Penn Psychiatric Center/Collegeville Psychological Center

3774 Ridge Pike
Collegeville, PA 19426
610-489-3333 / FAX: 610-489-9390

601 Gay Street, Suite 6
Phoenixville, PA 19460
610-917-2200 / FAX: 610-917-2360

Client Information Sheet

Client Name: ____ Date of Birth: _______/_______/_________
Last Name First Name MI Month Day Year

Other Name: ____
Social Security Number: _________________________

Sex: ☐ Male ☐ Female ☐ Transgender ☐ Unreported
Race: ☐__African American __☐Asian __☐Caucasian ☐Hispanic ☐Native American ☐ Other
If other, please list: _________________________

Marital Status: __Single __Married __Separated __Divorced __Widowed __Other: _______________________

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Decline

Primary Language: ______________________________

Address : ____

Home Phone: _________________________________

City, State, Zip: ____

Other Phone: _________________________________

E-mail: ____

Can a message be left on home phone: __Yes __No

Can a message be left on other phone: __ Yes __ No

Living Situation: __ Alone __Family __Personal Care Home __ Group Home __Homeless __Other

Employer: ____

Address: ____

City, State, Zip: ____

Emp. Status: __ Full Time __ Part-Time __Unemployed __Retired __Self-Employed __Disabled __Student __ Volunteer

Emergency Contact: _____________________________________

Relationship to client: ___________________________________

Address: ____

City, State, Zip: ____

Home Phone: _________________ Work: __________________

Primary Care Doctor: _________________________________

Practice Name: _____________________________________

Practice Phone: _____________________________________

Allergies/Medical Conditions: __________________________

Insurance Information:

Primary Insurance: ____

Insurance ID #: ____ Group/Policy #: ___________________________________

Subscribers Name: _____________________________________ Subscribers DOB: __________________________________

Relationship to client: __________________________________ Effective Date: ____________________________________

Subscriber's Employer: __________________________________

Secondary Insurance: ____

Insurance ID#: ____ Group/Policy #: __________________________________

Subscribes Name: ______________________________________ Subscribers DOB: __________________________________

Relationship to client: ___________________________________ Effective Date: ___________________________________

Subscriber's Employer: __________________________________

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: _______________________