Berkeley Therapy Institute New Patient Information Form

(Please complete all items)

Provider: Brian S. Sedgeley, MA

First Name: Initial: Last Name:		CA Driver's License#:	Social Security Number:
Address:		Phone: Home: Work: Other:	
Male ☐ Female ☐	Date of Birth:	Marital Status:	
Employment Status: Full Time ☐ Part Time ☐ FT Student ☐ PT Student ☐		Employer:	
How were you referred to Berkeley Therapy Institute?			

Because the Berkeley Therapy Institute is a non-profit community clinic, we are required to keep records on the diverse ppopulation we serve. Please complete the following:

Ethnicity:	Primary Language:	Family Size:
Monthly Family Income (before taxes): ☐ $0-500 ☐ $500-1,000 ☐ $1,000-1,500 ☐ $1,500-2,000 ☐ $2,000-3,000 ☐ $3,000-4,000 ☐ $4,000-5,000 ☐ $>$5,000		

Patient is financially responsible party: ☐

If not, Responsible Party Information:

First Name: Initial: Last Name:	Date of Birth:	Social Security Number:
Address:	Phone: Home: Work: Other:	

Signature:

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I understand that I am responsible payment of services.

Signature of Responsible Party

Date

Berkeley Therapy Institute Patient Insurance Information Form

(Please complete if you would like your insurance billed)

Patient is the Subscriber: ☐

If not, Insurance Policy Owner:

First Name: Initial: Last Name:		Date of Birth:	Social Security Number:
Address:	Phone: Home: Work: Other:		
Relation to Insured:	☐ Spouse	☐ Child	☐ Other

Insurance Carrier Name and Address:
(A copy of your card will be taken at the time of your first visit.)

Name:
Mailing Address:

Policy Information:

ID Number:	Group Number:	Plan Name:

*** Please attach an additional page if you have additional insurance coverage.**

Signature:
I authorize the release of information necessary to process claims.

Signature of Responsible Party ______________________ Date ____________

Signature:
I authorize medical benefits to be paid to the Berkeley Therapy Institute.

Signature of Responsible Party ______________________ Date ____________