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PSYCHOLOGY SERVICES, LLC

Jennifer Tarbox, PhD, HSPP & Stephanie Ridel, PsyD, HSPP (317) 775-3942

CLIENT INFORMATION

Last Name:	First Name:	M.I.:	Nickname:	
Birth Date:	Age:	Sex:		
Street Address:		City:	State:	ZIP:
Home Phone:	Cell Phone:			
Physician:	School or Occupation:			
Referred by: _____ Physician _____Friend _____Internet _____Other (please list):				
I give my consent to Bloom's providers and/or staff to contact the following person in the event of emergency.				
Emergency Contact:	Relationship to Patient:	Phone Number:		

Counseling and Psychological Services

Dr. Jenny Tarbox and Dr. Stephanie Ridel are licensed in the State of Indiana as psychologists, which authorizes them to provide psychological services (Indiana License 20042417A for Dr. Tarbox & 20042413A for Dr. Ridel). Such services may include and are not limited to assessment services, including tests and procedures, as well as therapeutic treatments. Dr. Tarbox and Dr. Ridel are ethically and legally bound to provide only those services for which they have a license and have been trained. Should you require any service for which Dr. Tarbox or Dr. Ridel is not qualified, they will refer you to someone with the required expertise. Your psychologist's responsibility is to facilitate arrangements for referral. Your responsibility for continuity of care is to follow through with the best plan you can make based on all recommendations you gather.

Consent to Treat

I hereby request and authorize Bloom Psychology Services, LLC and its respective personnel to provide mental health services/treatment to me. I understand that mental health services/treatment may include psychological assessment and/or psychotherapy. I am agreeing only to those services that Bloom Psychology Services, LLC is qualified to provide within the scope of the provider's license, certification, and training. I also understand that, at any time, I can terminate this consent for treatment by putting such request in writing.

_____

Signature of Client Date

Policies and Procedures

This document contains important information about Bloom Psychology Services, LLC's professional services and business policies. Please read it carefully and feel free to ask if any questions that arise. When you sign this document, it represents an agreement between us.

Confidentiality

Confidentiality is a cornerstone of the therapist-client relationship. Therapy is most effective in the context of a trusting, supportive, confidential therapist-client relationship. In addition, ethical standards require that the psychologist's work with you remains confidential.

The only occasions in which the psychologist would disclose something discussed in treatment without your permission are as follows:

- Child Abuse or Elder Abuse. Psychologists are mandated by law to report cases of suspected child abuse (of children and youth under age 18) and elder abuse (of adults over age 60) to the appropriate authorities.
- Suicide. If you are in imminent danger of killing yourself, the psychologist will need to breach confidentiality in order to keep you safe. This may include informing family member(s) or taking action to see that you are admitted to a hospital.
- Homicide. If you disclose that you are planning to kill or hurt someone, the psychologist is required by law to inform the police, inform the intended victim(s), and inform any other necessary individuals in order to prevent loss of life.
- As mandated by law. For example, if the psychologist receives a subpoena, the psychologist may be required to submit your records as part of a legal proceeding.

These situations are relatively rare. Should this occur in your case, the psychologist will make every effort to discuss it fully with you before taking any action.

Contacting Bloom Psychology Services, LLC

If you need to contact your psychologist between sessions, the best way to do so is by telephone.

Although we are often not immediately available by phone, voicemail is checked on a regular basis. We will make every effort to return your call on the same day you make it, or by the next business day, with the exception of weekends, holidays, and vacations. If you are unable to reach your psychologist and feel that you cannot wait for your call to be returned, dial 911 or proceed to your nearest emergency room immediately.

If you contact your psychologist via email, please note that email is used only for scheduling appointments. We do NOT conduct therapy through the Internet, and will NOT respond to questions related to your emotional or medical condition, except by telephone or in person. Please see Bloom Psychology Services, LLC's social media policy statement for more information on the use of the Internet and therapy.

Cancellations and Missed Appointments

If you wish to change a scheduled appointment, we require that you do so **48 hours prior (in business days)** to the appointment in order to avoid being billed for the session. Please note that if your appointment falls on a Monday, it must be changed by the prior Thursday; a Tuesday appointment must be changed by the prior Friday. Exceptions to this policy will be handled on an individual basis. Should two late cancelled or missed appointments occur in a row, payment of associated fees will be required to hold an appointment on your psychologist's schedule.

Professional Fees and Non-Covered Services

In order to offer consistent quality care and to coordinate this care with other providers or organizations, your psychologist may need to provide complementary treatment activities that are not covered or reimbursed by your insurance company. Examples include telephone calls; email or phone consultation with other professionals in relation to your treatment (e.g., a prescribing physician, previous treating therapists); review of psychological reports and records; preparation of reports, letters, or documents for other providers or organizations; duplication of your medical records; and legal proceedings requiring your psychologist's participation. Complementary treatment activities that total less than 15 minutes per month will not be charged; complementary treatment activities that total more than 15 minutes per month will be billed directly to you at the pro-rated standard hourly rate. If you have any questions regarding this policy, feel free to ask.

If you ever have difficulties with your bill, please address your questions or concerns as soon as possible. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Bloom Psychology Services, LLC reserves the right to use legal means to secure payment, which may include retaining the services of a collections agency or initiating a small claims suit.

Insurance Reimbursement

Payment (co-pay/co-insurance/deductible, etc.) must be made either by check, cash, or credit card at the time of your visit. Payment from your insurance company will be made directly to Bloom Psychology Services, LLC.

Due to the increased complexity of health insurance in recent years, **you are highly encouraged to call your insurance company prior to your initial appointment to fully clarify all important issues related to fees and financial responsibilities.** Please notify your psychologist immediately as to any change in your health insurance, place of employment, home address, or other information pertinent to our records. (Failure to do this may result in difficulty processing insurance claims and could disrupt your treatment.)

The financial responsibility for your treatment is ultimately yours, or that of the responsible party who signs below. If required, Bloom Psychology Services, LLC will file claims for insurance reimbursement as allowed by your policy. Bloom Psychology Services, LLC **files primary insurance only.** Bloom Psychology Services, LLC files your insurance as a courtesy and therefore will file only two times for any given date of service. Any monies remaining owed beyond this will be due from you. Bloom Psychology Services, LLC will make available to you any documentation necessary to assist you in filing claims for reimbursement purposes (and/or for secondary insurance).

Psychological Testing

Payment for testing services is expected on the date of the provided service. Depending on your insurance policy, payment may include a co-pay, coinsurance, or fees applied toward deductible. Some testing charges are not covered by insurance; should this be the case for your evaluation, these charges will be reviewed with you prior to testing. In addition to the fee charged for testing, your psychologist will hold a testing feedback session with you to review the results in person and answer any questions you may have. Please note that the feedback session is a separate charge.

Please note that in rare circumstances, an insurance company may review a testing charge and refuse to cover it. In such cases, you will be financially responsible for all testing fees (including cases in which the insurance company deems the testing "not medically necessary"). You may choose to appeal the insurance company's decision and seek reimbursement from the insurance company, but Bloom Psychology Services, LLC will not initiate such an appeal.

Appointments for psychological testing typically last between two to four hours, depending on the battery of tests selected. Should you need to cancel your testing session, please give no less than 48 hours' notice. **If a cancellation occurs with less than 48 hours' notice, you will be responsible for paying a late cancellation fee that is equal to 25% of your overall testing fee.** (For example, if your testing fee is $500, you would be responsible for paying $125 for a late cancellation). This fee is not covered by insurance.

Late Payments

There will a returned check fee of $25.00 should there be any problems clearing your check. If, for any reason, you do not pay your bill at the time of service or within 30 days from the date of your monthly invoice, a $35.00 late fee will be assessed for each 30 days that you do not pay. We understand that it can sometimes be difficult to stay on top of bills and payments. Thus, if you should have any concerns or questions about your fee or monthly invoice, please address them with your psychologist immediately.

PSYCHOLOGY SERVICES, LLC

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Authorization & Acknowledgements

By signing below, I acknowledge that I have reviewed Bloom Psychology Services, LLC's Policies and Procedures, understand the information included in this document, and freely choose to abide by its terms during our professional relationship. I am aware that a copy of this packet will be given to me if I ask for a copy. I can access this document at any time via the website at www.bloompsychologyservices.com.

_____

Signature of Client Date

I hereby acknowledge that I have reviewed a copy of Bloom Psychology Services, LLC's Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA) and understand the information included in this document. I am aware that a copy of this notice will be given to me if I ask for a copy. I understand that if I have further questions regarding the Notice or my privacy rights, I can address these questions to Bloom Psychology Services, LLC.

_____

Signature of Client Date

Consent to Use Email Communications

Bloom Psychology Services, LLC uses a secure, HIPAA-compliant email service provided by LuxSci to send and receive emails.

I hereby agree to sending and receiving from Bloom Psychology Services, LLC email communications as part of my comprehensive treatment. I understand that I will need to register my email address with LuxSci in order to send and receive the communications within a secure, confidential environment. I understand the risks of sending Protected Health Information (PHI) through email, and with this agreement I am accepting these risks to my PHI. I accept that Bloom Psychology Services, LLC shall not be held responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Bloom Psychology Services, LLC if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing Bloom Psychology Services, LLC in writing. With my signature, I believe that the benefits of using email communications for my healthcare outweigh the security risks.

_____

Signature of Client Date

Email Address: _____ (please print)

Bloom Psychology Services, LLC may leave messages at the following number: _____

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Financial Agreement – Responsible Party

**This section of the Registration Packet is necessary only in cases where the responsible party is someone other than the patient. If the patient is the responsible party, there is no need to complete this section.*

As the responsible party for the patient indicated below, I understand and freely agree to the following:

- Payment arrangements must be made by the responsible party prior to the initial visit. This may include the responsible party completing the Credit Card Authorization Form.
- All treatment fees (including fees associated with psychological testing and fees for all appointments not cancelled 48 hours in advance) associated with the patient named below remain the responsibility of the responsible party who signs this Financial Agreement.
- The responsible party is required to maintain prompt payment of bills associated with the patient's treatment. Account balances due after 60 days from the date of service will prompt the account to be reviewed for collections.
- If the account is turned over to a collection agency, the responsible party must resolve the unpaid balances with the agency.

By signing below, I acknowledge that I have reviewed Bloom Psychology Services, LLC's Policies and Procedures and the information above in the Financial Agreement – Responsible Party section of the registration packet, understand the information included in these documents, and freely choose to abide by their terms. I agree to act as the Responsible Party for the Patient listed below and assume sole financial responsibility for services rendered, including responsibility for all appointments not cancelled 48 hours in advance.

_____ _____
Patient Name DOB

_____ _____
Responsible Party (please print) Responsible Party's SS#

_____ _____
Relationship to patient Responsible Party's DOB

_____
Address of Responsible Party

_____
City/State/Zip

_____ _____
Home/Cell Phone Work Phone

_____ _____
Signature of Responsible Party Date

A Release of Information may be required if the Responsible Party is someone other than client

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PATIENT HISTORY QUESTIONNAIRE

Briefly describe the problems you are having & when they began:

_____

_____

_____

_____

_____

_____

_____

MENTAL HEALTH HISTORY

Please list any psychiatrist, psychologist, or counselor you are **currently** in treatment with:

_____

_____

_____

_____

Please list any psychiatrist/counselors you have seen in the **past** and response to treatment? [ ] **NONE**

_____

_____

_____

Please list any previous psychiatric hospitalizations or intensive outpatient programs: [ ] **NONE**

_____

_____

_____

_____

Please list all **past** *psychiatric medications* you have taken, dates, and response to each: [ ] **NONE**

_____

_____

Please list any family history of mental health/substance abuse problems: [ ] **NONE**

_____

_____

_____

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SYMPTOM CHECKLIST

Please check any symptoms you are experiencing

[ ] Addiction to _____
[ ] Anxiety
[ ] Appetite - Increase / Decrease
[ ] Avoidance of People
[ ] Body Pains
[ ] Change in Eating Habits
[ ] Compulsions
[ ] Concentration Problems
[ ] Dizziness
[ ] Fatigue
[ ] Fear of _____
[ ] Guilt
[ ] Hallucinations
[ ] Headaches
[ ] Hopelessness
[ ] Impulsivity
[ ] Indecisiveness
[ ] Irritability
[ ] Loneliness
[ ] Memory Problems
[ ] Mood Swings
[ ] Panic Attacks
[ ] Paranoid Feelings
[ ] Racing Thoughts
[ ] Restlessness
[ ] Sexual Difficulties
[ ] Sleeping Problems
[ ] Stomach Upset
[ ] Suicidal Thoughts
[ ] Tearfulness
[ ] Trembling
[ ] Weight - Gain / Loss

SUBSTANCE USE HISTORY

Please describe your current and/or previous use of **caffeine / alcohol / tobacco products / drugs:**

[ ] NONE

Substance Used	Current or Previous	Amount Used	How Often	Last Used

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GENERAL MEDICAL HISTORY

Please check any of the following that apply

[ ] Asthma
[ ] Arthritis
[ ] Cancer
[ ] Chronic Pain
[ ] Diabetes
[ ] Head Injury
[ ] Headaches
[ ] Heart Disease
[ ] Hepatitis
[ ] Hypertension
[ ] Hypoglycemia
[ ] Kidney Disease
[ ] Liver Disease
[ ] Loss of Consciousness
[ ] Lung Disease
[ ] Memory Problems
[ ] Meningitis
[ ] Seizures
[ ] Sexually Transmitted Disease
[ ] Thyroid Problems
[ ] Fibromyalgia Other (please list below)
[ ] High Fevers
[ ] HIV
[ ] TB

Please describe any checked items above, including age of onset:

_____
_____
_____
_____

List all medications you are **currently** taking including the date started, dose, & the prescribing doctor:

_____
_____
_____

List the names and specialties of all the physicians who you are currently seeing:

_____
_____
_____

List any allergies or medication intolerance you have:

_____
_____
_____

List any hospitalizations/surgeries you have had in the past:

Date: _____ Hospital: _____ Reason: _____

Date: _____ Hospital: _____ Reason: _____

Date: _____ Hospital: _____ Reason: _____

Please list any family history of medical problems:

_____

_____

_____

_____

RELATIONSHIP HISTORY

Marital Status: [ ] single [ ] married [ ] separated [ ] divorced [ ] widowed

Please describe your current relationship, including any stressors:

_____

_____

_____

_____

If married, length of marriage: _____ Spouse's name _____

Number of previous marriages: _____ Number of previous long-term relationships: _____

Describe prior marriages/long-term relationships and the reason for the divorce or break up:

_____

_____

List all people that are currently residing in your home and their relationship to you:

_____

_____

_____

FAMILY - SOCIAL HISTORY

Where did you grow up? _____ Did your family move around? YES / NO

If YES, please describe:_____

How many siblings do you have? _____ Half-Siblings? _____ Step-Siblings? _____

Which family members are you close to? _____

Describe your childhood:

_____

_____

_____

_____

Were you ever abused (physical, sexual, or emotional)?

_____

_____

Have there been major losses, changes, or crisis in your life? YES / NO

If YES, please describe:

_____

_____

_____

EDUCATIONAL HISTORY

What is the highest grade you completed? _____

Did you receive any special education services? YES / NO

Did you have any discipline problems at school? YES / NO

How did you get along with your teachers and peers? _____

OCCUPATIONAL HISTORY

Are you currently employed? YES / NO If yes: FULL-TIME / PART-TIME

If yes, where? _____ How long have you been there? _____

Current Position: _____ Do you like your job? YES / NO

Do you get along with your co-workers? YES / NO Have you ever been laid off / fired? YES / NO

If YES, Explain: _____

Longest job previously held - Where? _____ How long? _____

Are you currently on disability? YES / NO Are you currently applying for disability? YES / NO

RELIGIOUS/SPIRITUAL HISTORY

[ ] None [ ] Catholic [ ] Christian [ ] Jewish [ ] Muslim [ ] Other: _____

I attend services: [ ] Never [ ] Occasionally [ ] Monthly [ ] Weekly [ ] More than once a week

LEGAL HISTORY

Have you ever been arrested for or convicted of a crime? YES / NO

If so, please list charges and results (probation, incarceration, fine, etc):

_____
_____
_____
_____