Consent to Treatment

Benefits:
Psychotherapy can have many benefits. It can help you learn to communicate better in your relationships, feel more connected to the important people in your life, create a sense of hope and direction in your life, relieve feelings of frustration, depression, or anxiety. It can help give you the tools to change your thinking, behavior and feelings to create positive outcomes in your life. You will determine the nature and amount of change you wish to make.

Risks:
In psychotherapy, major life decisions are sometimes made, including decisions involving separation with families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience, as a result, of an individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at times. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

Records:
I am required by law to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply. Also, in order to file for insurance reimbursement, I have to assign you a diagnosis. If you have any questions about this, we can discuss it together.

Confidentiality:
With very few exceptions, the information discussed during your therapy session and all documentation (written or in any other medium) is kept private and confidential. Some very important exceptions to this rule are: If there is a court order for the therapist to appear, or to produce the client's record. If your insurance company is involved, some information will be given after you sign the release of information part off the insurance form. If the therapist learns that there exists a serious threat to any person, including yourself. If there is evidence or suspected child, dependent adult or elder abuse.

Time:
Sessions are 45 minutes long, starting on the hour and ending 15 minutes to the next hour. Longer sessions can be scheduled if we agree that it will be helpful.

Fees:
My standard fee is $175.00 per session. I accept checks, cash and all credit cards, please note if you choose to use a credit card there will be a fee charged for processing (typically about $5).

Insurance:
I do not take insurance. I will provide you with the necessary forms each month that you can submit to your insurance company. The amount of reimbursement and the amount of any co-pays or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental health conditions. You should also be aware that you are ultimately responsible for verifying and understanding the limits of your insurance coverage. Although I am willing to assist your efforts to seek insurance reimbursement, (I will provide an invoice), I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please know that for the sake of determining insurance coverage, the services rendered will be Outpatient Mental Health, and my license is an LMHC (Licensed Mental Health Counselor). Please discuss any questions or concerns that you may have.

Cancellation Policy:
I will be reserving the time for you, so please give me as much notice as possible if you will not be able to make your appointment. My voice mail (561) 585-8787 is available 24 hours a day to receive messages. If you do not provide at least 24 hours notice of a cancellation, you agree to pay the full fee ($175.00) for a missed session.

Ending Therapy:
Your participation in therapy is voluntary and you have the right to end therapy whenever you want. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a counseling session together. I ask that you allow at least, one final session for us to have an ending together, to review what we've done and to offer feedback to each other. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals, for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs.

Informed Consent Form
I/we have read, understand and agree to the information and policies described in the Informed Consent Form.
I/we have read, understand and agree to the cancellation policy.

I/we understand that if I/we miss a scheduled session and I/we do not provide at least 24 hours notice or if the absence is not due to a hospital emergency, I/we agree to pay the full payment ($175.00) or applicable co-pay for the missed session.

Print Name:

Signature:

Print Name:

Signature:

Leslie A. Zebel, PhD, LMHC, CAP, Psychotherapist

Leslie A. Zebel, PhD, Psychotherapist
Licensed Mental Health Counselor #4375
Certified Addictions Professional#1761
7401 South Olive Avenue , West Palm Beach, Florida 33405-5039
(561) 585-8787 www.drlesliezebel.com

Confidential Information

Please provide the following information . Please note: information you provide here is protected as confidential information.

Name:____
(Last) (First) (Date)

Address:____
(Street Address)

____
(City) (State) (Zip)

Home Phone: ( )____________________ May we leave a message? ☐ Yes ☐ No

Cell: ( )__________________ May we leave a message? ☐ Yes ☐ No

Emergency Contact : _________________________________/
phone:__________________________

Birth Date:____ /____ /____ **Age**: __________ ☐ Male ☐ Female

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age:
____

Email:____

Referred by: ____

Are you currently taking any prescription medication?
☐ Yes ☐ No

Please list:____
____
____
____
____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No

☐ Yes therapist/practitioner:____

Counseling History:____
____
____
____

Family Mental Health History

In the section below, identify a family history of any of the following. If yes, please indicate the family member's relationship to you. (father, grandmother, uncle, etc.)

Alcohol/Substance Abuse	☐ No	☐ Yes, family member ____________________
Anxiety	☐ No	☐ Yes, family member____________________
Depression	☐ No	☐ Yes, family member____________________
Domestic Violence	☐ No	☐ Yes, family member____________________
Eating Disorders	☐ No	☐ Yes, family member ____________________
Obesity	☐ No	☐ Yes, family member ____________________
Obsessive Compulsive Behavior	☐ No	☐ Yes, family member ____________________
Schizophrenia	☐ No	☐ Yes, family member ____________________
Suicide Attempts	☐ No	☐ Yes, family member ____________________

Additional Information:

1. Are you currently employed? ☐ Yes ☐ No Occupation:______________________________

2. What would you like to accomplish with psychotherapy?

____
____
____
____

____________ **PLEASE NOTE**: Cancellations without 24 hours notice are charged @ full fee.
(initials) Please, only use my office number @ 561-585-8787 to change appointment times. Thank you.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.
For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.
Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION.
Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

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9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

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7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on [August 1, 2014]
Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

I, ______________________________________, have read, understand, and agree to the Privacy Practices.

Signature ____Date _______________________________

Telemental Health Informed Consent

I, ______________________________________, hereby consent to participate in telemental health with,

____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at____________________ to discuss since we may have to re-schedule.

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7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: ____

and my emergency contact person's name, address, phone: ____________________________

____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

________________________________ ______________

Signature of client/parent/legal guardian Date

_________________________________ _______________

Signature of therapist Date

The information is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case. ***Nothing reported herein should be used as a substitute for the advice of competent counsel.***

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Credit Card Authorization Form

If you wish to pay for future visits scheduled with Leslie via credit card please fill out the following form.

PATIENT’S NAME :

PATIENT’S EMAIL :

NAME OF CARDHOLDER (How it appears on the card) :

BILLING ADDRESS :

CITY :

STATE :

ZIP CODE :

CARD TYPE:

- ☐ VISA
- ☐ MASTERCARD
- ☐ AMEX
- ☐ DISCOVER

CREDIT CARD NUMBER :

EXP DATE :

CVV NUMBER (3-digit number on the back of the card) :

I hereby authorize Leslie Zebel PhD, Psychotherapist to charge the above credit card for the patient name listed above. I certify I have full authority to make purchases on behalf of the account listed above. Please note in the event that you fail to come to your scheduled appointment, or do not provide at least 24 hour notice of your cancellation, your card will be charged a cancellation fee, as indicated by the Informed Consent policies.

SIGNATURE OF CARD HOLDER :

DATE :

PRINTED NAME :