Patient Information

Patient Name First Middle Last

Date of Birth Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address

Street City, State Zip

Primary Insurance Information

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (self, spouse, child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annual Deductible \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Information

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization For Release of Information and Assignment of Benefits for Insurance

I authorize the use or disclosure of my health insurance information necessary to submit and process insurance claims. I understand that the service authorized to receive the information is not a health plan or healthcare provider. I authorize payment of medical benefits to my provider for services rendered.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| For Therapist Use:  Diagnosis Code(s) |  |
| Number of Authorized Sessions  Date Range for Authorized Sessions | Authorization # |
|  |

Mental Health Disclosure Form

Information

Psychotherapy varies depending on the personalities of the therapist and patient, the particular problems and issues being addressed, the length of treatment, and the strategies used. Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings and/or working with unpleasant life events. Psychotherapy often leads to a significant reduction of distress, the resolution of specific problems, and better relationships. In order to be most successful, hard work on your part is required, both during our sessions and between them.

The first few sessions is the time during which we will discuss your presenting problems and symptoms, family background and history, personal strengths and planning of treatment. This will also be your opportunity to get to know my personal style, and philosophy of treatment. At any time during the course of our work you have the right to ask questions about my experience with the problem at hand, your treatment plan, and procedures used.

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
3. The patient presents as a danger to others (Tarasoff v Regents of University of California, 1967).
4. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions.

# Initial here: \_\_\_\_\_\_\_\_\_\_

## Release of Information

I authorize release of information to my/my child's Primary Care Physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit

administration and other purposes related to my health plan.

# Initial here: \_\_\_\_\_\_\_\_\_\_

Emergency Access

# Sometimes telephone contact is needed when issues arise or a crisis develops between regularly scheduled sessions. In emergencies, you can call me at the office number 588-7610, even on evenings and weekends. I monitor my voice mail frequently, but may not be able to get back to you immediately. If you feel that the situation is urgent, and you cannot wait for a return call, you should call emergency services at 586-5555. During my vacations, my voice mail message will refer you to a covering clinician.

# Initial here: \_\_\_\_\_\_\_\_\_\_

Financial Terms: Fees, Insurance Coverage and Copayments

INDIVIDUAL /FAMILY THERAPY. My fee is $110 per 45-minute session. Private insurance is also accepted. My fee structure will be reassessed annually. Fees are kept within the usual and customary schedule.

OTHER. Other professional services you may require, such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations that you have authorized, preparation of records or treatment summaries, are billed on a prorated basis of the individual therapy fee.

PAYMENT. All fees or co-pays are payable at the time of service or by other arrangement determined on an individual basis.

You are responsible for obtaining prior authorization for treatment from your insurance carrier and for co-payment amounts and deductibles as set by your benefit plan. At any time during treatment should you become ineligible for insurance coverage or change insurance coverage, you must notify the provider. If you do not do so, you may become responsible for 100% of the bill.

**Initial here: \_\_\_\_\_\_\_\_\_\_**

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you may be billed according to the scheduled fee and instructions of your benefit plan. Your insurance company cannot be billed for fees associated with missed or canceled appointments. If you are a private pay patient, your missed appointment fee is \_\_\_\_\_\_\_\_\_\_.

As the provider, I will try to give you as much advance notice as possible for when I will be on vacation or must cancel a session for other reasons. If I must cancel due to snow emergencies or sickness, I will call you as early in the morning as possible. I generally follow the Northampton Public School system’s schedule for delays and cancellations due to weather.

**Initial here: \_\_\_\_\_\_\_\_\_\_**

Email:

I give permission for email to be sent to me for purposes of scheduling and communication. I understand that the security of any health information exchanged by email cannot be guaranteed. I authorize you to contact me at the following email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Initial here: \_\_\_\_\_\_\_\_\_\_**

Consent for Treatment

I acknowledge that I have read and understand the above information. My signature signifies my understanding and agreement with these issues. I have also agreed to the payment schedule of $\_\_\_\_\_\_\_ per 45 minute session/co-pay.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Name Date

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Parent, Date

Guardian or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner/Witness Signature Date

Authorization for Use/Disclosure of Protected Health Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize **Leah Levine, LICSW** to use and disclose/obtain my protected health information to/from:

#### The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

I acknowledge that I have signed this Authorization voluntarily. I understand that information used or disclosed as a result of this Authorization may be further used or disclosed by someone who obtains that information and therefore may no longer be protected by federal privacy laws. Except to the extent allowed by relevant law, Leah Levine will not condition treatment on my signing this Authorization. I understand that I have the right to revoke this Authorization in writing at any time (to the above address), except to the extent that action has been taken in reliance on it.

If not previously revoked, this Authorization expires on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Parent, Date

Guardian or Personal Representative

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 45 C.F.R., Pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.**

**Below, please share the concerns that have led you to seek support for your child. Please include relevant history including issues at pregnancy, infancy, or overall development, medical issues, social difficulties, and family history (both biological and adoptive, if applicable). Take all the space you need and share as much as you’d like.**