The Couch
Immediate Mental Health Care
ORA FRANKEL, MD~ DANIELLE ROGERS-CANDEE, PMHNP-BC
LINDSAY HEISTER, PMHNP-BC~ LORI HENSON, PMHNP-BC~ LAUREN LAZARUS, PMHNP-BC
2327 LIME KILN LANE • SUITE B • LOUISVILLE, KENTUCKY 40222
(502) 414-4557 • FAX 502-873-0021

We thank you for choosing *The Couch* for your immediate and continual mental health needs. Let us know if we can assist you in any way. We strive to help you feel satisfied and fully comfortable with every aspect of your care and treatment. Here at *The Couch* ,we believe that "getting help should be comfortable".

If you do not mind, please help our business continue to grow by taking a few moments to fill out a few questions. All information that you provide is protected under HIPPA law, and will not be disclosed in any manner without your direct written consent. Thank you very much for your time. If there is anything our staff can do to help you, please do not hesitate to ask.

If you were referred to The Couch, who told you about the office?

_____

If no one referred you, how did you hear about The Couch?

_____

Do you currently see a therapist or psychiatrist? ___Yes _____No

If yes, whom do you see? _____

Who is your most recent employer?_____

Would you like any of your records from today's appointment to be sent to a physician's office, therapist, or psychiatrist that you currently are a patient of?

_____Yes _____NO
(If you select "YES", please include their name on the following authorization forms)

Primary Pharmacy:_____

Pharmacy Zip Code:_____
Pharmacy Telephone Number:_____

Authorization for Release of Information

The Couch Immediate Mental Health Care
2327 Lime Kiln Lame, Louisville, KY, 40222
Phone: (502) 414-4557 Fax (502) 414-4557

Patient Name: Patient Date of Birth:

***Individual Health Information to be Provided, Received, or Disclosed*:** By signing this document, you authorize *The Couch Immediate Mental Health Care, PLLC* and the parties listed below to provide, receive, or disclose the following information about you/your child, indicated by the boxes checked below:

- ☐ Psychiatric Assessments or Evaluations
- ☐ Psychosocial History
- ☐ Physician Notes
- ☐ Medications
- ☐ Therapy Assessment/notes
- ☐ D/C Summary/Program Completion

***Reason for disclosure (This authorization not valid unless stated):* Ongoing treatment and collaboration**

- ☐ Other:_____

Parties Who May Provide, Receive, or Disclose Your/Your Child's Individual Information: *The Couch Immediate Mental Health Care, PLLC* may provide, receive, or disclose information to the following practitioners, providers, clinics, individuals, or other entities either verbally or in written in form as indicated by the boxes checked below:

- ☐ Pediatrician/Primary Care Provider (PCP)_____
- ☐ Psychiatrist/Pychologist/Therapist_____
- ☐ Family Members_____
- ☐ School_____
- ☐ Insurance Provider_____
- ☐ Other Parties or Entity_____

Expiration date: This authorization will not expire unless indicated by the check box below

- ☐ Please change the expiration period to last for:_____

I understand this Authorization can be revoked at any time according to the Notice of Privacy Practices of *The Couch Immediate Mental Health Care, PLLC.* This request must be made in writing. Treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization.

I have read and understand this information. I have also been given the opportunity to ask questions. I understand that specific type of information to be disclosed may include HIV/AIDS, drug, alcohol, mental health, medical history, and physical treatment. I have received a copy of this form (if I requested a copy). I am the patient or authorized to act on behalf of the patient to sign this document verifying authorization for the use of the disclosure of the protected health information under the above state terms.

_____ _____
Signature of Patient (or parent/guardian) Signature of Witness

_____ _____
Relationship to patient Date