Deborah Bloome, Psy.D., P.A.

PY5484

14521 Walsingham Road, Largo, Florida 33774-3342

(727) 517-1938

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT [FLORIDA]

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you

decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule a 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. *Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control, such as illness]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.*

PROFESSIONAL FEES

My hourly fee is $150.00 for the Diagnostic Interview and $125.00 for each session following hourly session. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparations of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceeding.]

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 7PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail or occasionally by an office assistant. I will make every effort to return your call on the same day you make it, with the exception of Fridays, weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or go to the nearest emergency room or call 911.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advanced consent. You signature on this Agreement provides consent for those activities, as follows:

- **I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).**
- **You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.**

There are some situations where I am permitted or required to disclose information without either your consent or Authorizations:

- **If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me to disclose information.**
- **If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.**
- **If a patient files a complaint or lawsuit against me, I may disclose relevant**

information regarding that patient in order to defend myself.

- **If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.**

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- **If I know, or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.**
- **If I know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.**
- **If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.**

If such a situation arises, I will make every effort to fully discuss it with your before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you

and/or others or makes reference to another person (other than a healthcare provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, that can be misinterpreted and/or upsetting to untrained readers, for this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health profession so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). I may withhold copies of your records until payment of the copying fees has been made. If I refuse your request to access to your records, you have a right of review, with I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your records: requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of the Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential, it is usually my policy to

request an agreement with minors [over 14] and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more that 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

(Client/Parent/Guardian) **(Date)**

(Witness) **(Date)**

Deborah Bloome, Psy.D., P.A.
14521 Walsingham Road
Largo, FL 33774
PHONE: (727) 517-1938 FAX: (727) 517-1937

APPOINTMENT POLICIES, FEES AND AGREEMENTS

- Our office schedules appointments only when you contact our business office at (727) 517- 1938 Monday – Thursday. Appointments are available Monday – Thursday. Appointments are typically 45 minutes long.
- We will do our best to schedule the earliest available appointment that is convenient for you.
- If you must cancel an appointment, we REQUIRE a 24-hour notification unless there is a MUTALLY agreed upon emergency. No-shows and appointments cancelled with less than 24-hour notification will result in a charge for the missed appointment.
- No future sessions will be scheduled if more than three (3) appointments are either cancelled with less than 24-hour notice or you do not call or show for your scheduled appointment.
- You understand that you are expected to make a payment at the time services are rendered. It is the policy of our office not to schedule future sessions for patients with an outstanding balance on their account. In addition, a $5.00 service charge will be applied to your account if a statement needs to be sent to collect your payment.
- Our office will not release any medical records for patients with an outstanding balance on their account unless a $1.00 per page service charge is paid in full prior to the copying of the records.
- WE ACCEPT CASH, CHECKS, MONEY ORDERS, AND CREDIT CARDS.
- When services are rendered to a minor dependent, the PARENT WHO SIGNS THIS FORM is the one responsible for the balance.
- A $30.00 service charge will be added to all returned checks.
- PLEASE RESTRICT CELL PHONE USE TO OUTSIDE OF THE OFFICE.

If you have any questions regarding the above agreement, please feel free to speak with Dr. Bloome or the office staff.

_____ _____

Signature of patient or parent, if minor Date

Deborah Bloome, Psy. D.
PY5484
14521 Walsingham Road
Largo, FL 33774

PRIVATE PAY

I am electing to see Dr. Bloome as a Private Pay Client

Initial visit is $150.00, each subsequent visit is $125.00.

Payment is payable on each visit.

Signature Date

PLEASE NOTE: Dr. Bloome is not a Medicare provider. Bills cannot be submitted to them for payment.

Dr. Deborah Bloome
PY5484
14521 Walsingham Road
Largo, FL 33774
(727) 517-1938

CLIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Dr. Bloome will use your Psychological information for the following:

1) If you ask for a receipt for your insurance company, it will show your diagnosis and other Personal Health Information (PSI) as needed.

In conjunction with these privacy practices, you will need to provide us with the following information:

1) Name of person(s) we may speak to regarding your health, i.e. spouse, partner, child, etc.) including phone numbers.

   _____

   _____

2) May we leave a message regarding appointments on your answering/voicemail? List phone numbers we may use.

   Yes: _____ No: _____

   _____

   _____

   _____

_____ _____

Signature of Patient or Parent of Minor Date

_____ _____

Witness Date

Deborah Bloome, Psy. D.

Licensed Psychologist- PY5484

Today's Date:_____

1. IDENTYFYING INFORMATION

Name: _____ Date of Birth:_____Age:_____

Address: _____City: _____Zip:_____

Home Phone: _____ Work Phone: _____ Pager/Cell: _____

Social Security Number: _____ Marital Status: _____

Email address: _____(optional)

Spouse/Significant Other:

Name: _____ Phone: _____

Who referred you? _____ Phone: _____

May I contact person giving referral? _____Yes **_____No**

2. PRIMARY CARE PHYSICIAN

Doctors Name: _____ Phone: _____

If you enter treatment with me for psychological problems, may I contact your medical doctor so he/she can be fully informed and coordinate your treatment? Yes _____ No _____

3. CURRENT EMPLOYER

Employer: _____ Length of time: _____

City: _____

4. RESPONSIBLE PARTY

Name: _____ Employer: _____

Relation to Patient: _____ Birth date of responsible party: _____

Address: _____ City/State: _____

Social Security # _____ Work # _____

14521 Walsingham Rd. Largo FL 33774

(727) 517-1938 Phone (727) 517-1937 FAX

5. Describe situation/medications/health problems:

_____
_____
_____

6. In case of emergency contact:

Name: _____ Phone:_____

Relation: _____

Address: _____ City: _____ Zip:_____

Telephone calls: Clients are encouraged to call with questions or concerns. The office manager has been trained to answer many of your questions. If you feel the situation cannot wait, please contact the emergency room of the nearest hospital or call 911.

Missed appointments: Any visit not cancelled within 24 hours will be billed to the responsible person.

Dr. Bloome has opted out of Medicare Program and will no longer accept Medicare as insurance. Per Medicare requirements, you will not be able to submit a claim to Medicare nor can Dr. Bloome submit a claim for you.

•I authorize treatment of the above named patient. I have received the Florida Notice Form (HIPPA) as well as financial policies and procedures of the office. In consideration for clinician's services rendered for the above named patient by Deborah R. Bloome, Psy. D., I hereby assign Dr. Bloome the benefits due to me under any medical insurance that is in effect during my treatment. I agree that if benefits are insufficient to cover the entire expense, or if the treatment is not covered by my insurance, I will be responsible for the payment of the entire bill.

_____ _____

Signature of Responsible Person Date

_____ _____

Witness Signature Date

Office Use Only:

DX: _____

Dr. Deborah Bloome
PY5484
14521 Walsingham Road
Largo, FL 33774
(727) 517-1938

CONFIDENTIALITY AND EMERGENCY PROCEDURES

CONFIDENTIALITY: All communications between therapist and client is held in strictest confidence as guaranteed by Florida Statutes #490.0147 and #90.503. As the client, you hold privilege to release information regarding services obtained in our office. In general, we prefer that you sign release forms allowing us to mutually exchange information with important referral sources (i.e., family physician, school officials) or with previous therapist.

In cases of suspected child or elder abuse/neglect, all licensed therapists are required by law to inform legal authorities. Confidentiality cannot be guaranteed in cases where a judicial order is issued.

EMERGENCY PROCEDURES: Because Deborah Bloome, Psy.D. is an out-patient practitioner, there is no guarantee that she can respond to emergencies 24 hours a day. If you are having a psychiatric emergency, (i.e., where there is a risk that someone will be harmed), we suggest that you contact the nearest emergency room or call your managed care company for direction. If you have any questions regarding our emergency procedures, we encourage you to talk with your therapist at the beginning of treatment.

I have read and fully understand the Confidentiality and Emergency Procedure Policies of Deborah R. Bloome, Psy.D.

_____ _____

Signature of Patient or Parent of Minor Date

_____ _____

Witness Date

Deborah Bloome, Psy. D.
PY5484
14521 Walsingham Road
Largo FL 33774
727-517-1938 FAX: 727-517-1937

AUTHORIZATION RELEASE OF INFORMATION

The undersigned hereby authorizes Deborah Bloome, Psy.D. to receive or release the below listed information to or from the following named agency or physician:

Deborah Bloome, Psy.D.
14521 Walsingham Road
Largo, FL 33774
FAX: (727)517-1937

AND _____

_____

_____

INFORMATION:

_____ Psychotherapy Notes
_____ Diagnoses
_____ Intellectual/Psychological Evaluation
_____ Medication Records
_____ Appointment Dates
_____ Discharge Summary
_____ Intellectual/Psychological Evaluation
_____ Psychiatric Evaluation
_____ Social History/Intake
_____ Other

PATIENT:

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

The undersigned authorizes the release of information for the following purposes:

I understand that the information released by other professional to Deborah Bloome, Psy. D. will Be protected as private data according to the provisions of state and federal laws and, to the extent permitted by law, will not be released without my authorization. This does not mean that these materials will be protected from subpoena power.

I recognize that Deborah Bloome, Psy. D. cannot guarantee the privacy of information released, but it is my intent that the party I designate to receive it will consider it private according to the provisions of state and federal law.

Further, I understand that I may rescind this authorization at any time; otherwise it will expire 3 months after the case is closed.

My authorization is given freely and with competence and adequate understanding of purpose.

_____ _____
Signature of Patient or Parent of Minor Date

_____ _____
Witness Date