**Informed Consent**

This consent is a request for Lisa F. Levine, Lcsw to have contact with a psychiatrist, psychologist, therapist, school administration or other provider.

I am authorizing Lisa F. Levine, Lcsw to verbal communication through email, or phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(initial) I am not authorizing Lisa F. Levine, Lcsw to have verbal communication through email or phone or text\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(initial)

I am authorizing Lisa F. Levine, Lcsw to have written documents , reports or recommendations to Lisa F. Levine, Lcsw (this does not include notes of anyprovider)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initial)I am not authorizing written documents, reports or recommendations. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initial).

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

Name

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

Address

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

City, State and zip

The client named below is receiving therapy at this office with Lisa Levine, Lcsw. The client has consented by signing this to allow me communication with you. (Initial)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This notice be sent to the above-named doctor and further authorize consultations between the patient’s doctor and therapist relative to my medical and psychological care. This authorization is in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Signature of patient or guardian of minor.

Lisa F. Levine, Lcsw [www.bocatherapyservices.com](http://www.bocatherapyservices.com) 954-815-5252

**Client Rights and Important Information**

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, and my fee. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time in writing and not by a text unless this is a court ordered situation, than the judge and the legal system will make a determination.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies, or registers the therapist.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client’s consent. There are several exceptions to confidentiality, which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; (5) I am required to report abuse of a senior, who is 70 years of age or older, which I believe has probably occurred, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and (6) I may be required by Court Order to disclose treatment information. (7) I am required by law to report any threats against locations such as churches, schools, theatres, workplaces, etc. to law enforcement in which case confidentiality may be breached. (7) Florida law allows confidentiality to be breached if a mental health professional believes a client is a potential school shooter.

e. When I am concerned about a client’s safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treatment with me, you consent to this practice, if it should become necessary.

f. Under Florida Law, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Florida law and HIPAA Standards.

g. I agree not to record our sessions without your written consent; and you agree not to tape record a session or a conversation with me without my written consent.

h. There may be times when I need to consult with a colleague or another professional about issues raised by clients in therapy.  Client confidentiality is still protected during consultation by me and the professional consulted.  Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

i. In marriage and family counseling, the therapist holds to a “no secrets” policy.  All members of the couple or family system are treated equally and “secrets” are not kept by the therapist. There is no differential or discriminatory treatment of family members.

j. Your client records will be destroyed seven years after termination of psychotherapy pursuant to Rules and Regulations in the State of Florida. Any staff member and/or therapist acting on behalf of **Lisa Levine, Lcsw** will be authorized to communicate with you by telephone, text message, email and mail. In spite of efforts to keep the contents of the telephonic or text communication confidential, due to the nature of certain types of telephones, such as cell phones or mobile phones operating on radio transmissions, the possibility exists that other parties may overhear the contents of the transmission.

**Children and Adolescents and Adults**

A child 17 or younger seen in this office must have the signature of a parent.  In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody. When a client is 18 years of age or older, that client is the privilege holder for himself or herself.

**Disclosure Regarding Divorce and Custody Litigation**

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family’s children.

**Services**

I provide non-emergency psychotherapeutic services by scheduled appointment.  If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate or consult. If, for any reason, you are unable to contact me by telephone (954-815-5252, and you are having a true emergency, please call 911 or go to the nearest hospital emergency room.

**Insurance and Payment**

**I am on a number of managed care programs.  Additionally, many insurance companies refer to me as a provider.  I will work with your insurance carrier as a courtesy to you.  It is YOUR responsibility to contact your insurance company, EAP, or managed care company relative to eligibility and payment. All information about fees and payments are contained in the STATEMENT OF FEE POLICY which you will be requested to read and sign.  
  
My fee is $150.00 plus depending on what type of therapy per session for clinical services and any related paper work. This is determined on a case b y case basis. If this is a legal situation, Lisa Farah Levine, Lcsw has the right to terminate her involvement at anytime.**   
  
**If you have any questions or would like additional information, please feel free to ask during the initial session or anytime during the psychotherapy process.  
  
INFORMED CONSENT FOR TREATMENT  
  
I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Client or Responsible Party Date Client or Responsible Party Date**

**STATEMENT OF FEE POLICY**

It is important that you understand the Fee Policy. Please read-complete the section which states you insurance and your co-pay-Sign and Date. If you are a cash pay, you and your therapist will complete the section relative to fee.

Lisa Levine, Lcsw provides psychotherapy, educational and consultation services. I am requesting that you read and sign this statement to acknowledge your understanding of my policy. Your signature does not bind you to therapy. It does make you responsible for charges incurred.

**Insurance Billing:** This will be handled on a case by case basis. You are asked to contact your insurance company relative to your benefits. This office has made every effort to be a provider for a variety of managed care companies. As a service to you, Lisa Levine, Lcsw, may bill Client’s insurance company on Client’s behalf. **If for any reason a claim is denied, it is the Client’s responsibility to contact the insurance company and clear up any reasons for its denial. Client is responsible for verifying insurance coverage, obtaining any necessary pre-authorization, and resolving any claim denials.**  If Client fails to do so, Client will pay provider’s full customary fee for all services rendered. For managed care claims and EAP referrals, we will bill as per the agreement with the managed care company. Because Lisa Levine, Lcsw is a licensed psychotherapist, most insurance companies will accept claims. Please check your insurance and what eligibility is. Lisa Levine, Lcsw works on a sliding fee scale to meet the needs of all clients.

**Co-Pay: If your managed care policy requires a co-pay, it is the individual’s responsibility to bring the co-pay to each session or make other arrangements. This office does NOT send out statements for co-pay.**

**Deductable:** Your health insurance may also have a deductible. If it is applied by your insurance company to any claim we submit, you are responsible for these amounts also. You should check with your insurance to see if a deductible applies.

**Auxiliary Service**: Occasionally requests are made for mental health evaluations and other reports. A fee of 250.00 or more depending on situations. You will be charged for these reports.

**Telephone Calls and E-mail**: There is a charge for telephone calls between Lisa F. Levine and other practitioners, and legal teams, this will be discussed between all parties depending on the situation. The fee is $125.00, you are responsible to pay this fee.

**Cancellations: The time of your scheduled appointment is reserved for you. It is our policy to charge the fee of a session when the appointment is canceled within three hours of the appointed time. It is our policy to charge for the entire session for a no show. We understand that circumstances arise that make it difficult to keep an appointment. We will work with you relative to these charges. All cancellations must be within 96 hours unless a dire emergency appears. THERE ARE NO EXCEPTIONS. The cost is 150.00 for cancels, last minute no shows, etc. I respect your time, please respect mine and my patients.**

Please provide a Credit card Number to pay for any co-pays, or appointments that are cancelled in less than 96hours **:CC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV:\_\_\_\_\_\_\_\_\_**

**Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Length of Session**: A session is generally 45- 55minutes. Children sometimes will only have a 30 minute session. There is no extra charge for other individuals such as spouse, children, relatives or friends who may need to attend at your request.

**Fees:** Please speak opening to me about my fees. It is my desire to work with you as much as possible as to payment.

**I give my consent and authorization to Lisa Levine, Lcsw to bill my insurance and my credit card if I do NOT SHOW for an appointment, the fee is $150.00, noted above and I further acknowledge that my co-pay is to be paid at the time of the session or at the time otherwise arranged. My signature also represents my understanding of the above fee policies. My signature also understands that I am responsible to make payments if the insurance company is not paying or if client has not met the deductible. Please make sure that you contact your insurance company to find out what you need to pay at the time of the session. Lisa F. Levine’s medical biller will also be a point of contact for all payments.**

**Signature\_Of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

,

## **Consent For Treatment Between Lisa F. Levine, Lcsw and Patient**

## I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as parent/guardian of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize Lisa Levine, LCSW to provide therapy.

* The fee agreed upon is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per session.
* I certify that I am responsible for paying the cost of my treatment.
* Payment is due at the beginning of each session by check or cash. Make checks payable to Lisa F **Levine, LCSW. Please have your check prepared in advance so that session time can be best utilized. All cancellations not within 96 hours are $150.00 fee.**
* Appointments must be canceled at least 96 hours prior to the appointment or the client will be billed for that session.
* Therapy sessions consist of a 50-minute “hour”. If session last longer than 55 minutes, they may be billed on a pro-rated basis.
* There will be a $50.00 charge on all returned checks
* If you find yourself in an emergency situation, you should call 911 or go to your nearest Emergency Room
* **Confidentiality:** All information you reveal will be treated strictly confidential according to HIPPA regulations. This means that the information will not be shared with anyone with the following three exceptions (1) when you have given written consent to share the information with a specific person or agency, (2) when it is deemed that you are at risk of hurting yourself or another person and (3) when as a mandated reporter Florida law requires me to report abuse or neglect of a child or elderly person.
* **This release will be in effect until it is in writing by the parent/guardian that the release is no longer valid.**

I certify that I have read and understand all of the above information.

Mother’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Consent for Treatment Between Lisa F. Levine, Lcsw and Patient**

## I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Lisa Levine, LCSW to provide therapy.

* The fee agreed upon is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per session.
* **I certify that I am responsible for paying the cost of my treatment. I am responsible to pay $150.00 for any cancellations not made within 96 hours.**
* Payment is due at the beginning of each session by check or cash. Make checks payable to Lisa F Levine, LCSW. Please have your check prepared in advance so that session time can be best utilized.
* Appointments must be canceled at least 24 hours prior to the appointment or the client will be billed for that session.
* Therapy sessions consist of a 55-minute “hour”. If session last longer than 55 minutes, they may be billed on a pro-rated basis.
* There will be a $50 charge on all returned checks
* Please not all co-pays are made at the start of a session.
* **All cancellations must be within 96 hrs of the scheduled appointment or the client will be billed for a session.**
* If you find yourself in an emergency situation, you should call 911 or go to your nearest Emergency Room
* This release will be in effect until in writing there is in writing that the consent for treatment has been relinquished.
* **Confidentiality:** All information you reveal will be treated strictly confidential according to HIPPA regulations. This means that the information will not be shared with anyone with the following three exceptions (1) when you have given written consent to share the information with a specific person or agency, (2) when it is deemed that you are at risk of hurting yourself or another person and (3) when as a mandated reporter Florida law requires me to report abuse or neglect of a child or elderly person.
* **This release will be in effect until it is in writing by the parent/guardian that the release is no longer valid**

I certify that I have read and understand all of the above information.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Physician and/or Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications prescribed by this M.D. (Name and dosage)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Are you are under the care of a psychiatrist? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Name of Psychiatrist or Psychiatric Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication and dosage prescribed by Psychiatrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you been hospitalized for emotional problems? Yes\_\_\_\_\_\_\_\_\_-No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so: When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous individual therapy? Yes\_\_\_\_No\_\_\_\_\_ Dates:\_\_\_\_\_\_\_

Name of Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for substance abuse? Yes \_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated now for substance abuse? Yes \_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_

Please list any and all physical illnesses that are now being treated by M.D.

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

What would you want your therapist to know about your physical or emotional health:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Lisa Levine, Lcsw to contact by telephone or mail the following medical professionals for the purpose of consulting and coordinating care for my therapy and treatment.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization Signature

**COURT APPEARANCE POLICY**

I am a Licensed Clinical Social Worker, who provides clinical services to parents, families and children. This clinical work takes the form of individual counseling, marital counseling, and services to children. In my clinical role, I cannot assist my clients in divorce or custody litigation, and I disclose this fact to each client and client family who come to me for services. As a Licensed Clinical Social Worker, I cannot disclose any marital therapy, couples counseling or family therapy information without the consent of all my clients. This is required by Florida law, HIPAA Standards, and the Code of Ethics. I will **not release any records**, including progress notes, assessments etc.. If this is the case Lisa Farah Levine has the right to remove self from the case.

Please do not ask me to write any reports for the court as I cannot do so. Please do not ask me to provide my notes as they are confidential. Do not ask me to testify in court, because this will destroy my professional relationship with my clients. I am not a custody evaluator and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI, Guardian Ad Litem, or a PR/PT evaluator, those are the individuals that can make recommendations to the court. I cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed my role as a therapist, and would adversely affect my ability to help families, parents and children. I will discuss progress toward treatment goals and session attendance, I will not again, disclose or violate my clients confidentiality unless they are in danger, being victimized or abused by a parent, person or family member. I am a mandated reporter and will contact DCF if there are factual reports of any emotional, physical or verbal abuse.

I/we have read and fully understand the forgoing statement and agree to its terms as a condition of counseling services.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA DISCLOSURES RE CONFIDENTIAL INFORMATION**

**THIS NOTICE CONTAINS INFORMATION CONCERNING HOW CONFIDENTIAL MENTAL HEALTH TREATMENT INFORMATION CONCERNING YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY AND LET US KNOW ANY QUESTIONS THAT YOU MAY HAVE CONCERNING THIS NOTICE**.During the process of providing services to you, **Lisa Levine, Lcsw** will obtain and use mental health and medical information concerning you that is both confidential and privileged.Ordinarily this confidential information will be used in the manner that is described in this statement, and will not be disclosed without your consent, except for the circumstances described in this Notice**. Please be advised, Lisa Levine will not under any circumstance release a case record including, progress notes, assessments or a whole case file. Ms. Levine has the right at anytime to remove herself from any cases that are legally involved.**

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not requiring the Client’s Consent.  **Lisa Levine, Lcsw** will use and disclose protected health information in the following ways.

1. *Treatment*.Treatment refers to the provision, coordination, or management of mental health care and related services by one or more health care providers.For example,**Lisa Levine, Lcsw** Therapists and staff involved with your care may use your information to plan your course of treatment and consult with other health care professionals or their staff concerning services needed or provided to you.

2. *Payment*.Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care.For example, **Lisa Levine, Lcsw** and other health care professionals will use information that identifies you, including information concerning your diagnosis, services provided to you, dates of services, and services needed by you, and may disclose such information to insurance companies, to businesses that review bills for health care services and handle claims for payment of health care benefits in order to obtain payment for services.If you are covered by Medicaid, information may be provided to the State of Florida’s Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

3. *Health Care Operations*.Health Care Operations means activities undertaken by health insurance companies, businesses that administer health plans, and companies that review bills for health care services in order to process claims for health care benefits.These functions include management and administrative activities.For example, such companies may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and Accreditation, certification, licensing and credentialing activities.

4. *Contacting the Client*. ***Lisa Levine, Lcsw***may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. *Required by Law*.**Lisa Levine, Lcsw** will disclose protected health information when required by law.This includes, but is not limited to: (a) reporting child abuse or neglect to the Department of Human Services or to law enforcement; (b) when court ordered to release information; (c) when there is a legal duty to warn of a threat that a client has made of imminent physical violence, health care professionals are required to notify the potential victim of such a threat, and report it to law enforcement; (d) when a client is imminently dangerous to herself/himself or to others, or is gravely disabled, health care professionals may have a duty to hospitalize the client in order to obtain a 72-hour evaluation of the client; and (e) when required to report a threat to the national security of the United States.

6. *Health Oversight Activities*.Your confidential, protected health information may be disclosed to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.

7. *Crimes on the premises or observed* by **Lisa Levine, Lcsw** *personnel*.Crimes that are observed by **Lisa Levine, Lcsw** staff that are directed toward staff, or occur on **Lisa Levine, Lcsw** premises will be reported to law enforcement.

8. *Business Associates*.Confidential health care information concerning you, provided to insurers or to plans for purposes or payment for services that you receive may be disclosed to business associates.For example, some administrative, clinical, quality assurance, billing, legal, auditing and practice management services may be provided by contracting with outside entities to perform those services.In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks.Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. *Research*.Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the Federal HIPAA Privacy Regulations are followed.

10. *Involuntary Clients*.Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed in compliance with Colorado law.

11. *Family Members*.Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client’s consent.In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion.However, if the client objects, protected health information will not be disclosed.

12. *Emergencies*.In life threatening emergencies **Lisa Levine, Lcsw** staff will disclose information necessary to avoid serious harm or death.

B. Client Release of Information or Authorization.**Lisa Levine, Lcsw** and other health care professionals may not use or disclose protected health information in any way without a signed release of information or authorization.When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing.The revocation will apply, except to the extent **Lisa Levine, Lcsw** has already taken action in reliance thereon.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information.You have the right to receive a summary of confidential health information concerning you concerning mental health services needed or provided to you.There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies.To make a request, ask **Lisa Levine, Lcsw** staff for the appropriate request form.

B. Amendment of Your Record.You have the right to request that **Lisa Levine, Lcsw** or your health care professionals amend your protected health information.**Lisa Levine, Lcsw** is not required to amend the record if it is determined that the record is accurate and complete.There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you.To make a request, ask **Lisa Levine, Lcsw** staff for the appropriate request form.

C. Accounting of Disclosures.You have the right to receive an accounting of certain disclosures **Lisa Levine, Lcsw** has made regarding your protected health information.However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations.In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003.There are other exceptions that will be provided to you, should you request an accounting.To make a request, ask **Lisa Levine, Lcsw**staff for the appropriate request form.

D. Additional Restrictions.You have the right to request additional restrictions on the use or disclosure of your health information.**Lisa Levine, Lcsw** does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request.To make a request, ask **Lisa Levine, Lcsw** staff for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications.You have the right to request that you receive communications of protected health information from **Lisa Levine, Lcsw** by alternative means or at alternative locations.For example, if you do not want **Lisa Levine, Lcsw** to mail bills or other materials to your home, you can request that this information be sent to another address.There are limitations to the granting of such requests, which will be provided to you at the time of the request process.To make a request, ask **Lisa Levine, Lcsw** staff for the appropriate request form.

F. Copy of this Notice.You have a right to obtain another copy of this Notice upon request.

III. NOTICE REGARDING USE OF TECHNOLOGY

1. *E-mail Communications*.Unencrypted e-mail may not be confidential, and any information regarding PHI sent by e-mail may not be confidential.

2. *Skype, or Other Similar Video Conferencing Technology*.Communication through Skype or FaceTime may not be confidential.

3. *Internet Communications*.Counseling or communication through the Internet may not be confidential. Lisa Levie does everything possible to ensure safety and confidentiality.

4. *Storage of Health Care Information*.Health care records and information maintained on a Cloud may not be confidential, depending on the number of servers involved.

5. *Voicemail*.Telephone messages left through voicemail may not be confidential, if they may be accessed by individuals other than the client.Please let me know if you do **not** want me to use voicemail in contacting you.

6. *Facsimile Communication*.The submission of health care information or records by fax may not be confidential, and may lead to a disclosure of confidential information to third parties if the wrong fax number is used to send the information.

7. *Communication by U.S. Mail*.Communication of information by U.S. mail may lead to disclosure of private information to third parties, depending on who may open the mail.Please let me know if you do **not** want me to send you correspondence, billing invoices, or other information through the U.S. mail.

IV. ADDITIONAL INFORMATION

A. Privacy Laws.**Lisa Levine, Lcsw** is required by State and Federal law to maintain the privacy of protected health information.In addition, **Lisa Levine, Lcsw** is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information.That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice.**Lisa Levine, Lcsw** is required to abide by the terms of this Notice, or any amended Notice that may follow.**Lisa Levine, Lcsw** reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains.When the Notice is revised, the revised Notice will be posted in **Lisa Levine, Lcsw** service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights.If you believe **Lisa Levine, Lcsw** has violated your privacy rights, you have the right to complain to **Lisa Levine, Lcsw**.Please submit a statement, in writing, addressed to **Lisa Levine, Lcsw 7000 W. Palmetto Park Road Boca Raton, Fla 33433**

D. Additional Information.If you desire additional information about your privacy rights at **Lisa Levine, Lcsw**, please ask us any questions that you may have.

V. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

A. The confidentiality of alcohol and drug abuse patient records maintained by **Lisa Levine, Lcsw** is protected by Federal law and regulations.Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or **drug/substance abuser** unless:

1. The patient consents in writing;

2. The disclosure is allowed by a court order; or

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

This does not include clients that are not substance users, **Lisa Levine** will not release any records under any circumstance.

B. Violation of the Federal Law and regulations by a program is a crime.Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

C. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.Disclosure may be made concerning any threat made by a client to commit imminent physical violence against another person to the potential victim who has been threatened and to law enforcement.

D. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

VI. EFFECTIVE DATE, THIS NOTICE IS EFFECTIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2\_\_\_\_.

I understand these disclosures.I have received a copy of this Disclosure Statement and Notice of Privacy Rights.

Client Signature

**ACKNOWLEDGMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

\*\*You May Refuse to Sign This Acknowledgment\*\*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices.

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Signature

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

Date

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For Office Use Only

**Lisa Levine, Lcsw**, attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained because:

\_\_\_\_ Individual refused to sign

\_\_\_\_ Communications barriers prohibited obtaining the acknowledgment

\_\_\_\_ An emergency situation prevented us from obtaining acknowledgment

\_\_\_\_ Other

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