



Peak View Psychology, LLC

Dawn M. Kugler, PhD

6745 Rangewood Dr., Suite 105

Colorado Springs, CO 80918-7329

Phone : (719) 268-0099 Fax : (719) 268-0097

Email : drdawn.kugler@peakviewpsychology.com

The reception area for Peak View Psychology, LLC is located at the following address:

Peak View Psychology, LLC  
6745 Rangewood Dr., Suite 104  
Colorado Springs, CO 80918

(719) 268-0099

**CLIENT REGISTRATION FORM**  
**PEAK VIEW PSYCHOLOGY, LLC**  
 Welcome and thank you for choosing Peak View Psychology

DATE \_\_\_\_\_

Are you a returning client? \_\_\_\_\_ If so, what was your last name then? \_\_\_\_\_

CLIENT'S LEGAL NAME \_\_\_\_\_ Maiden Name \_\_\_\_\_  
FIRST, MIDDLE, LAST

MAILING ADDRESS: \_\_\_\_\_  
NUMBER & STREET APT. # CITY STATE ZIP

PHONE: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Others that may be contacted for scheduling: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

MARITAL STATUS (circle one) N/A-CHILD SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SEX M\_\_\_ F\_\_\_ AGE\_\_\_\_ BIRTHDATE \_\_\_\_-\_\_\_\_-\_\_\_\_ SOC. SEC. # \_\_\_\_-\_\_\_\_-\_\_\_\_

REFERRED BY: \_\_\_\_\_ PRIMARY PHYSICIAN \_\_\_\_\_

\_\_\_SELF, FAMILY, FRIEND \_\_\_PHYSICIAN \_\_\_DHS \_\_\_ATTORNEY  
 \_\_\_YELLOW PAGES \_\_\_COURTS \_\_\_DDS \_\_\_OTHER \_\_\_\_\_

PLEASE LIST PAST THERAPY/TREATMENT/EVALUATION (Name, approximate dates)

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_-\_\_\_\_-\_\_\_\_

SPOUSE'S EMPLOYER NAME & ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**ADDITIONAL INFORMATION - WHEN CLIENT IS A MINOR**  
 (ONLY PROVIDE INFORMATION NOT GIVEN ABOVE)

LEGAL GUARDIAN/S (if other than parents) \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT \_\_\_\_\_

NAME OF FATHER \_\_\_\_\_ DOB \_\_\_\_\_ STEP-MOTHER (if any) \_\_\_\_\_

FATHER'S ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

NAME OF MOTHER \_\_\_\_\_ DOB \_\_\_\_\_ STEP-FATHER (if any) \_\_\_\_\_

MOTHER'S ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

\* CHILD'S SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

\* SCHOOL CONTACT PERSON \_\_\_\_\_ TITLE \_\_\_\_\_

\*OTHER PEOPLE LIVING IN HOME:

*NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**\*\*TURN THIS FORM OVER AND COMPLETE REVERSE SIDE\*\***

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Carrier\_\_\_\_\_

Carrier\_\_\_\_\_

Policyholder\_\_\_\_\_Relationship\_\_\_\_\_

Policyholder\_\_\_\_\_Relationship\_\_\_\_\_

Policyholder's DOB\_\_\_\_\_

Policyholder's DOB\_\_\_\_\_

Policyholder's SS#\_\_\_\_\_

Policyholder's SS#\_\_\_\_\_

**PLEASE FILL IN COMPLETELY-NOT ALL INFORMATION IS ALWAYS ON YOUR INSURANCE CARD**

Payment for your portion of charges is due at the time of service, unless other arrangements have been made. Appointments must be cancelled at least 24 hours in advance, as you may be billed for missed or late cancelled appointments.

\_\_\_\_\_ Initial here to acknowledge you've been made aware of this policy.

\*\*\*\*\*  
If you have any questions about psychotherapy or our office policies, please ask before signing below. Your signature indicates that you have read our office policies and that you seek and agree to enter into mental health services under those conditions. You understand that no promises have been made to you as to the results of any treatment or procedure provided by this provider. Further, it indicates your understanding that Peak View Psychology may terminate services if there is a lack of compliance with these policies or if we believe that you are not benefiting from treatment.

**CONSENTS**

**1. Consent For Evaluation and Treatment:**

Consent is given for evaluation and treatment by Peak View Psychology, LLC. It is agreed that either the provider or I may discontinue evaluation, consultation and/or treatment at any time and that the client is free to accept or reject the services offered or provided.

**2. Assignment of Insurance Benefits / Payment Agreement:**

Peak View Psychology will file all insurance claims unless otherwise directed. In the event that a client or responsible party is entitled to insurance benefits of any type arising from any policy which insures the client or other liable person, those benefits are hereby assigned to the provider for credit toward bills. The client and/or responsible party shall be financially responsible for any charges not paid by insurance. If payment is not made directly to the provider, payment in full is due from the client or responsible party. The undersigned agrees to pay the provider the assessed charges, in full, at the time of service unless other arrangements have been authorized. Payment may be made by cash or credit card. Personal checks will not be accepted. Note to divorced parents: Peak View Psychology will not bill the other parent unless that parent makes arrangements with us. It is your responsibility to seek any reimbursement from that parent.

**3. Release of Information for Medical Insurance Coverage to Insurance, Managed Care or EAP Company:**

In order to process and determine benefits payable, I hereby authorize my provider to release any necessary part of the client's record, as specified by the Notice of Privacy Practices, to any insurance carrier or entitlement program, which may be obligated to pay all or part of treatment charges. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain in effect and valid until this office receives a written revocation signed by the client or other authorized person. I certify that the information I have furnished is true and correct.

**4. Client Satisfaction Survey:**

I agree / do not agree (circle one) to possibly be contacted in the future for a confidential survey concerning the services received at Peak View Psychology.

**5. Notice of Privacy Practices:**

I acknowledge that I have received the Notice of Privacy Practices from Peak View Psychology.

\_\_\_\_\_  
Signature of Adult Client, or Minor Client's Parent or Guardian

\_\_\_\_\_  
Date

FOR OFFICE USE ONLY: DX and Therapist Initials\_\_\_\_\_



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Email : drdawn.kugler@peakviewpsychology.com

## Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychotherapist.
  - *Payment* is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our office and practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office or practice group, such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances where we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that, (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances: (see Colorado statutes: Section 12-43-218, CRS., in particular).

- *Child Abuse* - If we have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, we must immediately report this to the appropriate authorities.
- *Adult and Domestic Abuse* - If we have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then we must report this belief to the appropriate authorities.
- *Health Oversight Activities* - If the Colorado State Board of Psychologist Examiners or an authorized professional review committee is reviewing our services, we may disclose PHI to that board or committee.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party which has contracted for an evaluation of you, or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* - If you communicate to us a serious threat of imminent physical violence against a specific person or persons, we have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If we believe that you are at imminent risk of inflicting serious harm on yourself, we may disclose information necessary to protect you. In either case, we may disclose information in order to initiate hospitalization.
- *Worker's Compensation* - We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

### IV. Patient's Rights and Psychologist's Duties

#### Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a written copy in person if possible, otherwise a copy will be mailed to you.

**V. Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact:

Department of Regulatory Agencies, Mental Health Section  
1560 Broadway, Suite #1350  
Denver, Colorado 80202  
(303) 894-7800  
<https://www.doradls.state.co.us/alison.php>

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The department listed above can provide you with the appropriate address upon request.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Email : [drdawn.kugler@peakviewpsychology.com](mailto:drdawn.kugler@peakviewpsychology.com)

## Mandatory Disclosure Statement

### Therapist Information:

- Dawn M. Kugler, PhD
- Doctor of Philosophy from the University of North Dakota
- Colorado Licensed Psychologist #3482
- South Dakota Licensed Psychologist #328

### Client Rights and Important Information:

- You are entitled to receive information about my methods of therapy, the techniques I use, the duration of your therapy (if it can be determined), and my fee structure.
- Treatment and evaluations are voluntary and you have the right to terminate treatment or the evaluation at any time. You also have the right to seek a second opinion from another therapist at any time.
- Psychotherapy is not an exact science and there are no guarantees as to the outcome of treatment.
- The relationship between a therapist and a client is a professional relationship. Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.
- Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.
- Information disclosed to a therapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.
- *Please Note:* For individuals who are court ordered for treatment or evaluations and/or are under the supervision of probation, parole, or community corrections, the laws protecting confidentiality do not apply.
- There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Revised Statutes (C.R.S. 12-43-218) and in the Notice of Privacy Practices you were given and include: lawsuits against the therapist; complaints, disciplinary proceedings, and reviews of professional conduct; reporting child abuse and neglect; and *duty to warn* of serious threat of imminent physical violence to oneself or a specific person or persons. Other exceptions will be identified to you as the situations arise during therapy.
- Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed or registered mental health professionals. The agency within the Department that has responsibility specifically for licensed and registered psychotherapists is the Department of Regulatory Agencies, Mental Health Section. You can contact this agency by calling or writing:

1560 Broadway, Suite #1350  
Denver, Colorado 80202  
(303) 894-7800  
<https://www.doradls.state.co.us/alison.php>

As to the regulatory requirements applicable to mental health professionals: A Licensed Clinical Social Worker, A Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

If you have any questions or would like additional information, please feel free to ask. By signing below, you are in agreement that you have read the preceding information and understand your rights as a client. Your signature also confirms you have been given this information verbally.

\_\_\_\_\_  
Client Signature (Printed Name) Date

\_\_\_\_\_  
Authorized Signature (Printed Name) Date  
if Client is a minor

\_\_\_\_\_  
Minor Child's name (your relationship to child)

\_\_\_\_\_  
Therapist Signature (Printed Name) Date





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### OFFICE PROCEDURES AND CLIENT RESPONSIBILITIES

Welcome and thank you for choosing Peak View Psychology. We want to let you know about our policies. Please discuss any questions you may have with your therapist.

**APPOINTMENTS** -- Therapy sessions usually last approximately fifty minutes. Therapy will usually take a minimum of several sessions to be effective. You are encouraged to schedule an appointment whenever you think it is needed.

**ETHICAL AND PROFESSIONAL STANDARDS** -- As a mental health professional provider licensed by the State of Colorado, we do our best to uphold the most responsible and ethical standards possible. The laws of the State of Colorado require that most issues discussed during the course of therapy with a psychologist or social worker remain confidential. Please see the "confidentiality" section of this letter for specific details. If you have any questions or concerns about services provided by us, please first discuss these with your therapist.

#### **ELECTRONIC COMMUNICATIONS** -

**Email** - While the Electronic Communications Privacy Act prohibits interception of any electronic communications, email cannot be completely secure or private unless encrypted. At this time, email communications from Dr. Dawn Kugler and/or Peak View Psychology come from a secure server but are not encrypted. While we accept email communications, the content of electronic exchanges to and from us cannot be guaranteed to be confidential. For this and other reasons, Dr. Kugler does not conduct therapy over email. Please restrict email use to administrative issues (changing appointments, etc.) and be aware that any therapeutic content in emails will be retained in your permanent medical record.

**Social networking sites** - We do not accept friend requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Nor do we follow current or former clients on blogs or Twitter. Our reason for this is that we believe adding clients as friends or following online blogs can compromise confidentiality and blur the boundaries of our therapeutic relationship. If you have questions about this, please feel free to bring them up in session.

**Use of search engines** -It is NOT a regular part of our practice to search for clients on Google or other search engines. Exceptions to this may be made during times of crisis if we suspect you may be in danger. These are extremely rare situations and if we ever resort to such means, we will discuss this with you when we next meet.

**FEES** – Peak View Psychology’s fee schedule is:

- Initial session -- \$200
- Subsequent therapy sessions for individual or family therapy -- \$125 (phone consultations, except in case of emergency, may be pro-rated at this rate)
- Psychological evaluations -- \$175 per hour (includes test scoring and report writing; many managed care companies have negotiated alternate rates—we accept assignment from Medicare, Tricare and private insurance companies with whom we have a contract)
- Court testimony services -- \$300 per hour (testimony time, commuting, records review, and affidavit writing will be billed at this rate)

Legally, we cannot bill other individuals (including ex-spouses) for your services or any services which you consent to for your child. In such cases, we will bill you and it is your responsibility to get a guarantee of payment or reimbursement from the person who has agreed to pay or has legal responsibility for your bill. If a school district or the court system has contracted with us to provide services, please provide us with appropriate documentation and we will bill them accordingly.

Hourly fees include not only therapy, but can involve printed material, reports, letters, consultations, travel time for out of office services, and telephone calls. If you have any questions regarding your billing, please contact us at 719-268-0099.

**CONFIDENTIALITY** – The communication between you and your therapist is confidential. This means you have the privilege to refuse to disclose and to prevent your therapist from disclosing confidential communications made for the purpose of diagnosis or treatment without your written consent.

No disclosure can be made, with the following exceptions:

- If you have abused or are abusing a child or an adult
- If you are a danger to yourself or others
- If you assert that your mental condition is an issue in a claim or defense as part of civil or criminal law proceedings
- If your assessment and/or treatment is court ordered
- If you seek reimbursement for the cost of your therapy from an HMO, managed care, or insurance company. Your direction that such information be provided does not constitute a waiver of your privilege and your therapist will continue to protect that privilege after providing information to an HMO, managed care, or insurance company. *Your therapist cannot, however, control how such information may be treated by an HMO, managed care, or insurance company. The waiver you sign with your insurance company may make your records available to case management, utilization review, and other entities which request your records, such as life insurance companies.*
- In proceedings to assist you with entering a hospital for emotional and/or chemical dependency treatment when you and/or therapist in the course of diagnosis or treatment, determine that you are in need of hospitalization.
- If one’s account becomes delinquent for more than 60 days, collection proceedings may be initiated and confidential information may be disclosed during this process.

**CLIENT RESPONSIBILITIES** -- \*Please read carefully and initial each statement.\*

\_\_\_\_\_ 1. *You are responsible for rendering payment at the time of service.* We accept cash or one of the following credit cards: Visa, Mastercard, Discover, Diner's Club, JCB, or American Express.

\_\_\_\_\_ 2. Balances due older than 30 days can be subject to additional collection fees and interest charges of 1.5% per month.

\_\_\_\_\_ 3. Peak View Psychology will submit claims to your insurance company on your behalf. Please be aware that it is still your responsibility to verify benefits and obtain pre-authorization for services, if necessary. ***If your insurance does not make prompt payment—for any reason—you will be responsible for the charges.***

\_\_\_\_\_ 4. It is your responsibility to respect the confidentiality of others. We must request that you NEVER discuss the presence of any other client you may meet or see at our office.

\_\_\_\_\_ 5. ***If you need to reschedule an appointment, it is your responsibility to contact our office at least 24 hours in advance. Late cancellations and/or failure to keep your appointment will be billed at \$125 per session. If you need to make changes to a Monday appointment, changes need to be made by the previous Friday. These fees are not paid by your insurance company.***

\_\_\_\_\_ 6. You are welcome to email your therapist, but please be aware that email communications cannot be considered confidential. Therapy will not be conducted via email although you are welcome to ask routine questions or handle administrative issues like appointment changes by email.

\_\_\_\_\_ 7. Although you have the right to terminate counseling at any time, we strongly recommend that a termination appointment be scheduled before you conclude therapy. It is advantageous to both you and your therapist to have a sense of closure regarding your treatment.

*I have read and understand the limits to confidentiality and my responsibilities as a client of Peak View Psychology. I have discussed any questions or concerns about these policies and procedures with my therapist and will do my best to adhere to the policies presented above.*

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date



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## Background Interview

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Consultation: \_\_\_\_\_

Ethnic Identity: \_\_\_\_\_ Gender: Male Female

The following information will provide us with important information about your current struggles and the sources of your concerns. It will help us get to know you and will be kept strictly confidential.

What are your primary concerns or complaints?

What is the history of this concern? How long have you struggled with this problem and what were the events that led up to it?

What makes you want to seek treatment now?

Have you had any previous psychological help?

Any drug or alcohol use? How long have you been using and what substances do you use? Have you had any negative effects from your use?

How is your sleep generally? When do you go to bed? How long does it take you to fall asleep? When do you get up out of bed? Do you sleep through the night? Do you have nightmares? Do you nap during the day?

How is your appetite generally? Have you gained weight or lost weight recently? Have you purposely been trying to lose or gain weight? Do you feel you have an eating disorder? Do you feel you eat a healthy diet?

Have you ever had or are you having thoughts of hurting yourself or others, or killing yourself or others? Have you been hospitalized in the past for suicidal thoughts or attempts? Have you been hospitalized in the past for homicidal thoughts or attempts?

Have you ever heard or seen things that others didn't hear or see?

Do you have any history of trauma, abuse, or violence? Please describe that history briefly.

Do you think you have any self-destructive or troubling behaviors? Have others told you that you have self-destructive or troubling behaviors? Please describe those behaviors.

How would you describe your typical feelings or emotions? Do you feel you have good control over your feelings and emotions? How do you typically feel on a day to day basis? What are some of your emotional triggers that can get you upset?

What kinds of thoughts do you have? What do you tell yourself? Do you feel you tell yourself good things about yourself? Do you feel you tell yourself negative things about yourself? Are you able to catch any negative thoughts and replace them with positive ones?

How are your interpersonal interactions or social relationships with coworkers, significant others, family, etc.? How would others describe your interactions with them? Have you had long term relationships? Do you feel that your relationships are strained?

Do you have any medical problems or concerns? Please list any significant medical issues that you have received treatment for that might affect your mental health. Do you have chronic pain? Do you have physical limitations?

What is your family like? How was your childhood? Do you feel that there are any issues from childhood that are affecting you today? Do you and your significant others get along well? Is there discord in your relationships?

Where do you work? What do you do at work? What has your work history been like?

What medications are you taking, what are the dosages and who prescribes them for you?





CONSENT FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Provider information requested between:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dawn M. Kugler, PhD  
Office located at:  
AND Peak View Psychology, LLC  
6745 Rangewood Drive, Suite 105  
Colorado Springs, CO 80918  
(719) 268-0099, Fax: (719) 268-0097

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Other Names: \_\_\_\_\_

Dates of Treatment From: \_\_\_\_\_ To: \_\_\_\_\_

I, \_\_\_\_\_, authorize Peak View Psychology, LLC to release and/or receive records to/from the service provider named above.

For the Purpose of: \_\_\_\_\_

SPECIFIC INFORMATION TO BE DISCLOSED:

- |  |   |
|--|---|
| <input type="checkbox"/> Intake Summaries                          | <input type="checkbox"/> Substance Abuse Evaluation   |
| <input type="checkbox"/> Treatment Plans                           | <input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus) |
| <input type="checkbox"/> Psychological Evaluation Results          | <input type="checkbox"/> Academic Records   |
| <input type="checkbox"/> Psychiatric Evaluation and Notes          | <input type="checkbox"/> Therapy Notes  |
| <input type="checkbox"/> Diagnosis Only                            |   |
| <input type="checkbox"/> Medication Information Only               |   |
| <input type="checkbox"/> Psychiatric Medication Management Records |   |
| <input type="checkbox"/> Other _____                               |   |
| <input type="checkbox"/> All of the Above                          |   |

I have been informed of specific information requested and the benefits and disadvantages of releasing information. I give my consent freely and voluntarily. Treatment services are not contingent upon whether this information is released or not.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without expressed written consent is prohibited.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_

\_\_\_\_\_  
(Witness) (Title of Witness) (Date)

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Home Telephone</b> _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number      | <input type="checkbox"/> <b>Written Communication</b><br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> <b>Work Telephone</b> _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only |   |
| <input type="checkbox"/> <b>Other</b> _____   |   |

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client and Relationship to Client

\_\_\_\_\_  
Birth Date

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

### Record of Disclosures of Protected Health Information

Date	Disclosed to Whom: Address or Fax Number	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed (Initial)	(2)	(3)

- (1) Check this box if the disclosure is authorized  
 (2) Type Key: T = Treatment Records, P = Payment Information, O = Health Care Operations, A = Authorization on File, D = Discretionary  
 (3) Enter how disclosure was made: F = Fax, E = Email, M = Mail, O = Other