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

Attached are the following:

1. Intake packet – Please complete and return prior to your first appointment.
2. Consent for Release and Retrieval of Medical/Mental Health information.
3. New Patient Intake Questionnaire
4. No Show and Late Show Policy – must be signed and returned with packet
5. Consent for Metric Questionnaires
6. Electronic Payment Authorization through NueMD.
7. Financial information including explanation of Electronic Payment service, fees

**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 Patient or Guardian Date

# NEW PATIENT INTAKE QUESTIONNAIRE

**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 (educational or psychological), please provide copies at the time of submitting completed intake packet.

Patient'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/work 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): _____
Patient's primary care physician (PCP): _____
Street Address:_____City:_____
State:_____Zip: _____
Phone:_____
Work Phone: _____
Place of Employment: _____
Employment Status: full-time part-time unemployed Occupation: _____
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 you ever experience any type of trauma (physical, emotional, sexual, medical abuse, exposure toviolence)? YES NO

If YES, please explain:

_____

_____

_____

_____

_____

_____

Your Past Therapists, Counselors, Psychiatrists (if any):

| Name | Address | Phone Number | Dates of Service |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**FAMILY BACKGROUND**

Are you:

| | | | |
|---|---|---|---|
| Married | YES | NO | Date:_____ |
| Separated | YES | NO | Date:_____ |
| Divorced | YES | NO | Date:_____ |
| Remarried | YES | NO | Date (1st Caregiver/Mother):_____ |
| | | | Date (2nd Caregiver/Father):_____ |

Do you have any children?

| | | | |
|---|---|---|---|
| Biological | YES | NO | Date of birth:_____ |
| | | | Date of birth:_____ |
| | | | Date of birth:_____ |
| | | | Date of birth:_____ |
| | | | Date of birth:_____ |
| Not biological | YES | NO | Date of birth:_____ |
| | | | Date of birth:_____ |
| | | | Date of birth:_____ |
| | | | Date of birth:_____ |
| | | | Date of birth:_____ |

Are your Parents/Caregivers:

| | | | |
|---|---|---|---|
| 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:_____

Are you 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 individuals living in the home:
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: _____

**EDUCATION/WORKPLACE INFORMATION:**
School/Workplace:_____Phone:_____

Type of school attended: Public Private

Special_____

Grades repeated:_____Grades skipped:_____

Expelled? YES NO How many times?_____

Highest education level achieved:_____

Do you have any known learning disabilities? YES NO

Did you have an IEP (Individual Education Plan)? YES NO

Did you receive any special education services (speech, reading, etc?)
YES NO

How has your behavior and academic/work performance been over the past month?

**MEDICAL HISTORY: Have you 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 you currently take, with dosages:

_____

_____

_____

_____

ALCOHOL/SUBSTANCE USE:
How much Alcohol do you drink?

Preferred beverage:_____
Drinks per day: _____
Drinks per week:_____

How many cigarettes do you smoke?

Per day:_____
Per week:_____

What other substances do you use with any regularity?

| Substance | Amount per day | Amount per month |
|---|---|---|
| Marijuana | | |
| Cocaine (powder? Crack?) | | |
| Methamphetamine | | |
| Hallucinogens (LSD, mushrooms) | | |
| Ecstacy | | |
| Other: | | |
| | | |
| | | |

Family Medical History: Please check illnesses that any of your 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** | | | | | | |

If known, **DEVELOPMENTAL AND MEDICAL:**

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

Biological father's age at time of birth: _____

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

_____

_____

_____

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

Were you clumsier than other children? YES NO

Did you point to things? YES NO

Age of first words?_____Age of talking in sentences? _____

Are you: Right-handed____ Left-handed _____ Uses both hands equally ____

**CURRENT SLEEP ROUTINES:**

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

Usual bedtimes: During school/work week? _____

Weekends/vacations?_____

Wake up time? During school/work 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 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.

Printed Name:

_____Date: _____

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 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 treatment can be managed by the patient's primary care/pediatric physician.

# ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice and NueMD Payment Systems Authority. The following forms of payment are accepted: 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): Visa MasterCard DiscoverCard

Number:

_____

Expiration Date: _____

CVS (3-4 digit code):_____