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_____

☐ELF, FAMILY, FRIEND ☐PHYSICIAN ☐HS ☐TTORNEY

☐ELLOW PAGES ☐OURTS ☐DS ☐THER_____

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

Carrier_____

Policyholder_____Relationship_____

Policyholder's DOB_____

Policyholder's SS#_____

SECONDARY INSURANCE

Carrier_____

Policyholder_____Relationship_____

Policyholder's DOB_____

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 a / do no ee (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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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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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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CHILDHOOD AND FAMILY HISTORY FORM

Name: _____ Date: _____
Birth Date: _____ Sex: ___F ___M Age: _____ Grade: _____

Why are you seeking help for this child?

Mother's name: _____ Home Phone: _____
Father's name: _____ Work Phone: _____
Address:

(Check if applicable for parents): ___ Single ___ Separated ___ Divorced
Age of above child at time of divorce/separation _____
Joint Custody? ___ Yes ___ No Legal Custody with _____
Physical Custody with _____

*****Be aware that if the parents do not live together (never married, separated or divorced) and share joint decision making, both parents must complete all paperwork to provide written consent to treatment for your child, or your child cannot be seen.

Please list names of **all** people living in the home
Name, Age, Relationship to Child

Medical History and Child's Background

1. What problems did mother have during pregnancy? (Health, Illnesses, Injuries, Medication)

Was pregnancy full-term? ___Yes ___No How many weeks? ____ C-Section? ___ Forceps? ___
Breech presentation? ___ Birth weight? ___ lbs. ___oz. Apgar score _____

2. Newborn Infant Difficulties (check all that apply)

___ Born with cord around neck
___ Had trouble breathing
___ Turned blue (cyanosis)
___ Needed oxygen
___ Injured during birth
___ Born with a heart defect
___ Born with other defect(s)
___ Was in the hospital more than 7 days

3. Any other problems with labor or delivery?

Health Conditions-Child	Never	0-1 yrs.	2-5 yrs.	6-10 yrs.	11-15 yrs.	16+
Ear infections						
Meningitis						
Seizures or epilepsy						
High fevers (over 103 F or 39 C)						
Head injury						
Trouble with ears or hearing						
Trouble with eyes or seeing						
Surgery						
Hospitalizations						
Heart problems						
Lead poisoning						
Allergies to food						
Allergies to environment						
Anemia						
Poisoning or overdose						
Diabetes (since when)						
Asthma (since when)						
Pneumonia						

4. Child's Physician _____ Telephone _____

Is your child currently on any medication? ☐ No ☐ Yes Please list medication(s) and reason. _____

5. Please give any *important* medical information, injuries, and reasons for hospitalization or surgery:

6. Please share if your child had any prolonged illnesses. If they had to take medication over a long period of time, what was the medication and were there any side effects?:

7. Has your child ever had a neurological exam? ☐ No ☐ Yes If yes, please give information. Neurologist _____ Date _____ Reason _____

8. Do you have any other concerns about your child's health?

_____

Allergies

9. Allergy to medicines? If yes, describe. _____

10. Allergies to foods? If yes, describe. _____

_____

Developmental Milestones: Please list ages at which your child first:

Sat unaided _____, Crawled _____, Walked independently _____,
Spoke single words (other than mama and dada) _____, Talked using 2-3 words _____,
Was toilet trained _____(daytime), Toilet trained _____ (at night)

11. Please list any difficulties or delays that have occurred in your child's infant years:

_____

Functional Conditions in Early Life (check all that apply to show when condition began or existed)	Never	0-1 yrs.	2-5 yrs.	6-10 yrs.
Sleeping Problems				
Crying often and easily				
Clingy				
Possessive with parents				
Head Banging				
Thumb sucking				
Nail biting				
Rocks back and forth				
Has tics/twitches				
Accident prone				
Temper Tantrums				
Overactivity—seems to always be moving				
Irritability				
Self-destructive behavior				
Extreme reactions to noise or sudden movement				
Tactile sensitivity (bothered by tags or other materials)				
Tendency to make odd sounds, grunts or snorts				
Tendency to twitch or jerk arms or head				
Trouble getting along with peers				
Trouble listening to authority and following rules				
Seems to zone out				
Low self image or esteem (negative self-talk)				
Eating difficulties				
Eats odd things (non-nutritive)				
Wetting or soiling problems				

Coordination	Good	Average	Poor
Walking			
Running			
Balancing			
Throwing			
Catching			
Shoelace tying			
Buttoning			

Temperament

Please indicate whether your child exhibits any of the following behaviors:

Is easily overstimulated in play	☐	No	Yes _____
Seems overly energetic in play	☐	No	Yes _____
Has a short attention span	☐	No	Yes _____
Seems impulsive	☐	No	Yes _____
Lacks self-control	☐	No	Yes _____
Overreacts to problems	☐	No	Yes _____
Seems unhappy most of the time	☐	No	Yes _____
Withholds affection	☐	No	Yes _____
Uncomfortable meeting new people	☐	No	Yes _____
Hides feelings	☐	No	Yes _____
Has trouble with changes	☐	No	Yes _____
Cannot calm down	☐	No	Yes _____
Requires lots of attention	☐	No	Yes _____
Has fears	☐	No	Yes _____

12. What does your child do when he/she is stressed, angry, or frustrated?

13. How does your child express his/her sadness?

Behavioral Symptoms – Attention/Inattention (check all that currently apply)	Not at All	Just a Little	Quite a Bit	Very Much
Fails to give close attention to details, makes careless mistakes				
Has difficulty maintaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish work				
Has difficulty organizing tasks and activities				
Avoids or reluctantly engages in tasks requiring sustained mental effort				
Loses things necessary for activities				
Is distracted by things around him/her				
Is forgetful in daily activities				
Difficulty maintaining alertness, listening to requests, executing decisions				
Fidgets with hands or feet or squirms in seat				
Leaves seat in classroom in which remaining seated is expected				
Runs about or climbs excessively in situations when it is inappropriate				
Has difficulty playing or engaging in activities quietly				
Is "on the go" or often acts as if "driven by a motor"				
Talks excessively				
Blurts out answers before questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others				
Has difficulty sitting still, being quiet or resisting impulses				
Seems to look around or stare a lot, daydreams				

Behavioral Symptoms (additional)	Not at All	Just a Little	Quite a Bit	Very Much
Depressed mood or irritable mood most of the day				
Persistent fear of social or performance situations				
Decrease in pleasure in activities (things are less fun)				
Excessive fear of specific objects or situations				
Decrease or an increase in appetite				
Excessive or persistent worry about a parent or caregiver				
Difficulty sleeping or seems to sleep a lot				
Reluctance or refusal to go to school				
Fatigue or loss of energy (tires easily or seems tired often)				
Excessive need for reassurance				
Feelings of worthlessness, down on himself/herself				
Concerns about their competence or ability				
Loss of ability to concentrate				
Inability to relax				
Reluctance to be alone, wants parent or caregiver around				
Complains of aches and pains				
Feels hopeless, may wish he/she was dead				
Unusual fears or aversions				

School Concerns and Relationships

14. Did your child attend a preschool/nursery school? If yes, were there any difficulties with your child's behavior? Please share briefly:

15. Has your child experienced learning or academic problems? ☐ Yes ☐ No If yes, please describe:

16. Was your child ever retained? If yes, what grade?

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17. Does your child have difficulty with doing homework/daily work, taking tests, etc.?

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18. Has your child ever been evaluated/tested? ☐ Yes ☐ No If so, when and where?

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19. Have special education services been provided in the past? ☐ Yes ☐ No If yes, describe:

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20. Describe any *academic* problems reported by teachers:

21. Describe any *behavior* problems reported by teachers:

Early Educational Experience	Did Well	Some Problems	Serious Problems	Cannot Say
Learning to read in 1st, 2nd grade				
Reading level in 3rd – 6th grade				
Learning to spell in 1st, 2nd grade				
Spelling in 3rd – 6th grade				
Spelling in 4th – 6th grade				
Learning mathematics 1st – 3rd grade				
Learning mathematics 4th – 6th grade				
Writing words and sentences				
Understanding spoken directions				
Understanding written directions				
Getting homework done in school				
Paying attention in the classroom				
Getting along with other children				
Poor memory				

Communication – Speech

22. Does your child have any *speech or language* problems? ☐ Yes ☐ No If yes, when was the problem first noticed? ☐ ☐ Have there been any previous speech/language services? ☐ Yes ☐ No If yes, when and where?

23. Are there any other concerns or relevant information <u>in relation to school</u> that you wish to share and would assist us in meeting your child's needs?

Family History/Health

Concern	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)	Others: (specify)
Alcohol/Drug difficulties					
Nervousness					
Seizures or Epilepsy					
Tourette's Syndrome					
Migraine headaches					
Depression					
Anxiety or nervousness					
Emotional disturbance					
Behavior disorder					
Mood Disorder					
Reading problems					
Math problems					
Learning disability					
Speech difficulties					
Hyperactive					
Attention difficulties					

24. Are there any other family concerns or information <u>in relation to your family</u> that you wish to share and may assist us in meeting your child's needs?

Home Behavior

25. Types of discipline you use with your child?

26. What form of discipline do you find to be most effective?

27. What are your child's main hobbies and interests?

28. What does your child enjoy doing the most?

29. What do you see as your child's strengths, abilities, talents?

Other Professionals

30. Has your child ever had psychological counseling or therapy? ☐ No ☐ Yes
Counselor's name _____
Reason for counseling _____

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

Child Intake Interview

Child's Name: _____ Date of Birth: _____

Date of Consultation: _____ Child's 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 regarding your child? What do you think needs to change first?

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

What makes you want to seek treatment for your child now?

Has your child had any previous psychological help?

Has your child ever used alcohol or drugs? How long have they been using and what substances do they use? Have you noticed any negative effects from their use?

How is their sleep generally? When do they typically go to bed? Do you have difficulties getting them to go to sleep? Do they sleep through the night? Do they have nightmares or night terrors? What time do they typically wake up in the morning? Do they tend to wake up happy, rested and ready to go? Are they slow to wake up? Do they take naps during the day?

How is their appetite generally? Have they recently gained or lost weight? Do they seem to be concerned about their body image? Do they eat non-food items? Do they eat a balanced diet? Do they have food texture issues? Would you describe them to be a picky eater?

Have they ever had or are they having thoughts of hurting themselves or others, or killing themselves or others? Have they ever been hospitalized for any of these reasons?

Do they ever complain of hearing or seeing things you cannot hear or see?

Do they have any history of trauma, abuse, or violence? Include witnessing any violence.

Do you think they have any self-destructive or troubling behaviors? Would your child agree that they have self-destructive or troubling behaviors? Which of their behaviors are of greatest concern for you?

How would you describe their typical feelings or emotions? On a day to day basis, how would you describe their mood? What things can change their mood? When things don't go their way, how do they handle it? Would you say that you feel that they get stuck emotionally when upset?

What kinds of thoughts do you think they have? Do they seem to feel good about themselves and say positive things? Do you feel that there are negative thoughts? Do you feel that they can bounce back from adversity?

How are their interpersonal interactions or social relationships with friends, classmates, neighbors, family? Do you have concerns about their ability to make and maintain friendships? Do you have concerns about them being a bully? Do you have concern that they bully others? Do you have any concerns about sibling relationships?

Do they have any medical problems or concerns? Have they been receiving treatment for any medical conditions?

Are there any concerns about their prenatal health or postnatal development?

What is the family like? What has their childhood been like thus far? How does everyone get along? How do your child's difficulties affect the family?

How is their academic and cognitive performance in school? What are their behaviors like at school?

What medications does your child take, what are the dosages and who prescribes them?

Peak View Psychology, LLC

CONSENT FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Provider information requested between:

_____

_____

_____

_____

AND

Dawn M. Kugler, PhD
Office located at:
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:

- ☐ Intake Summaries
- ☐ Treatment Plans
- ☐ Psychological Evaluation Results
- ☐ Psychiatric Evaluation and Notes
- ☐ Diagnosis Only
- ☐ Medication Information Only
- ☐ Psychiatric Medication Management Records
- ☐ Other _____
- ☐ All of the Above
- ☐ Substance Abuse Evaluation
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)
- ☐ Academic Records
- ☐ Therapy Notes

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):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number_____

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

_____ _____
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