Peak View Psychology, LLC

Dawn M. Kugler, PhD

5373 North Union Blvd, Suite 101
Colorado Springs, CO 80918-2073
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

5373 N. Union Blvd, Ste 101

Colorado Springs, CO 80918-2073

719-268-0099

When you enter the building, the waiting area is in the hallway on the north end of the lobby. Please do not knock on the door. Have a seat on the couches. Dr. Kugler will come out to get you when she is ready.

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 and Street Apt # City State Zip Code

PHONE Home (_____) _____ Work (_____) _____ Cell (_____) _____ **EMAIL ADDRESS** _____

Others we may contact for scheduling Name _____ Relationship_____ Phone _____

MARITAL STATUS (circle one) N/A – Child ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SEX M ☐ **F** ☐ **OTHER IDENTITY** _____ **BIRTHDATE** _____ **SOCIAL SECURITY NUMBER** _____

REFERRED BY _____ **PRIMARY PHYSICIAN** _____ **PHONE** _____ **FAX** _____

PLEASE LIST PAST THERAPY/TREATMENT/EVALUATIONS (Who did you see and what were the approx. dates?)

_____

EMPLOYER _____ **OCCUPATION** _____

EMPLOYER ADDRESS _____ **WORK PHONE** _____

SPOUSE'S NAME _____ **SPOUSE'S BIRTHDATE** _____ **SPOUSE'S 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-PARENT (if any)**_____

FATHER'S ADDRESS _____ **CELL PHONE** _____

EMPLOYER _____ **WORK PHONE** _____ **OCCUPATION** _____

NAME OF MOTHER _____ **DOB** _____ **STEP-PARENT (if any)**_____

MOTHER'S ADDRESS _____ **CELL PHONE** _____

EMPLOYER _____ **WORK PHONE** _____ **_OCCUPATION** _____

CHILD'S SCHOOL _____ **GRADE** _____ **SCHOOL CONTACT PERSON** _____

OTHER PEOPLE LIVING IN THE HOME(S)

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

PRIMARY INSURANCE **SECONDARY INSURANCE**

Carrier _____ **Carrier** _____

Policy Holder _____ **Relationship** _____ **Policy Holder** _____ **Relationship** _____

Policy Holder's DOB and SSAN _____ **Policy Holder's DOB and SSAN** _____

Policy Number _____ **Group Number** _____ **Policy Number** _____ **Group Number** _____

PLEASE FILL IN COMPLETELY AS 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 canceled at least 24 hours in advance, as you may otherwise be billed sfor missed or late canceled appointments.

_____ Initial here to acknowledge that you've been made aware of this policy.

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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 benefitting 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 insure 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 no 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 have 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. 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 Parent's Parent or Guardian **Date**

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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.

1. 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 f 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 related 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.

2. Uses and Disclosures Requiring Authorization

We may use of 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 sked 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 Treatment Notes. "Psychotherapy Treatment 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 Treatment 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.

3. 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 of 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.

4. 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 PHE 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 your for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstance, but in some cases you may have this decision reviews. On your request, we will discuss with you the details of the request and denial process.

4. Patient's Rights and Psychologist's Duties

Patient's Rights: (continued)

- **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 this 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.

5. 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, CO 80202
(303) 894-7800
https://www.doradls.state.co.us/alison.php

You may also send a written complain 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

Clients 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 of 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 law protecting confidentiality do not apply.
- There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Revised Statues (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 person. Other exceptions will be identified to you as the situations arise during therapy.

Clients Rights and Important Information: (Continued)

- 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 the 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 maters 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 1,000 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 masters 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 that you have been given this information verbally.

_____ _____
Client Signature (printed name) Date

_____ _____
Authorized Signature if Child is a Minor (printed name) Date

_____
Minor Child's Name (your relationship to child)

_____ _____
Psychologist 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. It is important that you use https://sendsafely.com/u/drdawn.kugler@peakviewpsychology.com to send information to ensure that it is encrypted. Dr. Kugler does not conduct therapy via email. Please restrict email use to administrative issues such as changing appointment times, and be aware that any therapeutic content in emails will be retained in your permanent medical record.

Social Networking Sites – I do no accept friend requests from current or former clients on social networking sites. I believe that adding clients as friends can compromise confidentiality and blur the boundaries of our therapeutic relationship. If you have questions about this, please feel free to bring them up with me in session.

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

FEES – Peak View Psychology's fee schedule is as follows:

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)
Court Testimony Services - $300 per hour PAID IN ADVANCE WITH A GOOD FAITH ESTIMATE This includes testimony time, commuting, records, review, and affidavit writing will be billed at this rate.

Legally, I 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 me to provide services, please provide me with appropriate documentation and I 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 me at 719-268-0099.

CONFIDENTIALITY – The communication between you and your psychologist is confidential. This means you have the privilege to refuse to disclose and to prevent your psychologist 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 a 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 psychologist will continue to protect that privilege after providing information to an HMO, managed care or insurance company. **Your psychologist 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 psychologist 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.** I 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. I must request that you NEVER discuss the presence of any other client you may meet or see at my office.

_____ 5. **If you need to reschedule an appointment, it is your responsibility to contact my office at least 24 hours in advance. Late cancelations 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 make by the previous Friday. These fees are not paid by your insurance company.**

_____ 6. You are welcome to email me, but to ensure encryption of email, you must use the send safely link https://sendsafely.com/u/drdawn.kugler@peakviewpsychology.com. Therapy will not be conducted via email.

_____ 7. Although you have the right to terminate therapy at any time, I strongly recommend that a termination appointment be scheduled before you conclude therapy. It is advantageous to both you and to me to haves 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

_____ _____

Psychologist Signature Date

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CHILDHOOD AND FAMILY HISTORY FORM

Child's Name: _____ Date: _____
Birthdate: _____ Sex ☐ M ☐ F ☐ other Age: _____ Grade ____

What brings you to my office regarding this child?

Parents' Names: _____
Phone number(s): _____
Email address(es): _____
Home address :

Check if applicable for parents: ☐ Single ☐ Separated ☐ Divorced
Age of child at time of separation/divorce: _____
Joint Custody? ☐ Yes ☐ No If no, legal decision making for whom: _____
Parenting time arrangement: _____

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

Please list name of **all** persons living in the home including name, age and relationship to the child

Medical History and Child's Background

1. What problems did the mother have during pregnancy? (Health, illnesses, Injuries and Medications)

Was the pregnancy full-term? ☐ Yes ☐ No How many weeks of pregnancy? _____ C-Section ☐ Forceps ☐ Breech presentation ☐ Birth weight _____ lbs _____ oz Apgar score birth [ ] 5 min [ ]

2. Newborn Infant difficulties (please check all that apply)

☐ cord around neck ☐ born with heart defect ☐ had trouble breathing ☐ birth defects ☐ turned blue (cyanosis) ☐ needed oxygen ☐ injured during birth ☐ was in the hospital more than 7 days

3. Any other problems with labor or delivery?

Health Conditions for the Child	Never	0-1yrs	2-5yrs	6-10yrs	11-15 yrs	16+yrs
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	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐	☐

4. Child's Physician: _____ Telephone: _____

Is your child currently on any medications? ☐ No ☐ Yes If yes, please list any medications and reason your child is taking them _____

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

6. Please share if your child has had any prolonged illnesses. If he/she 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 examination? ☐ No ☐ Yes If yes, please list the following information: Neurologist Name _____ Date _____ Reason for the examination:

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

Allergies

9. Allergies to medications? If yes, please describe

10. Allergies to foods? If yes, please describe

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

Sat Unaided_____ Crawled _____ Walked independently _____
Spoke single words (other than mama or dada) _____ Spoke using 2-3 words together _____
Was toilet trained for daytime _____ for nighttime _____

11. Please list any difficulties or delays that have occurred in your child's first few years of life:

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 be always moving	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Self-Destructive Behavior	☐	☐	☐	☐
Extreme Reactions to noise or sudden movements	☐	☐	☐	☐
Tactile Sensititivity (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 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	☐	☐	☐	☐
Has 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 his/her 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) (check all that currently apply)	**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	☐	☐	☐	☐
Reluctance or refusal to go to school	☐	☐	☐	☐
Difficulty sleeping or sleeps a lot	☐	☐	☐	☐
Fatigue or loss of energy (tires easily or seems tired more often)	☐	☐	☐	☐
Excessive need for reassurance	☐	☐	☐	☐
Feelings of worthlessness, down on himself/herself	☐	☐	☐	☐
Concerns about their competence or abilities	☐	☐	☐	☐
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? ☐ No ☐ Yes If yes, please describe:

16. Has your child ever been retained in school? If yes, what grade and for what reason?

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

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

19. Have special education services been provided for your child? ☐ No ☐ Yes If yes, please describe:

20. Please describe any academic problems reported by teachers:

Early Educational Experience	Did Well	Some Problems	Serious Problems	Cannot Say
Learning to read In Kindergarten, 1st and 2nd grade	☐	☐	☐	☐
Reading level in 3rd to 6th grade	☐	☐	☐	☐
Learning to spell in Kindergarten, 1st and 2nd grade	☐	☐	☐	☐
Spelling in 3rd to 4th grade	☐	☐	☐	☐
Spelling in 5th to 6th grade	☐	☐	☐	☐
Learning mathematics in Kindergarten to 3rd grade	☐	☐	☐	☐
Learning mathematics in 4th to 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? ☐ No ☐ Yes If yes, when was the problem first noticed?

Have there been any previous speech/language services? ☐ No ☐ Yes If yes, where and when?

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

Family History/Health

Concern	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)	Other Family
Alcohol/Drug Difficulties	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐
Seizures or Epilepsy	☐	☐	☐	☐	☐
Tourette's Syndrome	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Emotional Disturbance	☐	☐	☐	☐	☐
Behavior Disorder	☐	☐	☐	☐	☐
Mood Disorder	☐	☐	☐	☐	☐
Reading Problems	☐	☐	☐	☐	☐
Math Problems	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐
Speech Difficulties	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Attention Difficulties	☐	☐	☐	☐	☐

24. Are there any other family concerns or information related to your family that you wish to share and may assist me in meeting your child's needs?

Home Behavior

25. Types of discipline you use with your child?

26. What type of discipline do you find 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 and interests?

Other Professionals

30. Has your child had previous psychological counseling or therapy? ☐ No ☐ Yes

Therapist's name and contact information

Reason for Therapy

Peak View Psychology, LLC

Dawn M. Kugler, PhD

5373 North Union Blvd, Suite 101
Colorado Springs, CO 80918-2073
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:

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

What are your primary concerns or complains regarding your child? What do you think needs to change first?

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

What makes you seek treatment for your child at this time?

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? Do they sleep through the night? 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 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?

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

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

Do they have a history of trauma, abuse or violence? Have they ever witnessed violence?

Do you think your child has 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 your child's 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 your child has? 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 your child's interpersonal interactions or social relationships with friends, classmates, neighbors and family members? Do you have concerns about their ability to make and maintain friendships? Do you have concerns about your child being a bullied? Do you have concerns that they bully others? Do you have any concerns about sibling relationships?

Does your child have any medical problems or concerns? Has your child been receiving treatment for any medical conditions?

Are there concerns about prenatal or postnatal development?

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

How is your child's academic and cognitive performance at 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:

_____

_____

_____

Telephone _____ Fax _____

AND

Dawn M. Kugler, PhD
Office located at:
Peak View Psychology, LLC
5373 N. Union Blvd, Suite 101
Colorado Springs, CO 80918-2073
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
- ☐ Diagnosis Only
- ☐ Medication Information Only
- ☐ Psychiatric Medication Management Records
- ☐ Other _____
- ☐ All of the Above
- ☐ Substance Abuse Evaluation
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- ☐ Academic Records

I have been informed of the 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)

Peak View Psychology, LLC

Dawn M. Kugler, PhD

5373 North Union Blvd, Suite 101
Colorado Springs, CO 80918-2073
Phone (719) 268-0099 Fax (719) 268-0097
Email drdawn.kugler@peakviewpsychology.com

January 15, 2023

At this time, Dr. Dawn Kugler will be available to have appointments via the Zoom application. The Zoom application is HIPAA compliant. There is a dedicated waiting room for you to join at your appointment time. The Zoom appointments are password protected. Dr. Kugler is the only person who can admit you to your session.

You agree that there will be no video/audio recording of sessions on your end and Dr. Kugler agrees to the same. Video/audio recordings require additional written authorization.

Dr. Kugler's billing system sends out automated reminders to your cell phone and/or email address. That reminder will give you the link and password to your appointment. Those reminders are sent out multiple times prior to your appointment.

Should there be a technology interruption, Dr. Kugler will attempt to call you to troubleshoot. Depending on how much of the session has taken place at that time, the appointment might be ended for the day or rescheduled to a mutually convenient time. It is possible that the session might be completed over the telephone.

Should there be a true emergency situation, Dr. Kugler will work with you to do a face to face assessment. Going to a local emergency room or calling 911 is always an acceptable option if you are having a mental health crisis.

By signing this page, you are agreeing to the above listed conditions for appointments via the Zoom application.

_____
Printed name

_____
Signature

_____
Date

_____
Dawn M. Kugler, PhD Date

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

· Your insurer will pay out-of-network providers and facilities directly.

· Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

· Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

· No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.