Lori Karch, LCSW
Advanced Certified Imago Therapist

Today's Date _____

Name _____ Partner's Name _____

How long have you been in relationship with each other? _____

Do you live together? Y N If yes, for how long? _____ Are you married? Y N

Address _____

City/State/Zip_____

Phone _____Mobile _____

Email _____

Birthdate _____/_____/_____ Age _____ Anniversary date _____

Social Security # (only if you want insurance or third party billing paperwork)_____

How did you hear about us?_____

What made you come in for an appointment today? _____

_____

What would you like to achieve from your sessions? _____

_____

Are you currently receiving psychotherapy, psychiatric or professional counseling services elsewhere? Yes___ No ____

Names of concurrent or previous therapists _____

Current medications: _____

_____

How is your physical health?	Poor 1	2	3	4	Excellent 5
How do you sleep at night?	Poor 1	2	3	4	Excellent 5
How is your nutrition?	Poor 1	2	3	4	Excellent 5
How is your mental health?	Poor 1	2	3	4	Excellent 5

Please list children's names and ages

_____ _____ _____

_____ _____ _____

How would you describe your parents' relationship? _____

_____

List the names and order of your siblings including yourself

_____ _____ _____

_____ _____ _____

Are you currently having a problem with or do you have a history of having a problem with any of the following?

Addictions	Yes	No	Homicidal ideas/attempts	Yes	No
Affairs	Yes	No	Legal problems	Yes	No
Anger	Yes	No	Lying	Yes	No
Anxiety	Yes	No	Panic Attacks	Yes	No
Bi-Polar disorder	Yes	No	Past relationships	Yes	No
Borderline personality	Yes	No	Physical abuse	Yes	No
Compulsive behaviors	Yes	No	Schizophrenia	Yes	No
Depression	Yes	No	Sexual abuse	Yes	No
Eating disorder	Yes	No	Sexual desire	Yes	No
Emotional abuse	Yes	No	Sexual performance	Yes	No
Financial difficulties	Yes	No	Suicidal ideas/attempt	Yes	No
Gambling	Yes	No	Trauma history	Yes	No
Hoarding	Yes	No	Working too much	Yes	No

Release of Information

I hereby authorize Evolve Therapy and Lori Karch, LCSW, to release any and all information, documents or records of any kind, verbally or in writing by telephone, fax, email or mail regarding _____ to my partner _____ .
(fill in your name) *(fill in your partner's name)*

Signed _____ Date _____

Witnessed and signed by Evolve Representative:

_____date _____

Payment Information

Payment is due at the time of service. The fee is $110.00 per 50 minute session, $165.00 for 80 minute session. Insurance assignments are not accepted, but your therapist will assist you if you believe a third-party payor will reimburse a portion of your bill. The therapist does not negotiate the above fee with insurance companies. Sessions not cancelled 24 hours in advance will be billed.

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize **Lori Karch, LCSW** to use and disclose the health and clinical information of ***(print your name)***_____ for the purposes of Treatment*, Payment** and Health Care Operations***.

***Treatment** (includes activities performed by Lori Karch, LCSW, providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional).

****Payment** (includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre-certification and pre-authorization).

*****Health Care Operations** (includes the administrative and business functions of this practice).

You should review my ***Notice Of Privacy Practices*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because we reserve the right to change our privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted *in my office* indicating the effective date of our current ***Notice of Privacy Practices*** in the upper left hand corner. We will offer you a copy of the ***Notice of Privacy Practices*** on your first visit to us after the effective date of the current ***Notice of Privacy Practices***. *Y*ou will be given a copy of the ***Notice of Privacy Practices*** at your request.

As more fully explained in the ***Notice of Privacy Practices***, you may have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations. *We are not required to agree to your request*. If we agree, we are required to comply with your request unless the information is needed to provide emergency treatment to you.

Other practitioners who provide coverage for this practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices*** .

Please verify that you have received a copy of our ***Notice of Privacy Practices*** by signing your initials here _____.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that this practice has already used or disclosed the information in reliance on this CONSENT.

***Signature of Client*_____*Date*_____**

– OR –

*Signature of Legal Guardian or Representative*_____*Date*_____*
*Please indicate the nature of your relationship to the client*_____*