Child/Adolescent Information Sheet

Provider: Belinda Leventhal, Ph.D., LPC, LCSW
Today's Date:_____

Child's Full Name (first, middle initial, last):_____

Street Address:_____

City/State/Zip:_____

Home Phone:(___)_____ Sex:_____ Age:_____

Birthdate:_____ Social Security Number:_____

Highest Grade Completed:_____ Current School:_____

Mother's Name:_____

Street Address: _____ City/State/Zip _ _____

Home Phone:(___)_____Work Phone:(___)_____

Cellular Phone:(___)_____ Pager:(___)_____

Birthdate:_____ Social Security Number:_____

Occupation:_____ Employer:_____

Father's Name:_____

Street Address: _____ City/State/Zip _____

Home Phone(___)_____ Work Phone:(___)_____

Cellular Phone:(___)_____ Pager:(___)_____

Birthdate:_____ Social Security Number:_____

Occupation:_____ Employer:_____

Who should be contacted in case of emergency?_____

Phone:(___)_____ Relationship to child:_____

There may be occasions in which our office needs to contact you concerning your appointments, billing problems, or any other situation relating to your visit at our office. Please indicate if you give our office permission to leave messages (on an answering machine or with anyone that answers the phone) at the following locations:

Home Phone:	Yes	No
Work Phone:	Yes	No
Cell Phone:	Yes	No

Other numbers we may use to contact you:_____

_____

Are the child's parents separated or divorced? YES NO If YES, when?_____

Who has legal custody of this child? Mother Father Other_____

List the child's brothers/sisters and/or stepsiblings:
Name_____ Age____ Living with Child?____ Problems_____

Who referred you?_____ Phone:(___)_____ May I contact him/her to acknowledge the referral? YES NO

Briefly describe your reason for seeking help now:_____

How long has this been a problem ?_____

Primary Care Physician:_____ Phone:(___)_____ Does the child have any legal problems? YES NO (If YES, please explain)_____

Do you want this office to file insurance claims for you? YES NO
If "YES," complete this section. If "NO," skip this section.

Have you called your insurance company to pre-authorize these services? YES NO

Primary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

Secondary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

Who is responsible for the bill?_____

Will you be paying today by: Check_____ Cash_____ Credit Card_____

CONSENT TO EVALUATE/ASSESS/TREAT A MINOR

Patient:_____Date of Birth_____

Address:_____

I hereby authorize _____to evaluate, assess, and/or treat
(Please print provider's name)
my child/ward, _____.

Signature:_____ Date:_____
Parent or Legal Guardian

Witness:_____ Date:_____

PROFESSIONAL PSYCHOTHERAPY ASSOCIATES
1002 Bradford Way Kingston, TN 37763
Phone (865) 376-1585 FAX (865) 376-1587

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Belinda Leventhal, Ph.D., LPC, LCSW to release to my insurance company and/or insurance plan management company information requested on the HCFA-1500 claim form and/or the plan management company's outpatient treatment report for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by above-named therapist. I also authorize above-named therapist to release the information necessary to secure full payment of my account through other parties, such as a collection agency/credit bureau or court of law, if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my Insurance Company and/or insurance plan management company to pay Belinda Leventhal, Ph.D., LPC, LCSW such amount as may be payable pursuant to the provision of my contract. I also authorize above-named therapist to initiate a complaint to the Insurance Commissioner on my behalf if my insurance company fails to respond to a claim or to pay a claim in a timely fashion.

Date:_____ Patient or Guardian's Signature:_____

PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by Belinda Leventhal, Ph.D., LPC, LCSW. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the therapist agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by my dependent or myself. I understand that I may be charged for appointments not canceled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by above-named therapist in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

Client Rights and Limits of Confidentiality Handout and Acknowledgment

As a client at our clinic, you have the right to the following:

1. Be informed of your rights verbally and in writing. 2. Give informed consent acknowledging your permission for us to provide treatment. 3. Receive prompt and adequate treatment and refuse treatment that you do not want. 4. Receive written information about fees, payment methods, co-payment, length and duration of sessions and treatment 5. Be free from unnecessary or excessive medications; to receive clear information pertaining to any recommended medication, its possible benefits, side effects, and alternative medications. 6. Be provided a safe environment, free from physical, sexual, and emotional abuse. 7. Receive complete and accurate information about your treatment plan, goals, methods, potential risks, and benefits and progress. 8. Receive information about the professional capabilities and limitations of any clinician(s) involved in your treatment. 9. Be free from audio or video recording without informed consent. 10. Have the confidentiality of your treatment and treatment records protected. Information regarding your treatment will not be disclosed to any person or agency without your written permission except under circumstances where the law requires such information to be disclosed.

11. Have access to information in your treatment records:
    a. With the approval of the clinician during your treatment.
    b. To have information forwarded to a new therapist following your treatment at this facility.
    c. To challenge the accuracy, completeness, timeliness, and/or relevance of information in your record, and the right to have factual errors corrected and alternative interpretations added.
12. File a grievance if your rights have been denied or limited.

Client Confidentiality

Belinda Leventhal, PhD, LPC, LCSW, has a commitment to keeping the information you provide and your clinical record confidential. Beyond our commitment to Ethical Standards, HIPAA and state law require it. You can give permission to our clinic in writing if you wish your information to be shared with specific persons outside our agency. There are exceptions when we can/must release information without your written permission. Your clinical information will be released without your written consent if: (1) it is necessary to protect you or someone else from imminent physical harm; (2) we receive a valid court order or subpoena that mandates we release your information; or (3) you are reporting abuse of children, the elderly, or persons with disabilities.

Clinicians within the agency may, at times, consult with each other regarding your treatment in order to provide you with the best possible services to meet your needs.

If your child is in treatment with our facility and is a minor, we ask that parents/guardians agree that most details of what their child or adolescent tells the therapist be kept confidential. However, parents/guardians do have the right to general information about progress in treatment. The therapist may also have to share information that indicates the child/adolescent is in danger.

This is to acknowledge that I have read, understood, and agreed with the above information.

_____ _____

Signature of Client/Parent/Guardian Date

This acknowledges that I have reviewed and answered questions about the client's rights and confidentiality as well as our services.

_____ _____

Signature of Clinician Date

Clinician's Individual HIPAA Provider Number: _____

Client/Guardian's Name: _____

Signature: _____ Date: ___/___/___

CLINICAL ASSESSMENT SURVEY

ame: _____ Date: _____

rovider: _____

Below is a list of difficulties people sometimes experience. Please read each one carefully and mark the most appropriate answer.

How often were your troubled by:	not at all 1	occasionally 2	moderately 3	quite often 4	very frequently 5
Your feelings being easily hurt by others					
Feeling lonely					
Feeling fearful					
Thinking others are to blame for your troubles					
Nervousness, shakiness, or unsteadiness inside					
Problems remembering things					
The idea that something is wrong with your mind					
Feeling afraic when you are in open spaces					
Feeling guilty					
Feeling tense					
Thinking that others can control your thoughts					
Having thoughts of killing yourself					
Being easily annoyed or irritated					
Thinking that you cannot trust most people					
Feeling no interest in activities you used to enjoy					
Feeling like your eating is out of control					
Experiencing temper outbursts that you cannot control					
Your mind suddenly going blank					
Becoming scared for no reason					
Feeling that people dislike you					
Having to check over what you do several times					
Feeling inferior to other people					
Arguing frequently					
Feeling uneasy or nervous when alone					
Feeling like you couldn't sit still					
Feeling an urge to break things					
Feeling worthless					
Thoughts of death or dying					
Thinking you should be punished					
Experiencing difficulty making decisions					
Having trouble falling asleep					
Feeling others are watching or talking about you					
Feeling like you had to avoid certain things or places because they scared you					
Feeling hopeless					
Experiencing difficulty concentrating					
Feeling like you wanted to injure or harm someone					
Experiencing spells of terror or panic					
Thinking that people will take advantage of you if you let them					
Feeling physically weaker than normal					
Feeling others are not giving you the credit you deserve					

MEDICAL REVIEW FORM

NAME_____ DATE_____

FAMILY PHYSYCIAN_____ PHONE_____

REASON FOR LAST PHYSICAL EXAM_____ APPROXIMATE DATE_____

Have you ever been treated for or had indication of: (underline applicable items and explain in space below).

(A) High blood pressure, hypoglycemia, diabetes, anemia, or any disorder of the blood.

(B) Chest pains, shortness of breath, heart attack, stroke, rheumatic fever, heart murmur, irregular pulse or other disorders of the heart of blood vessels.

(C) Disorders of the thyroid, skin, or lymph glands.

(D) Sugar albumin, blood or pus in the urine or syphilis, gonorrhea or other sexually transmitted disease.

(E) Any disorder of the kidney, bladder, prostate, breast, or reproductive organs.

(F) Ulcer, chronic indigestion, intestinal bleeding, hepatitis, colitis, diarrhea, or other disorders of the stomach, intestine, rectum, spleen, pancreas, liver, or gall bladder.

(G) Asthma, tuberculosis, bronchitis, emphysema, or other disorders of the lung.

(H) Fainting, convulsions, tension or migraine headaches, paralysis, epilepsy, memory loss or confusion or any disorders of the brain or nervous system.

(I) Arthritis, gout, back pain, or other disorders of the muscles, bones or joints.

(J) Disorders of the eyes, ears, nose throat or sinuses.

(K) Other physical illnesses or concerns.

(L) Problems related to alcohol, prescription medication, non-prescription medication, smoking or drugs.

Have you noticed any recent changes in your (A) vision, hearing, coordination, balance, strength, speech, memory, or thinking; (B) changes in energy, sleeping, eating, elimination, menstrual cycle, sexual activity/interest. Please underline any changes.

Please list all allergies:_____

_____

Please list type and approximate dates of all surgeries:_____

_____

_____

Please list all prescription medicines you are currently taking:_____

_____

_____

Please list all non-prescription medicines you routinely use:_____

_____

_____

History of significant accidents:_____

_____

_____

Additional notes regarding personal or family medical/psychiatric history (use reverse side if necessary):

BELINDA LEVENTHAL, LCSW

Psychotherapy is a process of learning more about oneself in the context of a supportive professional relationship. Goals of psychotherapy may include a behavior change, stress management, or the identification and working through of personal concerns, emotions, or conflicts. When this happens, usually greater understanding of oneself and others is achieved as well as lessened insecurity and an enhanced ability to make choices and decisions in life.

People are often apprehensive when coming in for the first or early appointments. Please feel free to ask questions about our professional relationship, your treatment plan, the procedures of my office, or special financial arrangements at any time.

My practice includes individual, couple, family, and group psychotherapy. I am licensed as a Clinical Social Worker by the State of Tennessee.

Your sense of privacy is very important for successful treatment, so I strongly encourage you to raise any concerns you have about confidentiality or its limitations. The confidentiality of the therapy process is protected by law. This means that anything discussed or disclosed in the course of treatment will be held in strictest confidence. Should you wish me to release information to a third party, I will obtain your written consent to do so. That consent may be revoked by you at any time.

There are three circumstances under which a psychotherapist may be required to release information without patient consent: (1) if there is clear reason to believe that a patient poses imminent danger to him or herself or to a specific third person; (2) if there is reason to believe that a minor child is being or had been abused or neglected; and (3) if a judge specifically orders the release of records.

Sessions are scheduled for 50 minutes unless otherwise arranged. Please be prompt. The appointment time is reserved for you. Please give the earliest possible notice if you must miss an appointment. **You will be charged $25.00 for missed appointments if you do not cancel. This fee will not be paid by insurance. Fees are due and payable at the time of your appointment.** I am willing to file insurance as a service to you. Please let us know if you choose to use insurance. Some PPO's and HMO's have specific procedures. I will assist you in these, but it is your responsibility to follow the requirements of the health plan you elect to use. Please note that many insurance and managed care organizations require limited or full release of clinical information to authorize payment of claims and to document medical necessity for services provided. The information required may be limited to diagnosis and dates of service or may be as extensive as on-site review of all records relating to the case. Please feel free to speak with me or to contact your insurance carrier or managed care organization if you have questions about these procedures.

I work on an appointment only basis and cannot guarantee availability between your scheduled appointment times. If you need to reach me during working hours, call my office number (865) 376-1585. I have a confidential voice mailbox number (865) 376-1585 ext 107 where you may leave messages. If you would like me to return your call, please leave your phone number and I will get back with you as soon as possible. If your call is urgent, after recording your message follow the prompts and I will be paged. My cell number is (516)-581-5802 and is available for emergencies only. In the event that I am out of town or otherwise unavailable, my voice mail greeting will advise you of the name of the clinician who is providing emergency coverage. To work in outpatient psychotherapy, you must be able to maintain safety. This agreement requires you to present any suicidal or homicidal thoughts, plan, or intent. I will do everything I can to help manage your thoughts and feelings without violent behavior. Should an emergency arise and I am not available by telephone, you may wish to consult you physician or area hospital emergency room.

My current fees for psychotherapy per session are: **Individual $100, Family $125, group fees are negotiated separately. Initial evaluation, including establishing treatment and financial records is generally $135.** If you wish to pay for sessions on a fee-for-service basis, full payment is expected at the time of the appointment unless other arrangements are made. Please let me know if you wish to set up an incremental payment plan or schedule, I will be happy to discuss this with you. Master Card and Visa payment options are available for your convenience. If you wish to use your health insurance too help with the cost of sessions, **co-pay and deductible payments are expected at the time of the appointment.** You will be responsible for any unpaid balance with the exception of circumstances or fees specified in provider agreements with your insurance or managed care company. Patient billing statements are issued once monthly. Should you have any questions regarding your statement or insurance claim, please contact my office manager, Debra Patterson, at (865) 376-1585.

I recognize that from time to time circumstances may arise which impact one's capacity to meet payments on the agreed-upon schedule. Should this occur, please let me know. I will be happy to work with you on a payment plan, which is manageable for you. However, in the event that a good faith effort is not made toward addressing your financial obligations for payment for services, I reserve the right to turn delinquent accounts over to collection.

Consent to Treatment:

I/We hereby authorize Belinda Leventhal, LCSW, to administer treatment intervention as deemed necessary or desirable for my/our. I/we read, understand, and agree to the above treatment and financial responsibilities and procedures.

Signed:_____ DATE:_____

Therapist:_____ DATE:_____

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995