PROFESSIONAL PSYCHOTHERAPY ASSOCIATES

An Association of Independent Practitioners

Robert K. Albiston, Ph.D., P.C.
Lee Ensign, Ph.D.
Sharon Bryant, Ph.D.
Claude Robinson, Ph.D.

Judith Allson, L.C.S.W.
Belinda Leventhal, L.C.S.W.
Jan Lewis, L.C.S.W.

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOTHERAPY SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions and psychotherapist will explain how to use it.
- You need to use a webcam during the session- computer, ipad, tablet- or smartphone if the camera is accessible from your email account.
- It is important to be in a quiet, private environment that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public or free WiFi.
- It is important to be on time. If you need to cancel or change your tele-appointment you must notify your therapist in advance by phone or email.
- We need a back-up plan (e.g. phone number where you can be reached) to restart the session, or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest er to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in tele-psychotherapy sessions. You should confirm, with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, tele-psychotherapy is no longer appropriate and that we should resume our sessions in-person.

Psychotherapists Name/Signature:_____ Date:_____

Patient Name:_____

Signature of Patient/Patient's Legal Representative:_____ Date:_____

Relationship to Patient:_____

1002 Bradford Way Kingston, TN 37763 Tel: (865) 376-1585 Fax: (865) 376-1587
Belinda Leventhal's Email: drbleventhal@drbleventhal.hush.com phone ext. 107

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an agreement between us.

Decision to Meet Face to Face

We've agreed that it's better for us to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth if I think it's clinically appropriate. If you have concerns about going back to telehealth, we'll talk about it first and try to address your worries. You understand that I have the final say if I think it's best to go to telehealth.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services I will try to respect that decision, if it is clinically appropriate and feasible under the telehealth guidance from your state and insurer.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. Your failure or refusal to adhere to these safeguards may result in our starting / returning to a telehealth arrangement. **Initial each** to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __

- You will wait in your car or outside [or designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will keep a distance of 6 feet and will not shake hands or hug me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure. ___
- If you have a job that exposes you to those who are infected, you will let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know.
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know.___

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the virus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You Are Sick

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details of the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

If I [or my staff] test positive for the corona virus, I will notify you so that you can take appropriate precautions.

Informed Consent

This agreement supplements to the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Client Date

_____ _____

Therapist Date

ADULT INFORMATION SHEET

Provider: Belinda Leventhal, Ph.D., LPC, LCSW

Today's Date: _____

Full Name (first, middle initial, last):_____

Street Address:_____

City/State/Zip:_____

Home Phone:(____)_____ Work Phone:(____)_____

Cellular Phone:(____)_____ Pager:(____)_____

Age:_____ Birthdate:_____ Sex:_____ Social Security #:_____

Occupation:_____ Employer:_____

Marital Status:_____ Date Married:_____ Previous Marriages?:_____

Education:_____ Religion:_____

Spouse's/Partner's Name:_____

Street Address:_____

City/State/Zip:_____

Home Phone:(____)_____ Work Phone:(____)_____

Cellular Phone:(____)_____ Pager:(____)_____

Age:_____ Birthdate:_____ Sex:_____ Social Security #:_____

Occupation:_____ Employer:_____

Education:_____ Religion:_____

In case of emergency, call_____

Phone: (____)_____ Relationship to you:_____

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:_____

_____

List children:

Name _____ Age Education Occupation Resides_____

_____

_____

_____

List parents/siblings:

Name _____ Relationship Age Education Occupation Resides_____

_____

_____

_____

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 for you?_____

Primary Care Physician:_____ Phone ( ) _____

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:_____

_____

Are you experiencing any legal problems? YES NO (If YES, please explain) _____

_____

Who is responsible for the bill?_____

Will you be paying today by: Check_____ Cash_____ Credit Card_____

THANK YOU for completing this questionnaire. ***PLEASE*** let me know if any of the above information changes.

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:_____

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):

CLINICAL ASSESSMENT SURVEY

Name: _____ Date: _____

Provider: _____

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
1	Your feelings being easily hurt by others					
2	Feeling lonely					
3	Feeling fearful					
4	Thinking others are to blame for your troubles					
5	Nervousness, shakiness, or unsteadiness inside					
6	Problems remembering things					
7	The idea that something is wrong with your mind					
8	Feeling afraid when you are in open spaces					
9	Feeling guilty					
10	Feeling tense					
11	Thinking that others can control your thoughts					
12	Having thoughts of killing yourself					
13	Being easily annoyed or irritated					
14	Thinking that you cannot trust most people					
15	Feeling no interest in activities you used to enjoy					
16	Feeling like your eating is out of control					
17	Experiencing temper outbursts that you cannot control					
18	Your mind suddenly going blank					
19	Becoming scared for no reason					
20	Feeling that people dislike you					
21	Having to check over what you do several times					
22	Feeling inferior to other people					
23	Arguing frequently					
24	Feeling uneasy or nervous when alone					
25	Feeling like you couldn't sit still					
26	Feeling an urge to break things					
27	Feeling worthless					
28	Thoughts of death or dying					
29	Thinking you should be punished					
30	Experiencing difficulty making decisions					
31	Having trouble falling asleep					
32	Feeling others are watching or talking about you					
33	Feeling like you had to avoid certain things or places because they scared you					
34	Feeling hopeless					
35	Experiencing difficulty concentrating					
36	Feeling like you wanted to injure or harm someone					
37	Experiencing spells of terror or panic					
38	Thinking that people will take advantage of you if you let them					
39	Feeling physically weaker than normal					
40	Feeling others are not giving you the credit you deserve					

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					

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 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 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 confidentially 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 the 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 60 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 $65.00 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 fell 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 (865) 332-8201 and is available for emergencies only. In the event that I am out of town or otherwise unavailable , my voicemail 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 anything 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 your physician or area hospital emergency room.

My current fees for psychotherapy per session are: Individual $100, EMDR $125, group fees are negotiated separately, Initial evaluation, including establishing treatment and financial records is $145. 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, MasterCard and Visa payment options are available for your convenience. If you wish to use your health insurance to help with the cost of sessions, **co-pays 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 TNG Billing (Tina or Greg) at (865) 584-0629.

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 collections.

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

Signed:_____ Date_____

Therapist:_____ Date_____

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: ___/___/___

CANCELLATION POLICY

PLEASE BE ADVISED:

AS OF MARCH 1, 2018, YOU MUST GIVE A MINIMUM OF 24 HOURS NOTICE OF CANCELLATION OR YOU WILL BE CHARGED A **$65** MISSED VISIT FEE.

THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION