8 Hillside Avenue, Suite 206
Montclair, NJ 07042
www.evolve-ps.com

(917) 723-9986

Biographical Information

Personal Information:

Name: _____
Address: _____
_____
Home #: _____
Work #: _____
Mobile #: _____
Email: _____
Employer: _____
Occupation: _____
Address: _____
_____
DOB: _____ Age: _____
Gender: _____
Ethnicity: _____
Religion: _____
Language(s): _____
Marital status: _____
Children: _____

Emergency Contact Information:

Contact #1: _____
Relationship: _____
Address: _____
_____
Home #: _____
Work #: _____
Mobile #: _____
Email: _____

Contact #2: _____
Relationship: _____
Address: _____
_____
Home #: _____
Work #: _____
Mobile #: _____
Email: _____

Primary Insurance:

Insurance Company: _____
Plan Name: _____
Insured ID#: _____

Cardholder Name: _____
Employer: _____
DOB: _____

Referral Source:

□ Mental Health Provider: _____
□ Friend or Family Member
□ www.nicolegarciaphd.com
□ Other: _____

□ Primary Care Doctor: _____
□ Internet (google, yahoo, bing, etc): _____
□ www.psychologytoday.com

Forms of Communication:

Can psychologist leave messages on the mobile phone(s) provided above? □ Yes □ No
Can psychologist leave messages on the home phone(s) provided above? □ Yes □ No
Can psychologist communicate with me via text message (for non-clinical matters)? □ Yes □ No
Can psychologist communicate with me via the email (for non-clinical matters)? □ Yes □ No

_____ _____
Client Signature *Date*

Evolve Psychological Services, LLC

Client Report of the Problem

Name: _____ Date: _____

Description of Presenting Problem(s):
Briefly describe your reason(s) for seeking help.
Hong long have you had the problem(s)?
What do you think are the causes of your problem(s)?
Are there any kinds of support that make your problem(s) better, such as support from family, friends, others?
Are there any kinds of stresses that make your problem(s) worse, such as difficulties with money, family problems, medical problems, other kinds of issues?
Briefly describe any significant event(s) and/or change(s) that have occurred within the last year.
What have you done on your own to cope with your problem(s)?
Why did you decide to seek help now?
Has anything prevented you from getting the help that you need?
What kinds of help do you think would be most helpful to you at this time?

Current Household Composition:		
Name	Relationship	Age

Check any of the following items that apply to you:	
❒ Thoughts of suicide	❒ Thoughts of harming others
❒ Trouble getting to sleep	❒ History of attempts to kill yourself
❒ Waking during the night	❒ Cutting or hurting yourself
❒ Waking early every day	❒ Feelings of hopelessness
❒ Loss of appetite	❒ Inability to make decisions
❒ Excessive guilt	❒ Trouble controlling your temper
❒ Decreased motivation	❒ Large weight gain or loss
❒ Excessive energy	❒ Seeing things others do not
❒ Trouble concentrating	❒ Hearing voices
❒ Racing thoughts	❒ Violence toward others
❒ Forgetfulness	❒ Tingling or numbness
❒ Obsessional thoughts	❒ Flashbacks
❒ Compulsive behaviors	❒ Depressed mood
❒ Disorganized/Disruptive thoughts	❒ Irritability
❒ Paranoia	❒ Impulsivity
❒ Mood swings	❒ Expansive/Elevated mood
❒ Phobias	❒ Anorectic/Bulimic behavior
❒ Panic attacks	❒ Somatic symptoms
❒ Anxiety	❒ Learning problems
❒ History of physical abuse	❒ Problems at work
❒ History of sexual abuse	❒ Family problems
❒ Financial problems	❒ Legal problems
❒ Health problems	❒ Alcohol/substance abuse problems

Mental Health Treatment History:
Are you currently under the care of a psychiatrist? If yes: What is the name of the psychiatrist? What are your diagnoses? What medications, if any, are currently prescribed? Do you consistently take the medication prescribed? What are the positive and/or negative effects of the medication?
Have you ever received outpatient mental health treatment? If yes: For what reasons did you seek help? Did it help? With whom were you in treatment? How long were you in treatment? Were you prescribed any medication?
Have you ever received inpatient mental health treatment? If yes: For what reasons did you seek help? Did it help? In what hospital did you receive treatment?

How long were you in treatment? Were you prescribed any medication?
Do you have a family history of emotional problems? If yes: Who? Relationship?

Alcohol and Drug Use History (please check any of the following substances that you are currently using and provide information regarding usage)**:**					
Substance	Age first used	Weekday use	Weekend use	Monthly use	Last used
❒ Beer					
❒ Liquor					
❒ Wine					
❒ Marijuana					
❒ Cocaine/Crack					
❒ Methamphetamine					
❒ Heroin					
❒ Barbituates (downers)					
❒ PCP, LSD (hallucinogens)					
❒ Tobacco (any form)					
❒ Other:					
Have you ever felt like you should cut down on your drug/alcohol use?					□ Yes □ No
Has a friend or relative expressed concern about your use?					□ Yes □ No
Have you ever felt guilty about your drinking or drug use?					□ Yes □ No
Have you ever had to take a drink or use a drug the next day to steady your nerves?					□ Yes □ No
Are you in recovery from abusing alcohol or drugs?					□ Yes □ No
Is there a history of problems with drug or alcohol use in your family?					□ Yes □ No

Physical Health History:
Are you currently under the care of a primary care physician? If yes: What is the name of your physician? What are your diagnoses? What medications, if any, are currently prescribed? Are you consistently taking the medication prescribed? What are the positive and/or negative effects of the medication?
List any medical or physical problems and when they were diagnosed:
List any major surgeries you have had to date:
List any serious illness or injuries including any head injuries:
List any allergies to foods or drugs:
Date of last physical examination:

_____ _____

Client Signature *Date*

Evolve Psychological Services, LLC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the American Psychological Association Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse, neglect, or abandonment; the reporting of the abuse, neglect, or exploitation of an elderly or disabled person; or mandatory government agency audits or investigations (such as the psychology licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer: Nicole Garcia, PhD, Evolve Psychological Services, 8 Hillside Avenue, Suite 206, Montclair, NJ 07042**.**

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. This right includes medical records and billing records but does not include psychotherapy notes. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer: Nicole Garcia, PhD, Evolve Psychological Services, 8 Hillside Avenue, Suite 206, Montclair, NJ 07042, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2008.

Evolve Psychological Services, LLC

Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Evolve Psychological Services' Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Dr. Garcia, Owner, Evolve Psychological Services, at the address and/or phone number below:

8 Hillside Avenue, Suite 206
Montclair, NJ 07042
(917) 723-9986.

_____
Client Signature

_____
Relationship

_____
Date

Evolve Psychological Services, LLC

Informed Consent for Adult Psychotherapy

This form documents that I _____ hereby give my consent and agree to accept psychotherapeutic treatment from _____.

I have fully discussed with the psychologist what is involved in psychotherapy and I have agreed to the policies about scheduling, fees, missed appointments, third party payments and other matters outlined below. Our discussions have included the initial consultation phase of the treatment, provisional diagnostic formulations of my problems, the proposed method of treatment, the guidelines for confidentiality, and record keeping. I have been informed and understand the goals of treatment as well as the foreseeable benefits and risks of treatment. In addition, the psychologist has discussed how to reach the psychologist in emergency situations.

I understand that information about psychotherapy is kept confidential and will not be revealed to others without written consent. Some exceptions are:

1. The psychologist is required by law to report suspected child abuse or neglect or suspected abuse of an elderly person to the authorities.
2. In the event that I intend to harm another person or myself and there is immediate danger present the psychologist may be required to take steps to warn or protect the person at risk by informing that person, designated family members, the police, or other health care providers.
3. The psychologist may need to inform a covering therapist about some aspects of treatment when the therapist is away or unavailable.
4. If my health insurance or managed care plan will be reimbursing me for services rendered, it may require that I waive confidentiality and the psychologist to provide them with information about my treatment.

I understand that the sessions will be occurring at an agreed upon time and fee, $_____, lasting for 45-minutes and that I will be responsible for payment at the time of each session. Unless the psychologist receives 24 hours' notice of canceling the appointment, I am responsible for the payment of that session at the full fee, $_____. Additional clinical face-to-face time will be prorated in 15 minute increments according to the fee above. I also understand that I am responsible for the payment of other services that we may request including report writing, telephone consultations with other mental health providers, medical providers, etc, preparation of records or treatment summaries, and time spent performing any other service, and that such services will be prorated in 15 minute increments according to the fee above.

I understand that I can discuss the terms of the psychotherapy agreement with the psychologist including the goals and frequency as well as any financial aspects. By signing below I am attesting to the fact that I have read, discussed, and understood this form and give my consent to treatment.

_____ _____

Client Signature *Date*

Evolve Psychological Services, LLC

Consent for Release of Information

Client Name: _____ Date: _____

Address: _____ Home #: _____

_____ Mobile #: _____

Nature of information to be disclosed: Emotional, Behavioral, Medical and/or Academic Functioning

Purpose for release of information: Treatment Planning/Care Coordination

Information of professional providing information:

Name: _____ Office #: _____

Institution: _____ Fax #: _____

Information of psychologist receiving information:

Name: _____ Office #: _____

Institution: Evolve Psychological Services Fax #: (973) 744-2054

I hereby authorize the periodic release of the above information to the person identified above as often as necessary to plan for treatment or testing. I understand that I have the right to cancel my permission to release information at any time.

My consent to release information from the Person/Facility identified above will expire when I am no longer receiving services or one year from this date whichever occurs first.

_____ _____ _____

Signature of Client/Person Acting for Client *Relationship* *Date*