Douglass Bloomfield, PhD
Licensed Clinical Psychologist
804-728-1863 (Tel)

ADULT REGISTRATION FORM

All Information will be treated confidentially

4905 Dickens Road, Suite 104
Richmond VA, 23230
804-918-5213 (Fax)

Today's Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____ Email: _____

Preferred method of contact: ☐ Phone ☐ Cell ☐ Email
Leave message? ☐ Yes ☐ Yes

Age: _____ Birthdate: _____ Gender: _____ Marital Status: _____

Occupation: _____ Highest Education Level: _____

Employer: _____

In Emergency, notify: _____ Telephone #: _____

Who referred you to us? _____

Physician Name: _____ Physician Number: _____

If you believe your insurance may cover part of these costs, and you would like this office to file insurance, we will need the following information:

Is this an EAP (Employee Assistance Program) visit? ☐ Yes ☐ No
Does your insurance require pre-authorization? ☐ Yes ☐ No

Subscriber's Name | Date of Birth | Employer | ID Number

Subscriber's Address (if different from your own)

Preferred Billing Address (if different from above)

Primary Insurance Company | Primary Insurance Company Address

Secondary Insurance Company (if any) | Subscriber's Name | Date of Birth | ID Number

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Date of last doctor's visit: _____ Purpose: _____

Current or chronic illnesses: _____

Current medications: _____

Current physical health: ☐ Good ☐ Fair ☐ Poor

If you have ever received a mental health evaluation or treatment, please indicate the following

Therapist's Name and Address	Date Began	Date Ended
_____	_____	_____

Personal Symptoms History

Check any that apply to you now. Place a "P" by those that have been problems in the past but are not problems now.

- ☐ ____ Depression
- ☐ ____ Insomnia/Sleep Problems
- ☐ ____ No Appetite
- ☐ ____ Fatigue
- ☐ ____ Irritable
- ☐ ____ Can't Make Decisions
- ☐ ____ Low Self Esteem
- ☐ ____ Mood Swings
- ☐ ____ Inferiority Feelings
- ☐ ____ Anger Problems
- ☐ ____ Hyperactivity
- ☐ ____ Violent Behavior
- ☐ ____ Compulsive Behavior
- ☐ ____ Overeating
- ☐ ____ Weight Problems
- ☐ ____ Sexual Problems
- ☐ ____ Sexual Preoccupation
- ☐ ____ Suicidal Thoughts
- ☐ ____ Past Suicidal Attempts
- ☐ ____ Anxiety
- ☐ ____ Feel Tense
- ☐ ____ Constant Worrying
- ☐ ____ Panic Attacks
- ☐ ____ Excessive Fears
- ☐ ____ Withdrawn
- ☐ ____ Excessive Guilt
- ☐ ____ Over Ambitious
- ☐ ____ Overly Suspicious
- ☐ ____ Headaches
- ☐ ____ Dizziness
- ☐ ____ Fainting Spells
- ☐ ____ Seizures
- ☐ ____ Disorientation
- ☐ ____ Memory Problems
- ☐ ____ Stomach Problems
- ☐ ____ Nightmares
- ☐ ____ Chronic Medical Problems
- ☐ ____ Significant Childhood Illness
- ☐ ____ School Problems
- ☐ ____ Work Problems
- ☐ ____ Financial Problems
- ☐ ____ Legal Problems
- ☐ ____ Marital Problems
- ☐ ____ Relationship Problems
- ☐ ____ Physical Abuse
- ☐ ____ Emotional Abuse
- ☐ ____ Dislike Weekend/Holidays
- ☐ ____ Family Conflict
- ☐ ____ Recent Loss
- ☐ ____ Childhood Trauma
- ☐ ____ History of Sexual Abuse
- ☐ ____ History of Sexual Assau1t
- ☐ ____ Flashbacks
- ☐ ____ Hallucinations

Addictive Behaviors:

- ☐ ____ Alcohol Abuse
- ☐ ____ Drug Abuse
- ☐ ____ Gambling
- ☐ ____ Sexual Addiction

Other:

Major reason for seeking help at this time:

_____

Please add any information that you feel may be helpful:

_____

Medical History: (check all that apply)

☐ Appetite Disturbance ☐ Sleep Disturbance ☐ Seizures

☐ Head Trauma ☐ Allergies

Other: _____

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Hospitalizations? _____

Previous Mental Health Related Medications? _____

Side Effects? _____

Please check any of the following that have been present in the family (including the extended family on both mother's and father's side):

☐ Obsessive-Compulsive Disorder	☐ Depression	☐ Learning Disabilities	☐ Uncontrolled Anger
☐ Eating Problems	☐ Suicide	☐ Attention-Deficit/Hyperactivity Disorder	☐ Schizophrenia
☐ Bi-Polar Disorder	☐ Hospitalization for treatment of mental illnesses		☐ Anxiety
☐ Sexual Abuse	☐ Physical Abuse	☐ Social Fears	

Addictive Behaviors:

☐ Drug/Alcohol Abuse ☐ Gambling ☐ Sexual Addiction ☐ Other

Please elaborate on any of the above: _____

_____

Any history of academic difficulties? If "Yes", please describe. ☐ Yes ☐ No _____

_____

Any other relevant Family History: _____

_____

Please list others who live in your home (siblings, spouse, etc.): _____

_____

Note: The charge for an initial evaluation is $150 for a 45/50-minute session. Payment (or copayment if using insurance) is requested at the time of service. If you wish to make other arrangements, please discuss them with your therapist at your first appointment.

_____ _____

Date Signature of Person Responsible for Payment

Douglass Bloomfield, PhD
Licensed Clinical Psychologist
804-728-1863 (Tel)

Notice of Privacy Practices

Effective July 1, 2017

4905 Dickens Road, Suite 104
Richmond VA, 23230
804-918-5213 (Fax)

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

HIPAA requires that I give you the following Notice of Privacy Practices, which reads as a legal document. This note describes how clinical and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose or be required to disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. An "authorization" is written permission that permits only specific disclosures above and beyond your general consent. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes for any purpose except as noted otherwise herein. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to Child Protective Services – Virginia Department of Social Services.
- Adult Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to Adult Protective Services - Virginia Department of Social Services.
- Abuse by a Healthcare Provider: If I know, or have reasonable cause to suspect, that an inappropriate sexual relationship has taken place between a healthcare provider and patient.
- Health Oversight: If a complaint is filed against me with the Virginia Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me that is relevant to that complaint.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- Worker's Compensation: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen. Upon your request, I will send your bills to another location).
- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written notification, by mail, of those revisions on or before the effective date.

V. Complaints

If you are concerned that I have violated your privacy rights, or if you are dissatisfied with my privacy policies or procedures, you may file a complaint with my practice by contacting Douglass Bloomfield, PhD, at (804) 728-1863. You also may file a written compliant with the U.S. Department of Health and Human Services at the following address:

Secretary of Health & Human Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

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Effective July 1, 2017

4905 Dickens Road, Suite 104
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VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on July 1, 2017. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all pm that I maintain. I will provide my patients with a revised notice upon their next office visit (following the revision).

Your signature below indicates that you have received and read this privacy notice.

Signature _____ Date _____

Douglass Bloomfield, PhD
Licensed Clinical Psychologist
804-728-1863 (Tel)

Client Services Agreement & Informed Consent for Treatment

4905 Dickens Road, Suite 104 Richmond VA, 23230
804-918-5213 (Fax)

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

SERVICES

- Therapy can lead to many positive outcomes including improved mood, reduction in stress levels, better social relationships, and increased coping skills for dealing with life's challenges. At times, therapy may bring up uncomfortable feelings such as sadness, anger, and frustration.
- Therapy is best understood as a collaborative process that takes place over time. Throughout this process it is our mutual responsibility to clarify goals and monitor progress toward them. You are welcome to discuss any questions you have about the process with Dr. Bloomfield.
- Therapy is a voluntary process. You may end the process any time you wish. Dr. Bloomfield may end therapy if there is continued lack of progress, the relationship lacks productivity, or if you are no longer able to pay for services. Under these circumstances, Dr. Bloomfield will provide you with appropriate resources and referral information.

EMERGENCIES

- Douglass Bloomfield, PhD **does not offer 24-hour availability, crisis coverage, or emergency treatment**. As such, Dr. Bloomfield may be unavailable in the case of an emergency.
- **If you should experience a crisis, you should call 911, go to your local hospital emergency room, or contact the 24-hour crisis stabilization unit at your local community services board.** Local mental health crisis centers include Henrico Area Mental Health (804-727-8484), Chesterfield County Mental Health (804-748-6356), Hanover County (804-365-4200), and Richmond Behavioral Health Authority (804-819-4100).

CONTACTING DR. BLOOMFIELD

- If you wish to contact Dr. Bloomfield please either call (804-728-1863) or email him at drbloomfield@wiltonpark2.com. Even though he may have access to his voicemail remotely, Dr. Bloomfield will only respond to messages during business hours. Please know that there may be a delay in receiving a call back.
- Please limit email contacts to scheduling or canceling appointments. If you choose to send additional information via email, please remember that email is never 100% confidential. Please be aware that any email exchange may become part of your permanent record.

INSURANCE/ BILLING POLICIES

- Dr. Bloomfield is a provider for some, but not all, insurance companies. In checking your benefits, she may use a private billing contractor who uses tools provided by insurance companies. The benefit information received from your insurance carrier is advisory only and not a guarantee of coverage or payment.
- If Dr. Bloomfield is a provider for your insurance, you will be required to pay any copays or deductibles owed at the time of your visit. All patients are responsible for charges not covered by insurance which are allowable by contract and by law. Your insurance carrier will initially be billed for the full fee, and once payment is received from your carrier, the fee will be adjusted to the contracted rate.

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EVALUATIONS AND SPECIAL STATEMENTS

- Dr. Bloomfield will not provide evaluations or endorsement statements for the purpose of securing special benefits (e.g., Social Security Disability, disability insurance policies, emotional support animals, service animals, pre-surgical evaluations etc.). If you anticipate needing a doctor to evaluate or endorse you for special services, please discuss this with Dr. Bloomfield before your first session.

CANCELLATIONS AND MISSED APPOINTMENTS

- In the event you need to reschedule or cancel an appointment with Dr. Bloomfield, she can accommodate you with *AT LEAST 24 HOURS NOTICE. As a one-time courtesy, you will not be charged for the first missed appointment or late cancellation*. Thereafter, you will be charged $35 for subsequent missed appointments. If you use health insurance benefits for your therapy, be advised that your health insurance will not pay for missed or cancelled appointments. As such, you are solely responsible for the fee for missed appointments.

INSURANCE AND RELEASE OF INFORMATION

- If you are using insurance, your contract with your health insurance company requires that Dr. Bloomfield provide certain information relevant to the services you receive. Dr. Bloomfield is required to provide a clinical diagnosis and sometimes additional clinical information including, but not limited to, treatment plans, summaries, or your complete medical record.
- By signing this agreement, you authorize Dr. Bloomfield to provide requested information to your health insurance carrier. You always have the right to pay the full fee for Dr. Bloomfield' s services to avoid the disclosure of any information to your insurance company (unless prohibited by your insurance contract).

LEGAL MATTERS

- Dr. Bloomfield discourages the use of the psychotherapy services she provides for the intent of resolving legal matters. Please inform Dr. Bloomfield if you have any current or anticipate the need to use psychotherapy services and documentation for any legal matters.
- If Dr. Bloomfield is subpoenaed or court-ordered to provide testimony or records by any party in a legal matter in which you are involved, you are responsible for payment for time spent preparing for legal matters; travelling to/from legal settings; waiting to be called into legal settings; and in legal settings.
- His fee is $350.00 per hour for preparation and attendance at legal proceedings.

PROFESSIONAL RECORDS

- The standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will agree to send them to a mental health professional of your choice.
- Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents

CONFIDENTIALITY

- The law protects the privacy of all communications between you and your therapist. In most situations, I will only release information about your treatment to others if you sign a written Authorization Form for each release. Please refer to the Notice of Privacy Practices for a detailed list to limits on confidentiality.

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CONSENT TO TREATMENT

I consent to mental health services. I authorize Dr. Bloomfield, PhD, or a private billing contractor on his behalf, to bill my medical insurance and to release any information necessary to file a claim in order to be paid for services provided. I consent that Dr. Bloomfield may receive payment from my insurance carrier for any services she renders to me and I agree to pay for any amounts not paid by my insurance. I understand that I have the right to refuse or terminate treatment at any time. I understand that my treatment will be considered terminated after 30 days without contact with Dr. Bloomfield, but that I can return for treatment in the future if Dr. Bloomfield has availability.

My signature below certifies that I have read and understand the information in this document, that I accept all specified terms and fees therein, that I have received answers to any questions I may have, and that I have received information on patient rights and the Health Insurance Portability and Accountability Act.

Patient Signature	Date
Legal Guardian if patient is a minor	Date