

Susan J Bloom Psy D, APNP, LLC

AUTHORIZATION TO RELEASE INFORMATION

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT RIGHTS AND RESPONSIBILITIES

Release of Information:

I authorize Susan J Bloom LLC to release to my insurance company any information from my medical record, which may be necessary to determine benefits payable under my policy and/or expedite treatment.

Assignment of Benefits:

I authorize payment directly to Susan J Bloom LLC. I understand I will be charged for missed appointments at the regular rate if I do not cancel at least 24 hours prior to my appointment.

I understand the fees associated with treatment. I also understand I am responsible for the balances to be paid within 60 days of treatment. Co-payments are due at the time of service.

Informed Consent:

I have been informed of my rights as they relate to treatment. I agree to sign a treatment plan after my first session that explains my diagnosis, types of treatment, goals for treatment, and consequences of not receiving recommended services.

I have been informed and have read my rights and responsibilities and have been given a copy. I am consenting to treatment.

Signature (Patient or Guardian)

Date

Witness