DAVID C. BLACKMON, PH.D.

LICENSED PSYCHOLOGIST, LIC. PY0004360

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ADULT- PATIENT INFORMATION

Patient Name: _____ M / F _____
Patient Social Security#: _____ DOB:_____ Age:_____
Address: _____
City: _____ State: _____ Zip: _____
(H) #: _____ (C) #:_____ (W) #: _____
(H) Email Address: _____ (W) Email Address: _____

Marital Status: (Please circle one) **Single Married Separated Divorced Widowed**

INSURANCE INFORMATION

Primary Insurance: _____ Insurance ID#: _____ Group ID#: _____
Insured/Guardian Name:_____ Employer:_____
Insured Social Security#:_____ DOB: _____

Secondary Insurance: _____ Insurance ID#:_____ Group ID#: _____
Insured/Guardian Name:_____ Employer:_____
Insured Social Security#: _____ DOB:_____

AUTHORIZATION FOR TREATMENT

My signature below indicates that I have consented to the evaluation and treatment by:

David C. Blackmon, Ph.D.

I certify that I understand the financial and insurance billing policies for this provider, and acknowledge that all of my questions, if any, have been answered to my satisfaction. Additionally, I authorized the release of any information necessary to process a claim on my behalf to all pertinent insurance carriers.

_____ _____
Patient Signature **Date**

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History Form

Please describe the nature of the problem or concern that brings you here:

_____
_____
_____
_____

Approximate date current problem started: _____

Have you had previous mental health treatment? (Circle one) Yes or No

If yes, please give date of first treatment:_____ Date of last treatment:_____

Name of previous Mental Health Care Provider: _____
Address: _____
City:_____ State: _____ Zip:_____
Office #:_____ Fax#:_____

Name of Primary Care Physician: _____
Address: _____
City:_____ State: _____ Zip:_____
Office #:_____ Fax#:_____

Who were you referred by or how did you hear about me? _____
_____

Are you involved with any current or potential litigation at this time? (Circle one) Yes or No

If yes, Please explain: _____
_____
_____
_____

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PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to efficient and effective care individualized to your needs. Your treatment provider will work with you to develop a treatment plan best suited to you. You and your treatment provider will use this plan to help you deal with your problems as quickly and effectively as possible.

You have the right to be treated with dignity and respect. You will be treated with respect at all times. You will report any misconduct by your treatment provider including social invitation, suggestive remarks, or unwanted touching to the appropriate state agency.

Your treatment provider will make every effort to meet with you at your scheduled appointment time. If your treatment provider is late, he or she will extend your session if possible or will make other arrangements by mutual agreement.

You have a right to privacy and confidentiality. All records and communication about you will be treated confidentially in compliance with applicable state and federal laws. These laws my obligate your treatment provider to report suspected abuse or neglect; domestic violence, and those who pose a danger to themselves or others. If you have any questions or concerns regarding your confidentiality rights, please speak to your treatment provider.

You have a right to access your protected health information. This includes the right to inspect and obtain a copy of such information and a right to an accounting of disclosures. In addition, you have the right to request amendment or correction of inaccurate or incomplete protected health information. To exercise these rights, please discuss directly with your treatment provider.

Patient Responsibilities: Scheduled appointments are commitments. You will make every effort to be on time for your appointment. If you are late for your appointment, you understand that time will be lost from your session. If you miss an appointment without 24 hours' notice, you understand that you will be charged a missed appointment fee.

You are responsible to pay at the time the service is rendered. David C. Blackmon, Ph.D. does not participate in any medical health insurance provider networks. (Only Participate with Tricare).

Your health is your responsibility. You will contact your treatment provider for any serious situation that arises, even if after normal office hours. To reach your treatment provider for an afterhour's emergency, call (904) 333-3389, and follow the instructions given. You will work with your provider to achieve your treatment goals and will advise your treatment provider of changes in your condition.

Patient (Print Name)	Patient or Guardian Signature	Date

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CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physician is important to help insure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. You may revoke this consent at any time to the extent that action has been taken in reliance upon it. If not revoked, this consent will remain in effect as long as you remain under my care or until all claims have been settled.

I, _____, _____, _____
(Patient- Print Name) (Patient date of birth) (Patient social security number)

for the purpose of coordinating care, authorize David C. Blackmon, Ph.D. to release information as indicated in the consent portion of the form to:

PCP Name: _____

PCP Address: _____
Street City State ZIP

PCP Phone: _____ PCP Fax: _____

CONSENT

I, the undersigned, understand that I may revoke this consent at any time to the extent that action has been taken in reliance upon it and that if not revoked, this consent will remain in effect as long as you remain under my care or until all claims have been settled. I have read and understand the above information and give my consent:

(Patient or guardian to check one of the following):
( ) To release any applicable mental health/substance abuse information to my primary care physician
( ) To release only medication information to my primary care physician
( ) I **do not** give my consent to release any information to my primary care physician

_____ _____
Patient signature (patients over 18 yrs. of age) Date

_____ _____
Guardian signature (patients under 18 yrs. of age) Date

_____ _____
Witness Signature Date

****

The following to be completed by David Blackmon, PH.D for PCP:

The patient was seen by me on _____ for diagnosis _____

Treatment Plan _____

The following medication(s) was/will be started _____

_____ Medication was not indicated _____ Patient refused medication _____Psychotherapy suggested before trying medication
_____ I recommend the following medical intervention by PCP before initiating medications:
Medical work-up for: _____
Lab tests for: ____CBC _____Thyroid Studies _____Chem panel _____EKG _____Other

PLEASE CALL ME AT (904) 333-3389 TO DISCUSS THIS CASE FURTHER OR IF NEED BE ANY OTHER INFORMATION.

_____ _____ _____
(Provider signature) (Provider printed name) (Licensure)

****

Notice to the recipient of this information. This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and the laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

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About Neuropsychological and Psychological Evaluation

Neuropsychological and Psychological evaluations are specialty services offered by Dr. David C. Blackmon, Ph.D. These evaluations are unique and require special billing accommodations. This kind of evaluation requires expensive equipment, specific training, and considerable experience. In addition, every hour of face to face contact requires one to two hours of follow-up work. This involves date analysis, scoring, interpretations, and report writing. This is reflected in the CPT codes which are used for billing. Assessment sessions will last approximately 1 ½ hours, but will be billed 2 hours to reflect the necessary follow-up work.

These evaluations often require specialized authorization. We will secure authorization and complete the necessary paperwork if I am a participating provider for your insurance. Any additional charges as a result of these evaluations will be explained to you before testing is started. Not all assessment procedures are covered by insurance companies. For example, psych-educational evaluation, often necessary in learning disability and Attention Deficit / Hyperactivity Disorder evaluations are typically not covered. These services can be obtained by your school board. However, there is often a long wait for the testing to be completed and you do not have control over how this information is communicated to the schools. When educational testing is a necessary part of the evaluation, an extra fee will be required to have the testing done at the office.

Following the completion of the assessment, a report will be written to allow for communication of the results in a through and usable fashion. The actual report is covered in the testing charges, however, a transcription fee (approx. $4.00 per page) will be charged to cover typing costs.

My signature below indicates that I have read and understand the above material, and any questions I may have regarding neuropsychological / psychological evaluations have been answered.

_____ _____

Patient (Print Name) Date

_____ _____

Patient or Guardian Signature Date

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Financial Agreements and Medical Insurance

If you have medical insurance, we will help you receive the maximum allowable available. In order to achieve this goal, we need your assistance and your understanding of our payment policies.

ALL PAYMENTS OR CO-PAYS ARE DUE AT THE TIME OF SERVICE

Returned checks will be subject to an additional collection fee which is determined by the depository bank. You will also be charged a fee for no shows and for appointments not canceled within 24 hours' notice. These fees must be paid prior to scheduling another appointment.

Should your account be placed with a collection agency due to delinquent status, the administrative cost for the action, along with attorney fees and court costs will be added to the balance of the account at the time of placement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
However, you must realize that:

1. My fees are based on the quality of service provided and generally fall within the "usual, customary and reasonable" standards by most insurance companies.
2. Benefits quoted by your insurance carrier are not a guarantee of payment. The balance of tour account is ultimately your responsibility.
3. Reports for evaluations will be written free of charge, however, you will be charged for the transcription fee.
4. Fees charged for no shows, late canceled appointments, letters and forms cannot be billed to your insurance carrier. These fees are your responsibility.

_____ _____

Patient (Print Name) Date

_____ _____

Patient or Guardian Signature Date

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CANCELLATIONS AND NO SHOW FEES

If for any reason you need to cancel or reschedule an appointment, you must notify the office at (904) 333-3389 within 24 hours. Failure to do so will result in a cancellation fee of $75.00 for therapy sessions and $150.00 for testing sessions (because these sessions are allotted for an hour and a half in the schedule book).

Furthermore, if you fail to show up a scheduled appointment there also will be a **No Show** charge of $75.00 which must be paid prior to the next scheduled appointment.

I UNDERSTAND THAT ILLNESS AND EMERGENGIES DO COME UP, HOWEVER, THE FEE WILL BE CHARGED EVEN IN THESE SITUATIONS BECAUSE I RESERVED THIS TIME FOR YOU AND I WILL NOT BE ABLE TO FILL THE APPOINMENT TIME WITH LITTLE OR NO NOTICE.

Please be aware that your insurance will not cover missed visits.
The missed appointment fee must be paid before your next scheduled appointment.

Thank you for your understanding.

_____ _____
Patient (Print Name) Date

_____ _____
Patient or Guardian Signature Date

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Credit /Debit Card Authorization Charge Form

Patient Name: _____
Date: _____

Name and Address Associated with Card:

Name:_____
Address: _____
City: _____ State: _____ Zip: _____

Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date: _____ /_____

CVC # on Back of Card: _____

_____ _____
Patient (Print Name) Date

_____ _____
Patient or Guardian Signature Date

(By signing above debit/credit card authorization form gives Dr. David C. Blackmon, Ph.D. permission to use the card information that only pertains to all office visits, no shows, and late cancellations fees that may apply).

(FOR OFFICE USE ONLY)