



# KERRY STUTZMAN, MSW

Marriage and Family Therapist

3600 S. YOSEMITE STREET SUITE 1050 DENVER, COLORADO 80237

## CLIENT INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_

Child's Name (if client) \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

*Please circle the phone # where messages can be left.*

E-mail \_\_\_\_\_ OK to send general email messages? Yes No

How did you find me? \_\_\_\_\_

May I acknowledge the person doing the referring? Yes No

If yes, please enter name of referring person/agency \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Religious affiliation \_\_\_\_\_

Level of involvement: High Medium Low

Relationship Status: Single Married Separated Divorced Widowed Coupled

Name of spouse or partner \_\_\_\_\_ Phone \_\_\_\_\_

Immediate family members (who live with you):

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever consulted a therapist or parent coach before? Yes No

If yes, when? \_\_\_\_\_ For how long? \_\_\_\_\_

Briefly state the reasons you sought counseling in the past. \_\_\_\_\_

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Do you think that, either now or in the past you have had an addiction to anything? Yes No

If yes, what? \_\_\_\_\_

Have you ever seriously considered or attempted suicide? Yes No

If yes, when? \_\_\_\_\_

Are you now taking any medications? Yes No

If yes, please list medications, dosages, and for what problem.

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Please describe any current or past experiences with abuse (physical, emotional, sexual).

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Any major medical issues affecting your current mental health? Yes No

If yes, please describe. \_\_\_\_\_

Your Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Briefly describe why you are seeking counseling now. \_\_\_\_\_

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In Case of Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## **SERVICE AGREEMENT AND FEE POLICY**

### **Appointments**

Your appointment is reserved for you, and I will make every effort to start and end your appointment on time. Since I am unable to fill a canceled or missed appointment on short notice, it is important to notify me at least 24 hours in advance if you must cancel or reschedule. The charge for an appointment canceled with less than 24 hours notice is full fee, and a full fee will be charged for any session missed without notification. Emergency situations such as bad weather, illness, etc. will be considered, but please discuss it with me to avoid changes.

### **Fees**

\$125 per 50 minute-hour for parent coaching or individual, couple or family therapy.

Any phone call over 10 minutes will be charged pro-rata.

\$75 per page for report writing. \$75 per hour for drive time.

\$175 per hour for court appearances, including travel expenses, lodging and meal reimbursement.

### **Fee Schedule**

A fee will be charged for all other auxiliary services including progress reports, collateral contacts, or any other report or services made at the request of the client. Fees for auxiliary services will be agreed upon prior to commencement of such services.

### **Payment Policy**

Payment is due in full at the completion of each session or any auxiliary service.

The client is responsible for any insurance claims and/or reimbursement.

### **Office Hours**

Office hours are by appointment only. Availability of dates and times for appointments will be discussed with each client. Voicemail is available 24-hours a day.

### **Emergencies**

I am not available on a 24-hour basis. I do not carry a pager. However, I do have voicemail, which can be accessed 24 hours a day. I will return your call at my earliest convenience, usually within one business day. Clients seen in outpatient psychotherapy or parenting consultation are assumed to be responsible for their day-to-day functioning. In the event of a true emergency, notify 911 immediately, and then notify me.

I have read, understand, and agree to the above information and services agreement and have received a copy. Your signature does not bind you to therapy or consultation; however, it does make you responsible for the charges incurred.

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Client Signature

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Date

## DISCLOSURE STATEMENT

### 1. INFORMATION

Kerry Stutzman, LMFT Candidate  
3600 S. Yosemite St. #1050  
Denver, CO 80237  
303-770-4667

### 2. CREDENTIALS

Licensure: Registered Psychotherapist

an unlicensed therapist, you must state: a registered psychotherapist

Degrees: BA, MSW

Professional Experience: Private psychotherapy practice, Parenting Instructor, Co-Founder of Seeking Common Ground.

Certifications: Certificate in Marriage & Family Therapy, Certified Love & Logic Instructor

### 3. REGULATION OF PSYCHOTHERAPISTS

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that 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-doctorial 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 masters degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

### 4. CLIENT RIGHTS AND IMPORTANT INFORMATION

- a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.
- b. You can seek a second opinion from another therapist or terminate therapy at any time.
- c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies or registers the therapist.
- d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.
- e. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

5. DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

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Client Printed Name

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Client Signature or Responsible Party

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Date

If signed by the Responsible Party, identify that party's legal authority to consent to treatment:

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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

Name \_\_\_\_\_ Date \_\_\_\_\_

By signing this form, you acknowledge that this office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

By my signature below I acknowledge that I have received a copy of this office's PRIVACY NOTICE regarding confidential health information, and have been given an opportunity to discuss my concerns and questions.

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Date

Therapist complete below if Acknowledgement of Receipt of Privacy Notice form is not signed.

1. Does the client have a copy of the Privacy Notice? Yes No
2. Please explain why the client (or his / her legal representative) was unable to sign an acknowledgement form and the therapist's efforts in trying to obtain the client's signature:

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

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

\_\_\_\_\_  
Date

## **NOTICE OF PRIVACY PRACTICES**

**This notice describes how medical information (including mental health) about you may be used and disclosed and how you can get access to this information.**

**Please review it carefully.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. You may call at any time to receive a revised copy of the privacy practices.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information Based Upon Your Written Consent**

our protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the therapist’s practice.

Following are examples of the types of uses and disclosures of your protected health care information that the therapist’s office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your signed permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other therapists who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a therapist to whom you have been referred to ensure that the therapist has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another therapist or health care provider (e.g., a specialist or laboratory) who, at the request of your therapist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your therapist.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of counseling students, licensing, and conducting or arranging for other business activities.

For example, we may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected



health information, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your therapist or another therapist in the practice is required by law to treat you and the therapist has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your therapist or another therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the therapist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

### **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made in accordance with state law for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, according to state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking

this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information under law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority

if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your therapist created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

### **You have the right to inspect and copy your protected health information.**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your therapist and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

### **You have the right to request a restriction of your protected health information.**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. You may request a restriction by contacting our office at 303-985-3020.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to have your therapist amend your protected health information.**

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.**

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Contact Kerry Stutzman at 303-770-4667 with any questions or complaints.