Margaret Berg, LCSW
Certified Imago Therapist

IMAGO RELATIONSHIPS

Today's Date _____

Name _____ Partner's Name _____

Please describe your:

Biological Sex:_____ Gender:_____ Sexual Orientation:_____

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

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

Relationship Status [married, single, etc.]: _____

Address _____

City/State/Zip_____

Phone _____Mobile _____

Email _____ May I email you?_____

Birthdate _____/_____/_____ Age _____

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.....5..... Excellent

How do you sleep at night? Poor 1.....2.....3.....4.....5..... Excellent

How is your nutrition? Poor 1.....2.....3.....4.....5..... Excellent

How is your mental health? Poor 1.....2.....3.....4.....5.....Excellent

How would you describe your satisfaction with your sex life/intimacy? _____

_____

Are you struggling with any sexual concerns? (Y or N) If Yes, what are they and how do they effect you? _____

_____

Please list children's names and ages

_____ _____ _____

_____ _____ _____

How would you describe your parent's 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

Have you or a loved one experienced any dramatic change or event recently? Is there anything else that would be beneficial for me to know? _____

_____

_____

Release of Information

I hereby authorize Margaret Berg, 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 _____

Witness:

_____date _____

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize **Margaret Berg, 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 Margaret Berg, 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 right 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*_____

Effective Date: May 21, 2008

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions or requests concerning this notice, please contact Margaret Berg, LCSW at 906-221-6629.

WHO WILL FOLLOW THIS NOTICE.

This notice describes the information privacy practices followed by this practice, professionals, staff and other office personnel including any practitioner who might provide "call coverage" for your practitioner.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the services you receive from this practice. We are required by HIPAA law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

By State law and the ethics of our mental health professions, we must have your written, signed Consent to use and disclose health information for the following purposes:

… **For Treatment.** We use health information about you to provide you with clinical services. We may disclose health information about you to office staff or other personnel who are involved in taking care of you and your health.

… **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. **It is our policy to release only diagnoses, date, and type of service when we have your consent to bill third party payers.** If more information is requested by a payer, we will request your written authorization for that disclosure.

… **For Health Care Operations**. We may use health information about you in order to run the practice and make sure you receive quality care:

... **Appointment Reminders.** We may contact you as a reminder that you have an appointment. Please notify us if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contact.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time. If you are receiving Substance Abuse Treatment Federal and State law require your written Authorization each time we release health information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time. However, if we are unable to fulfill our requirements related to treatment, payment or health care operations, we may choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

… **To Avert a Serious Threat to Health or Safety.** Based on professional judgment, we may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

… **Required By Law.** Based on professional judgment , we will disclose health information about you when required to do so by federal, state or local law. Disclosures may be compelled by DHHS for compliance and enforcement purposes

… **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena. Such disclosures would be based on professional judgment.

… **Law Enforcement**. We may release health information if required to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

… **Family and Friends.** In situations where you are not capable of giving authorization (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we would disclose only health information relevant to the person's involvement in your care. For example, if you were in a mental health crisis, we might involve a family member or friend in helping you get to an appropriate care facility.

Additional disclosures are permitted under HIPAA regulation. These additional disclosures will not be made by this practice without your authorization; and they may be contrary to state law. However, once information leaves this practice and becomes part of any data resource beyond our control, HIPAA permits disclosure in the following circumstances:

… **Research**. Health information about you can be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address or other information that reveals who you are.

… **Military. Veterans. National Security and Intelligence**. If you are or were a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of health information about you. HIPAA also permits release of information about foreign military personnel to the appropriate foreign military authority.

… **Workers' Compensation**. Health information about you may be released for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

… **Public Health Risks**. Health information about you may be disclosed for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

… **Health Oversight Activities**. Health information about you may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

… **Information Not Personally Identifiable**. Health information about you may be disclosed in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

This practice will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of *treatment, payment or health care operations*, we will require a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

… **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as clinical and billing records. You do not have the right to inspect and copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. You must submit a written request to the designated privacy contact in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

… **Right to Amend**. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, complete and submit a clear statement of the amendment you request to the designated privacy contact. We may deny your request for an amendment if it is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

… We did not create, unless the person or entity that created the information is no longer available to make the amendment

… Is not part of the health information that we keep

… You would not be permitted to inspect and copy

… Is accurate and complete

… **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request **in writing** to the designated privacy contact. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

… **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not call you at your office, or that we not communicate with a certain family member, no matter what the circumstance.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may simply advise us in writing of specific limitations or restrictions you want placed on our use of health information for treatment, payment or healthcare operations. We will not ask you the reason for your request. We will accommodate all reasonable requests.

… **Right to Request Confidential Communications**. You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may simply advise us in writing of specific limitations or restrictions you want placed on our communications with you. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

… **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Margaret Berg, LCSW.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.