Thank you for choosing B. Harrison Levine, MD. To help me get to know your family, please provide the information listed below to help me best help you and your child.

Attached are the following:

1. Intake packet – Please complete, sign all portions and return prior to your first appointment.
2. Treatment Contract
3. Custody/Divorce Agreement (if applicable)
4. Consent for Release and Retrieval of Medical/Mental Health Information
5. New Patient Intake Questionnaire
6. No-Show and Late-Show Policy
8. Consent for Metric Questionnaires
7. Electronic Payment Authorization.
8. Financial information including explanation of Electronic Payment service, fees

B. Harrison Levine, MD, Inc.
2060 Broadway, Suite 480
Boulder, CO 80302
720-389-5619

PATIENT
NAME:____

DATE OF BIRTH:____

PATIENT'S PARENT/GUARDIANS:____

____

1. I, ____ agree to guarantee and take responsibility for payment of all charges for services rendered to the above-named patient by Harrison Levine, MD. I understand and accept that my responsibility for such charges cannot be modified or assigned without the written consent of Dr. Levine.
2. I understand that Dr. Levine charges $400.00 per hour broken down by 15 minute intervals, or in-office consultation, that he charges $400.00 per hour, broken down into 15 minute intervals, for patient consultations via telephone extending over 15 minutes in length, and that he charges $400.00 per hour to review records and prepare reports, broken down by 15 minute intervals.
3. Follow-up appointments are at minimum every 3 months, unless otherwise determined by Dr. Levine
4. I understand that Dr. Levine requires direct payment at the time of service and does not bill insurance. Dr. Levine provides patients a statement that can be used for insurance reimbursement.
5. I understand that, other than in emergency situation, late cancellations (less than 24 hours notice prior to the appointment time) or "no shows" to scheduled appointment will result in my being held responsible for the full fee.
6. I understand that a delinquent account (over thirty days past due) will be charged interest at the legal limit of 1.5 percent (18% annual rate) thereafter until paid.
7. In the event that the above patient's account must be turned over to an attorney for collection, I accept full responsibility for all reasonable attorney's fees and costs that may be incurred by Dr. Levine in the collection of said account.

8. On behalf of the above named patient, a minor, I authorize Dr. Levine to release information pertinent to billing and collecting outstanding balances on patient's account.
9. With my signature, below, I provide my consent for Dr. Levine to provide treatment to the above named patient.

SIGNATURE OF GUARANTOR:____

GUARANTOR RELATIONSHIP TO PATIENT:_________________________________

SIGNATURE OF ADDITIONAL PARTY:_____________________________________

RELATIONSHIP TO PATIENT:____

DATE:____

B. Harrison Levine, MD, Inc.
2060 Broadway, Suite 490
Boulder, CO 80302

Informed Consent: Post Divorce/Two Family Agreement

Child: ______________________________ Is this a joint or sole custody? ___Joint ___Sole

Mother: ____________________________ Father: _______________________________

1: It is important for you to be informed about the services you will receive in this office. For your protection, you need to know the following.

A: **Litigation:** Psychiatrists provide diagnostic evaluations and medication management. Evaluations are often requested in terms of litigation that may arise post-divorce, for example, to help determine visitation or care patterns. The services I provide here are in the context of psychiatric care management. By signing this form, **I agree** not to request Dr. Levine to communicate with my attorney or with any court about what he knows about me or my child. Such communication can only occur through a second mental health professional hired specifically as an evaluator to offer recommendations to me or my attorney or the court. My child must place his or her trust on the services they receive here. Protecting the psychiatric process from litigation protects my child's trust.

B. **Special Circumstances regarding confidentiality. 1)** Psychiatrists working with children need to communicate openly with both parents, the child's therapist, pediatrician, and the school. Dr. Levine will make every effort to respect my privacy and maintain the appropriate boundaries between the two families. He will share only essential information with my child's physician and the school. By signing this form, **I agree** that information may be shared as Dr.Levine determines to be appropriate between members of my child's two families (including me and my child's other parent) , my child's therapist and the school personnel.

2) Psychiatrists working with children need to protect the trust the child places in his or her treating doctor. While general themes may be shared with parents, there are many specifics that may remain in the privacy of the psychiatrist's office. I understand my child's need for age-appropriate privacy in his/her psychiatric treatment.

C: **Involvement of both parents:** Dr. Levine will make every effort to make herself available for meetings with parents in a balanced fashion between households. Telephone contact is treated like a parent meeting and billed to the parent involved. I understand that reports are generally **not** available in this context.

By signing this form, I acknowledge having read and understood the above information, and agree to the above statements, conditions and limitations. I may request a copy of this form.

Signature of parent or guardian	Today's date
Signature of parent or guardian	Today's date

CONSENT FOR RELEASE & RETRIEVE OF MENTAL HEALTH INFORMATION

Patient Name: _____________________________ Date: ________

Please Note: If consultation is requested and information is to be exchanged between this provider and a third party, the name, address and phone number of the designated third party should be listed in both the* ***RELEASE and ***RETRIEVE*** *section below***

I hereby consent to **B. Harrison Levine, MD, Inc., to RELEASE** INFORMATION TO THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name Address Phone Number

____

____

____

____

____

I hereby consent to **B. Harrison Levine, MD, Inc,** to ***RETRIEVE*** INFORMATION FROM THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name Address Phone Number

____

____

____

____

____

AUTHORIZATION: I certify that this authorization to release and/or retrieve has been made voluntarily. I understand the information to be

released and/or retrieved may include information related to drug abuse, alcoholism or alcohol abuse. The released and/or retrieved information may also include psychiatric and HIV/AIDS conditions.

I understand that I may revoke this authorization at any time by giving written notice to **B. Harrison Levine, MD, Inc.**, except to the extent that **B. Harrison Levine, MD, Inc.**, has already taken action on this request. This authorization will expire six months from the date treatment is terminated.

____ _________________

Signature of Patient or Guardian Date

____ _________________

Witness Date

I am revoking consent and authorization to request or release information.

____ _________________

Signature of Patient or Guardian Date

NEW PATIENT INTAKE QUESTIONNAIRE

Please be advised that Parents/Caregivers who are divorced, or are currently divorcing and share custody, you must provide a signed consent to treat from both parents, a copy of the custody agreement designating parental decision making right, or both parents to participate in the initial appointment. **Dr. B. Harrison Levine does NOT offer custody/court ordered or forensic evaluations. He will not be able to testify in court or provide written or verbal recommendations related to parent fitness or custody.**

If you have any testing results for your child (educational or psychological), please provide copies at the time of submitting completed intake packet.

Child's Name: ____

Birth Date: _______________________________

Today's Date: _____________________________

Please describe the concerns you have that led to this referral. Examples: Concerning behaviors or disturbances in mood, sleep, appetite, anxiety, concerns about school performance, family or peer relations:

____

____

____

____

____

____

____

____

EMERGENCY CONTACT: (besides parent/legal guardian)
Full Name:____

Relationship to patient:________________________________Phone____________________

Today's date:__________________

PATIENT INFORMATION
Full Name:____
Date of Birth:_________/_________/_________
Social Security Number:__________-__________-__________
Street Address:____________________________________ City:__________________
State:_________ Zip: ________________
Home Phone (cell): __________________
Child's primary care physician (PCP, pediatrician): ____________________________
Street Address:____________________________________ City:__________________
State:_________ Zip: ________________
Phone:_____________________________
FAX:________________________________

PARENT OR LEGAL GUARDIAN #1
Relationship to patient: ____ Gender: M F
Full Name:____
Date of Birth:_________/_________/_________
Social Security Number:__________-__________-__________
Street Address:____________________________________ City:__________________
State:_________ Zip: ________________
Home Phone: __________________
Cell Phone: _____________________
Work Phone: ___________________
Place of Employment: ____
Employment Status: full-time part-time unemployed
Occupation: ____

PARENT OR LEGAL GUARDIAN #2
Relationship to patient: ____ Gender: M F
Full Name:____
Date of Birth:_________/_________/_________
Social Security Number:__________-__________-__________
Street Address:____________________________________ City:__________________
State:_________ Zip: ________________
Home Phone: __________________
Cell Phone: _____________________
Work Phone: ___________________
Place of Employment: ____
Employment Status: full-time part-time unemployed
Occupation: ____

Did your child ever experience any type of trauma (physical, emotional, sexual, medical abuse, exposure to violence)? YES NO

If YES, please explain:

____

____

____

____

____

____

Child's Past Therapists, Counselors, Psychiatrists (if any):

Name	Address	Phone Number	Dates of Service

Family Background

Are the Parents/Caregivers of this child:

Married YES NO Date:______________________

Separated YES NO Date:______________________

Divorced YES NO Date:______________________

Remarried YES NO Date (1st Caregiver/Mother):______________

Date (2nd Caregiver/Father):______________

Did the 1st caregiver/mother have any previous marriages? YES NO Date:_____

Did the 2nd caregiver/father have any previous marriages? YES NO Date:______

Is your child adopted? YES NO If yes, at what age?___________

Parents/Caregivers occupations?

1st caregiver/mother: ____________________________________

2nd caregiver/father: ____________________________________

Highest level of education of each parent/caregiver?

1st caregiver/mother: ____________________________________

2nd caregiver/father: ____________________________________

Other children living in the home:

Name, age: ____

Name, age: ____

Name, age: ____

Name, age: ____

Name, age: ____

Name, age: ____

Other relatives or persons living in the home:

Name, age: ____

Name, age: ____

Name, age: ____

Name, age: ____

Siblings/Half-Siblings/Step-Siblings NOT living in the home:
Name, age: ____

Name, age: ____

Name, age: ____

Name, age: ____

EDUCATIONAL INFORMATION:
Name of current school:___________________________________Phone:__________

Primary teacher's name:___________________________________Grade:__________

Type of school: Public Private Special____________________________________

Grades repeated:________ Grades skipped:________

Expelled? YES NO How many times?________

Does your child have any known learning disabilities? YES NO

Does your child have an IEP (Individual Education Plan)? YES NO

Is your child receiving any special education services (speech, reading, etc.?)?

YES NO

____

____

____

____

____

How has your child's behavior and academic performance been over the past month?

____

____

____

____

____

Please fill in for current and all previous school years:

Grade	School Name	Academic Performance			Behavior		
		Good	**Fair**	**Poor**	**Good**	**Fair**	**Poor**
Pre-K							
KG							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

MEDICAL HISTORY OF CHILD: Has your child had any of the following?

	YES	NO	Comments
Allergies			
Allergies to medications			
Asthma			
Hearing problems			
Vision problems			
Meningitis or encephalitis			
Head injury			
Concussion			
Seizures (convulsions)			
Heart problems?			
Dizzy or passed out with exercise?			
Irregular or abnormally rapid heart beat?			
Other injuries			
Other illnesses			
Any hospitalization?			

List all medications (psychiatric, medical, over the counter and/or herbal, supplements) that your child currently takes, with dosages:

____

____

____

____

____

____

____

____

FAMILY MEDICAL HISTORY: Please check illnesses that any of your child's BIOLOGICAL relatives have experienced:

Illness	Mother	Father	Sister/Brother	Aunt/Uncle	Grandparent	Cousin
ADHD						
Allergies						
Alcohol/drug abuse						
Anxiety						
Asthma						
Bipolar disorder						
Depression						
Sudden death before age 50						
Epilepsy (seizures)						
Learning problems						
Heart problems						
High blood pressure						
High cholesterol						
Legal problems						
Mania						
Obsessive-compulsive disorder (OCD)						
Panic disorder						
Schizophrenia						
Thyroid problem						
Tics						

DEVELOPMENT AND MEDICAL HISTORY

Birth History Biological mother's age at time of birth: ____________________

Biological father's age at time of birth: ______________________

Was this a planned pregnancy? YES NO

Was this a desired/wanted pregnancy? YES NO

Did biological mother smoke during pregnancy? YES NO

Drink alcohol? YES NO Use Illicit drugs? YES NO

Was biological mother under a doctor's care during pregnancy? YES NO

Were there any complications during pregnancy? YES NO

____

____

____

Was the delivery:

On time? YES NO

Early? _________ (number of weeks)

Vaginal? YES NO Forceps? YES NO Caesarean? YES NO

What were the APGAR scores? _______________________

Was the baby in the hospital for more than 2 days? YES NO

Did the baby require oxygen after birth? YES NO

____

____

____

As closely as you can remember:

Age of sitting alone _________ Age of rolling over _________ Age of walking _________

Large motor skills developed: FAST SLOW AVERAGE

Fine motor skills developed: FAST SLOW AVERAGE

Did your child seem clumsier than other children? YES NO

Did your child point to things? YES NO

Age of first words? _________ Age of talking in sentences? _________

Is your child: Right-handed_____ Left-handed _____ Uses both hands equally _____

Age when child chose one hand more than the other _____

Age when child stayed dry during day _____

Age when child stayed dry during night _____

Age when child was bowel trained _____

As an infant/toddler did your child establish the following routines normally?

Sleep/wake cycle YES NO Eating? YES NO Did your child have colic? YES NO

Was your child interested in other people? YES NO

Was your child overly sensitive to:

Sounds? (sirens, loud noises, etc) YES NO ______________________________

Sensations? (clothing tags, socks, light touch, movements such as swinging?)

YES NO ____

Smells? YES NO ____

Tastes? YES NO ____

Was your child Slow to Warm Up? YES NO Shy? YES NO

Underactive? YES NO Overactive? YES NO Aggressive? YES NO

Current sleep routines

On average, how many nights per week does your child

Sleep in his/her own bed? ______/7 nights

Fall asleep within 20 minutes? _____/7 nights

Sleep in Parent/Caregiver's bed? _____/7 nights

Complain of feeling tired or not rested? _____/7 nights

Usual bedtimes: During school week? _____________ Weekends/vacations? _________

Wake up time? During school week? _____________ Weekends/vacations? _________

No Show and Late Policy

No Show:
If you are unable to attend a scheduled appointment, please call 720-389-5619 to notify our staff **at least 24 hours in advance.**

If you fail to notify our staff of your intended absence of at least 24 hours in advance and you don't show for an appointment, you will be considered a "no show" for this appointment. If you cancel on the same day as your appointment you will be considered a "no show" for this appointment.

If you are a "no show" more than 2 times, you will be considered no longer under this provider's care and will be required to make further psychiatric arrangements on your own.

Late Show:
Patients and families who arrive 15 minutes or more past their scheduled appointment time will need to be rescheduled.

I, the undersigned, have read, understand and agree to follow the above conditions.

Parent or Guardian Printed Name:

____ Date: ____________________

Parent or Guardian Signature:

____

Metric Questionnaire Legal Agreement

I ___________________________ hereby give Dr. Harrison Levine & assistant Melanie Gordon permission to retrieve information from me via phone call in order to provide me with a metric of my progress. I understand that once a month I will be asked a series of yes or no and numerical rating scale questions and guarantee the answers I provide will be accurate to the best of my abilities.

I understand that the goal of this metric is to give a visual depiction of my progress from beginning of my medical treatment with Dr. Levine and subsequent advancement in mental health.

I am confident that my answers will be kept secure and not shared with anyone who is not on my release form. I am comfortable with answering questions on the phone and am aware that a questionnaire for metrics may take up to 10 minutes.

Signature: _______________________________

Payment Policy

My practice's policy is to securely store a form of payment on file for all of your sessions. I am deeply committed to the therapeutic climate and want your therapeutic experience to be focused on you and your treatment goals.
By allowing you to use a credit or debit card, I can avoid taking time away from your therapeutic work to check you in and process payment. Additionally, I want patients focused on their clinical work before session, during session and after you leave – paying each week disrupts this process and can distract you from focusing on getting better. With this method each session you attend is 100% focused on treatment. Each month you will receive an automated statement by email. Statements will show that you have paid for your services in full and are ready for you to forward to your insurance company if you wish to seek reimbursement.

I don't bill insurance carriers directly; my practice model depends on spending more time with patients rather than insurance paperwork. This way so we can insure that your experience in therapy is 100% focused on your care, versus adding another party to the insurance billing process which slows things down and which distracts us from our clinical work... However I am glad to hear you have insurance and I strongly advocate for patients utilizing their benefits... each month I provide all of my patients with an insurance ready statement that they can use for reimbursement, I advise all new patients to call their insurance carrier to see what their out of network benefits may be. Many of my patients receive reimbursement for the services they have paid for.

Payment Rates

Generally $400 per hour
New Evaluation: up to 2 hours ($800)
Return Visits: 20-30 minutes ($200)
Phone calls: Free and encouraged. If a phone call lasts longer than 15 minutes it will then be considered a session and charged according to the hourly rate.

Frequency of Visit Policy

To remain in the care of this doctor, you must be seen at least every 3 months. If less frequent visits are considered appropriate, we will discuss whether the patient's primary care/pediatric physician can manage treatment.

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: American Express, Visa, MasterCard and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Patient Information:

Patient Name: ____

Date of Birth: ___________________ Address: _________________________

City___________________ State: _______ Zip: ________

Home Number: ___________________________

Mobile Number: ___________________________

Cardholder Information:

Please indicate the name and address associated with the credit or debit card you wish to use. Name:
____

Address: _________________________ City___________________ State: _______

Zip: ________

Email: ____

I authorize any service fees to be deducted from the credit or debit card ending in _____________ (provide the last four digits of the card).

____ _____________________

Cardholder Signature Date

Credit/Debit Card Information:

Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your first payment has been made.

Card Type (circle one): Amex Visa MasterCard DiscoverCard

Number:

____

Expiration Date: ______________

CVS (3-4 digit code):__________________