

Peter LeVine, PH.D.

709 Kimbark St
Longmont, CO 80501
Phone: 303-678-7455
Fax: 303-772-3887

Credentials:

Licensed Clinical Psychologist (Colorado #2011)
PH.D, Clinical Psychology, The Fielding Institute, 1993
MA, Psychology, West Georgia College, 1980
BA, American History, Boston University, 1970

Your Rights as a Patient

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies, Mental Health Section. Any questions, concerns, or complaints regarding the practice of mental health may be directed to the State Board listed below.

You are entitled to receive information about, methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.

You may seek a second opinion from another therapist or may terminate therapy at any time.

You should know that in a professional relationship, sexual intimacy is never appropriate and should be reported to:

The Colorado State Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1340 Denver, CO 80202 or phone 303-894-7766.

You should understand that information provided by you during therapy is legally confidential if the therapist is certified school psychologist, a licensed marriage and family therapist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychologist. If the information is legally confidential the therapist cannot be forced to disclose the information without the client's consent.

There are exceptions to the general rule of confidentiality which are listed in the Colorado statutes (section 12-43219CRS). You should be aware that except in the case of information given to a licensed psychologist legal confidentiality does not apply to a criminal or delinquency proceeding. I will identify other exceptions as they arise during therapy.

General information and policies:

You may leave a message on my voice mail at any time. I make every effort to return calls within 24 hours. Urgent messages (dial 989 after phone number) should constitute clinical emergencies, not routine business matters, your bill or time of your appointment. You may ask any questions about my theory of therapy, my reasons for any policy about which you may have concern, or your bill.

Payment is expected at each session. **Cancellation must be made within 24 hours notice to avoid being charged for session.** In the event that any sums invoiced and due for services provided in connection with this agreement are not paid when due, client and any person who has assumed the obligation of client agrees to pay, and as a consequence of non-payment, all costs and expenses, including reasonable attorneys' fees, which may be incurred in collecting any sums which may be due and owing, or any parts thereof, whether or not litigation is commenced or initiated.

The information you provide during therapy is confidential except for certain conditions which I will discuss with you. I am also requesting permission to provide your insurance company or its representatives with any information regarding your diagnosis and treatment or for the individual for whom you are the legal guardian. This information may include (but not be limited to) information about diagnosis and treatment, insurability and peer review for the purpose of determining continued insurance support.

I have read the preceding information and understand my rights as a patient.

I hereby acknowledge that I have received the provider's notice of Privacy Rights.

Patient Signature and Date:

Therapist Signature and Date:
