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: _____