Sarah Rosenbloom, Ph.D.
& ASSOCIATES

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Informed Consent and Signed Authorizations

Patient Name: _____ **Date:** _____

Patient Name: _____ **Date:** _____

Provider: _____

Informed Consent to Evaluation and Treatment

I hereby authorize and consent to psychological evaluation and treatment with **Dr. Sarah Rosenbloom & Associates.**

Signed and Agreed: _____ Date: _____

Acknowledgement of Receipt of Notice of Policies and Practices to Protect the Privacy of My Health Information

I acknowledge that I received notice of **Dr. Sarah Rosenbloom & Associates'** policies and practices to protect the privacy of my health information.

Signed and Agreed: _____ Date: _____

Authorization to Bill Insurance and for Payment

I authorize **Dr. Sarah Rosenbloom & Associates** to bill my insurance company for psychological services rendered to me. I also authorize my insurance carrier to make payment to **Dr. Sarah Rosenbloom & Associates** for services rendered to me for evaluation and treatment. I authorize **Dr. Sarah Rosenbloom & Associates** to furnish my insurance company with medical and other information about me (e.g., evaluation reports, treatment notes) required for processing my claim for medical benefits to be paid. I realize that I am responsible for all charges that are not covered by insurance.

Signed and Agreed: _____ Date: _____

Email Authorization

I give **Sarah Rosenbloom, PhD. & Associates** authorization to contact me via email about administrative issues such as scheduling and billing. I understand that email is not guaranteed to be a secure form of communication and therefore clinical or personal matters will not be addressed.

Signed and Agreed: _____ Date: _____

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24-Hour Cancellation

I understand that my appointment time is reserved for me, and that any cancellation made ***less than 24 hours in advance*** will result in a cancellation fee equal to the full session fee. I understand that my insurance carrier will not reimburse for services not rendered, and that the full session fee is my responsibility.

Signed and Agreed: _____ Date: _____

Delinquent Accounts

I understand that any account balance which is **60 days** past due should be paid in full and may be subject to late fees. Any insurance payments received after that time may be applied to my account or refunded to me.

Signed and Agreed: _____ Date: _____

Credit Card Number:

CCV: | | **Exp date:** | | | | |
|---|---|---|---|---|---|

Cardholder's name as it appears on the card:

Cardholder's billing address:

Street:		
City:	State:	Zip:

I authorize Sarah Rosenbloom, PhD. & Associates to charge my credit card for payment for services as agreed upon, or in the event of account balances over 60 days old. I understand that I will be held responsible for any costs associated with denied credit card payments.

Signed: _____ Date: _____

Cardholder's phone number:
