You may request a copy of this Notice at any time.

As noted in our "Notice of Privacy Practice," 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 if that number is given as the contact number. Although it is not common practice for this office to contact a person's place of employment regarding appointments, if a patient makes a request to be contacted by phone at their place of employment, than this office may attempt contact. 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 regulations allow for reasonable use of voice mail messages, etc., this office will make every effort to respect your request.

Messages may be left at my residence (answering machine or responsible adult)_____ YES _____ NO

Messages may be left on my cellular voicemail (if applicable): _____YES _____ NO

Message may be left at my place of employment: _____ YES _____NO

I HAVE BEEN INFORMED OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient Signature (Parent/Guardian if necessary) Date

_____

Please Print Patient Name